The quality of mental health care received by

homeless inpatients

<u>Louise Kathrine Gregor</u>

University of East London School of Psychology

Thesis submitted to University of East London in partial fulfilment of the requirements of

the degree of Professional Doctorate in Clinical Psychology

June 2020

Word count: 29,862

DECLARATION

I declare that this thesis has been composed by myself, and that the work contained herein has not been submitted for any other degree or professional qualification. Except where explicitly stated otherwise in the text, I confirm that the work submitted is my own.

ACKNOWLEDGEMENTS

ABSTRACT

Background: Homeless individuals are among the most vulnerable to mental health difficulties yet their access to, and utilisation of, mental health services are poor. When they do access and utilise services, their mental health needs often remain unmet, suggesting potential issues with the quality of mental health care provided to this population. This thesis aimed to compare the demographic and clinical profiles of homeless and housed service users admitted to hospital for treatment of anxiety and/or depression. It then aimed to examine the quality of care received by homeless and housed service users, including referrals for psychological therapy, and investigate demographic and clinical predictors of referrals of homeless service users for psychological therapy.

Method: A secondary analysis of existing data compared homeless (n=223) and housed (n=3572) service user groups on demographic, clinical and quality of care variables using Pearson Chi-square tests. The demographic and clinical characteristics of homeless service users referred for psychological therapy were compared with those of homeless service users who were not referred. A logistic regression was performed to establish predictors of referral of homeless service users to psychological therapy.

Results: The demographic and clinical profiles of homeless service users differed significantly from those of housed service users. Homeless service users were significantly more likely than housed service users to be male, younger, of ethnic minority background and unemployed. Over half were diagnosed with stress-related disorders (52.2%), more than one third had comorbid substance-related disorders (35.4%), planned admissions were infrequent (4%) and they fared worse than housed service users on nearly all quality of care variables from assessment to post-discharge. Homeless service users (27.8%) were significantly less likely than housed service users (39.7%) to be referred for psychological therapy, though there were no significant differences in the characteristics of homeless service users who were and were not referred. The logistic regression yielded no significant predictive effects of age, gender or primary diagnosis on referral of homeless service users for therapy.

Conclusions: This thesis reviewed the quality of mental health care received by homeless service users from admission to post-discharge. Results underscore that homeless service users fare worse than housed service users across multiple quality of care indicators; such inequality represents a violation of the human right to health. There is a moral obligation for services to meet the needs of this marginalised faction of our communities and to address the health inequalities it faces.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

BAME	Black Asian and Minority Ethnic
BPS	British Psychological Society
CCQI	College Centre for Quality Improvement
CRHT	Crisis Resolution and Home Treatment
CMHT	Community Mental Health Team
EBSCO	Elton B. Stephens Company
ED	Emergency Department
GP	General Practitioner
HQIP	Healthcare Quality Improvement Partnership
IAPT	Improving Access to Psychological Therapies
ICD-10	International Classification of Disease
LGBT	Lesbian, Bisexual, Gay, Transgender
LOS	Length of Stay
NAO	National Audit Office
NHS	Nation Health Service
NICE	National Institute for Health and Care Excellence
NCAAD	National Clinical Audit of Anxiety and Depression
ONS	Office for National Statistics
PTSD	Post-Traumatic Stress Disorder
RCP	Royal College Psychiatrists
S.D	Standard Deviation
SLAM	South London and Maudsley
SMI	Serious Mental Illness
SPSS	Statistical Package for Social Sciences
TTO	To-Take-Out Medication
UK	United Kingdom
WHO	World Health Organisation

THESIS STRUCTURE

This thesis examines the quality of mental health care received by homeless service users admitted to National Health Service (NHS) inpatient services in England for treatment of anxiety and/or depression. Chapter one provides a broad introduction to the issue of homelessness, including the prevalence of homelessness in the United Kingdom (UK), contributing factors, and the impact at the individual and system level. Discussion of the relationship between homelessness and mental health is then provided, considering empirical evidence, theoretical understandings and relevant UK legislation and policy. A review of the literature on secondary mental health care in the homeless population is then provided and the rationale and aims for the present thesis are outlined. Chapter two describes the Royal College of Psychiatrists' (RCP) methodological approach to the National Clinical Audit of Anxiety and Depression (NCAAD; RCP, 2019); the primary audit upon which the present study was based. The method of the present thesis, a secondary analysis of the NCAAD data, is then outlined. Chapter three describes the results of the secondary analysis, in relation to the research questions. Chapter four provides discussion of the main results, which are considered in relation to the current literature on mental health care in the homeless population, along with the clinical implications of these findings. The strengths and limitations of the present thesis are also discussed, avenues for future research are proposed and conclusions are drawn.

RESEARCHER POSITION STATEMENT

The researcher's professional training has been delivered through a critical lens, encouraging critical appreciation of the damaging impact of unequal power structures and social inequalities upon the lives of disadvantaged and disempowered individuals within society. Individuals experiencing homelessness are an epitomised example of the ways in which multiple levels of disadvantage and numerous system failures, including ineffective policy enforcement and disjointed agency working, can give rise to social inequalities and injustices of the most extreme degree. Homeless individuals are among the most vulnerable in society, often experiencing lifelong trauma and disadvantage that results in homelessness. They then continue to experience disempowerment and discrimination by virtue of being homeless. These experiences may equate to psychological distress and the need for support; a need that too often remains unmet. Experiencing first-hand the effect of social inequality on the lives of disadvantaged individuals facing psychological distress, Clinical Psychologists are well positioned to use their relative professional power to advocate for macro-level socio-economic reforms which can significantly improve outcomes for society's most vulnerable members (Harper et al., 2015; McGrath, Griffin & Mundy, 2015).

The research conducted as part of this thesis was informed by a critical realist epistemology whereby that which is observed is not free from interference from subjective factors that influence perception. In other words, critical realism posits that while it is possible to objectively observe the natural world, the complex nature of the social world makes it difficult to apply purely realist philosophies to its' study, and as such it acknowledges and addresses the subjectivity with which social researchers interpret their findings, and encourages critical reflection on, and attention to, the limits of subjective perception (Bhaskar, 2009; 2013). This research endeavours to contribute to current understandings of the state of mental health service provision for the homeless population, and for these understandings to give rise to both improved services and better outcomes for homeless individuals and those who support them.

1. CHAPTER ONE: INTRODUCTION

1.1. Chapter Overview

Mental health difficulties are highly prevalent among the homeless population (Homeless Link, 2014), with both individual and systemic level risk factors widely reported (Bramley & Fitzpatrick, 2018). However, despite widespread acknowledgement of the relationship between mental health and homelessness across academic, healthcare, and political spheres, a policy-provision gap in mental health services continues to exist and the mental health outcomes of homeless individuals remain consequently affected (Homeless Link, 2010). The factors that perpetuate this provision gap and the resultant health inequalities experienced by homeless populations are multifaceted and complex, but must be better understood if this issue is to be addressed. While the health inequalities experienced by homeless individuals can, in part, be explained by the inaccessibility and underutilisation of appropriate mental health services by this population, this explanation does not account for the full picture. Even when homeless individuals do access the correct services, the full depth and breadth of their needs often remain unmet (Homeless Link, 2011). This suggests that the mental health services received by those homeless individuals who do access appropriate support may not be of sufficient quality to address their needs.

To better understand the mental health policy-provision gap, and the resultant health inequalities experienced by homeless populations, this chapter provides a broad introduction to the issue of homelessness in the UK, including its prevalence, contributing factors, and impact. The relationship between homelessness and mental health is then discussed, in consideration of empirical evidence, theoretical understandings and relevant UK legislation and policy. The focus of this chapter is also to provide an extensive review of the literature on mental health service provision to the homeless population. Specifically, the evidence on mental health service accessibility and utilisation are discussed, and research findings on admission, duration of intervention, treatment approaches, discharge and follow up care are addressed. The rationale and aims of the present study are outlined.

1.2. Defining Homelessness

Homelessness is a complex and multifaceted problem encompassing deprivation across a broad array of domains, and as such can be approached from multiple perspectives by a multitude of stakeholders (Somerville, 2013). This presents a challenge to those attempting to define homelessness and contributes to it as an intractable, open-ended 'wicked issue' (Head, 2008). The experience of homelessness has physiological, psychological, social, spiritual, economic, territorial and political consequences, with each arena representing a potential inroad into defining, formulating and intervening (Brown, Keast & Waterhouse, 2013). Attempts to define homelessness have been made by a range of stakeholders, from government bodies and policy-makers, to non-government organisations and health and social care professions. However, these attempts have resulted in a lack of a universally agreed upon definition, which has wide-reaching ramifications for policy-making, research, joined-up service delivery, and the ability of homeless individuals to access essential support services. While it is beyond the scope of this thesis to review the diverse array of existing definitions, acknowledgement of the difficulty in defining homelessness and the implications of this are necessary.

For the purpose of this thesis the definition of homelessness encompasses both 'rough sleepers', as those individuals who are literally roofless and street-dwelling, and the 'hidden homeless', which include those who may be living in temporary accommodation, night shelters or with friends and family (National Audit Office; NAO, 2017). This is in line with English law, which considers an individual to be homeless if they have no accommodation, or it is not reasonable for them to continue to occupy the accommodation they have (NAO, 2017). This can be referred to as 'core homelessness', a concept developed by Crisis and Heriot-Watt University (Bramley, 2017), which focuses on those in the most extreme homeless situations and encompasses: rough sleeping; quasi-rough sleeping such as in cars or tents; squatting, hostel-, refuge- and shelter-dwelling; those in unsuitable temporary accommodation such as Bed & Breakfasts; and sofa surfing. 'Core homelessness' helpfully captures a large range of experiences and enables examination of the broader picture.

1.3. Prevalence of Homelessness in the UK

The aforementioned issues in defining homelessness present many difficulties in estimating its prevalence (Williams, 2010). However, while surveillance and enumeration of this population has proven challenging, the UK government attempts to provide official 'point-in-time' estimates of people sleeping on streets 'on any given night' (Ortiz-Ospina & Roser, 2017). These estimates are either based on active counts conducted on a single night, or on information provided by agencies including outreach workers, police or the voluntary sector. The government also obtains figures from Local Authorities on the levels, types and outcomes of homelessness applications received by councils across England (Homeless Link, 2018a). It is important to note that these figures are a likely underestimation of the true extent of the problem, since they are based only on those in contact with homelessness services; as such these figures may represent 'the tip of the iceberg' with the hidden homeless being a 'difficult to reach' population, and those not using services remaining uncounted (Clarke, 2016).

1.3.1. Rough Sleeping

In the six-year period from 2010 to 2017 figures on rough sleeping more than doubled, with an estimated 4,751 people sleeping rough on any given night in 2017 (Ministry of Housing, Communities & Local Government, 2019a). In 2018, the official rough sleeping total was 165 % higher than in 2010 (Fitzpatrick et al., 2019). In the same period, one in five hostel bed spaces for single homeless people have been lost (Homeless Link, 2018b). However, "rough sleeping is at the extreme and visible end of homelessness" (Aldridge, 2019, pp.1).

1.3.2. Hidden Homelessness

In a survey of single homeless people Reeve and Batty (2011) found that 62% of respondents were hidden homeless on the night they were surveyed, staying in squats or sofa surfing with no statutory entitlement to housing, and 92% reported experience of hidden homelessness in the past. However, establishing the true prevalence of hidden homelessness is challenging, since these individuals are rarely in contact with services, often not 'visible'.

1.3.3. <u>Statutory Homelessness</u>

Statutory homelessness refers to individuals who have approached their Local Authority for homelessness assistance. The number of households that have been accepted as statutory homeless and been placed into temporary accommodation by their Local Authority has increased by 60% under the government's austerity programme (NAO, 2017). By mid-2018, 85,000 homeless households, equating to over 200,000 individuals, were in temporary accommodation; a 260% increase between 2010 and 2017 (Fitzpatrick et al., 2019). As homelessness increases and the number of social lettings decreases, Local Authorities are placed under increasing pressure.

1.3.4. <u>Core Homelessness</u>

As previously mentioned, 'core homelessness' (Bramley, 2017) attempts to capture the broadest range of experiences from rough sleeping and squatting to occupying temporary accommodation and sofa surfing. In the period between 2010 and 2017, the number of people experiencing core homelessness in England on any given night rose from 120,000 to 153,000, representing a 28% increase (Fitzpatrick et al., 2019). Funding restrictions during this time reduced hostel capacity by 20%, and rough sleeping increased consequentially (Fitzpatrick et al., 2019). Sofa surfing continues to be the largest category of core homelessness, growing by 26% between 2010 and 2017 (Fitzpatrick et al., 2019).

1.4. Demographic Profile of the UK Homeless Population

In the UK, homelessness tends to affect younger age groups, with the majority of the homeless population aged between 25 to 49 years (Office for National Statistics; ONS, 2019), though low average life expectancy among the homeless population may account for this trend (ONS, 2018). Homelessness is also a male dominated issue, with 80% of hostel and day-centre users being men (Homeless Link, 2013). Reasons for becoming homeless are typically gendered, with males typically citing loss of employment, institutional discharge, mental health difficulties, and substance misuse problems as their route into homelessness, and with females tending to report interpersonal conflict and loss of social support as the primary catalyst (Tessler, Rosenheck & Gamache, 2001).

While the UK homeless population is a White majority, it has a higher proportion of people from Black, Asian and Minority Ethnic (BAME) groups than the general population (Ministry of Housing, Communities and Local Government, 2019b). The Race Disparity Audit (Cabinet Office, 2017) revealed that one in three homeless households are BAME, compared to around one in seven households in the general population not affected by homelessness. The audit also found that between 2013 and 2017 there was a 22% increase in statutory homelessness; among White households statutory homelessness rose by 9% compared with BAME households, where it rose by 48%. This highlights systematic racial disadvantage and discrimination in the UK housing system. That homelessness disproportionately affects people from BAME backgrounds perhaps reflects the ways in which the intersectionality of multiple characteristics leads to discrimination and disadvantage (Lurie, Schuster & Rankin, 2015).

The picture regarding employment in the UK's homeless population is complex. For homeless households in temporary accommodation, some 55% remain in employment (Shelter, 2018). However, according to the 2015 report 'Supporting homeless people into work', just 7% of the people in contact with charity St Mungo's Broadway, are in employment (Employment Related Services Association, 2015). Homeless people face many barriers to securing, maintaining, and generating significant earnings from employment including often transient or chaotic lifestyle, which can be complicated by disability associated with mental and physical health issues (Zuvekas & Hill, 2000).

1.5.   Pathways to Homelessness in the UK

Tessler and colleagues (2001) proposed there to be three interrelated pathways to homelessness. The first, termed 'social selection', involves mental health difficulties or substance misuse resulting in an individual's reduced capacity to live independently. The second pathway, 'social adversity', involves socioeconomic events such as loss of employment resulting in financial deficits and loss of accommodation. 'Traumatic experiences', such as domestic violence, are the third hypothesised pathway to homelessness, which result in the individual experiencing difficulty to sustain social roles and support systems.

While these pathways may be helpful to conceptualise some of the experiences that homeless people may encounter, they tend to locate the problem within the person experiencing homelessness and fail to account for the systemic factors involved.

In a well-intentioned effort to avoid 'othering' disadvantaged individuals, it is often argued that homelessness 'can happen to anyone' (Marsh, 2016). However, while the causes are indeed broad, such statements imply that homelessness is randomly distributed across the population and thus can serve to "distract from the reality of a profoundly unequal set of risks, and potentially disguise deeper structural, and other causes that may be identifiable, and possibly also preventable, should the political will be found" (Bramley & Fitzpatrick, 2018; pp 97). Typically, it has been conventional to attribute homelessness to either systemic or individual explanations (Benjaminsen & Bastholm-Andrade, 2015; Johnson, Scutella, Tseng & Wood, 2015), though an integrated account may be preferred. While it is beyond the scope of this thesis to provide an exhaustive account of all contributing factors this section outlines some of the core factors established in the literature, to provide understanding of some of the adversities faced by individuals prior to becoming homeless and consider their role in the development of psychological distress in this population.

1.5.1. Individual Factors

In a recent systematic review and meta-analysis of 116 independent studies on risk factors for becoming homeless, Nilsson, Nordentoft and Hjorthøj (2019) found that physical abuse, experience of the social care system, history of incarceration, suicidality, mental health difficulties and alcohol and substance misuse problems to be significant individual-level factors associated with risk of homelessness.

Intimate partner violence and breakdown of interpersonal relationships are also widely accepted individual level predictors of homelessness, particularly among homeless women (Vichta & Husband, 2017). For many, interpersonal violence acts not least as a pathway to homelessness, but continues as a recurring theme that is aggravated by experience of homelessness itself (Finfgeld-Connett, 2010).

Themes of trauma across the life course are also widely reported among homeless individuals, with early experience of childhood neglect (Sacks, McKendrick & Banks, 2008) and abuse being common factors (Huey, Fthenos & Hryniewicz, 2012), and with many also reporting community violence, accidents, natural disasters and combat-related trauma by the time they reach adulthood (Hopper, Bassuk & Olivet, 2010).

However, caution is required when considering the individual-level factors as there is a "tendency to conflate individualist explanations with personal 'agency'" (Bramley & Fitzpatrick, 2018, pp. 98). To attribute homelessness to individual failings and deficiencies is to neutralise the extent to which homelessness evidences significant system failings (Marcuse, 1988) and can serve to further stigmatise and alienate already disenfranchised individuals (Elwood & Lawson, 2017). As such, it is necessary to also consider the systemic-level factors that create the context for homelessness.

1.5.2. <u>Systemic Factors</u>

The financial crash of 2008 significantly affected the UK economy, the housing market collapsed and unemployment rates increased. The UK coalition government reacted by applying austerity measures, including significant spending cuts and welfare reforms (Ellison, 2016). It has since been evidenced that these austerity measures affected deprived groups the most (Stuckler, Reeves, Loopstra, Karanikolos & McKee, 2017), and arguably played a leading role in the sharp rise in rates of homelessness in the years that followed (Fransham & Dorling, 2018). The impacts of homelessness were felt even harder as funding cuts were experienced by 60% of homeless organisations during the same period (The European Federation of National Organisations Working with Homeless People; FEANTSA, 2011).

Since 2008 there was a steep decline in private sector tenancies, and the cost of the remaining available tenancies increased three times faster than earnings across England since 2010 (NAO, 2017). In 2017, 18,000 fewer social lets were made to homeless households compared with those in 2010, despite the substantial rise in statutory homelessness in that period (Fitzpatrick et al., 2019).

Welfare cuts also impacted upon vulnerability to homelessness, with the poor transition from Housing Benefit to Universal Credit resulting in destitution in some cases, and two thirds of Local Authorities anticipate a further significant rise in homelessness with the full roll-out of Universal Credit (Fitzpatrick et al., 2019).

Unemployment and a falling job market brought on by the 2008 recession contributed towards homelessness, with those on the lowest incomes most at risk (Fitzpatrick et al., 2019). While it is true that homelessness follows unemployment for some people (Holmqvist, 2009), this is not to say that unemployment is a necessary factor in homelessness and it remains unclear which factors mediate the link between unemployment and homelessness (Steen, Mackenzie & McCormack, 2012).

Poverty and childhood poverty in particular are also significant risk factors to adult homelessness (Bramley & Fitzpatrick, 2018). Childhood poverty is strongly linked to a range of experiences, including school truancy and leaving school at an earlier age (Zhang, 2003). Poverty and poor academic attainment in childhood is associated with poorer outcomes in adulthood that can perpetuate the cycle of poverty and thus can lead to homelessness (Walker-Dalhouse & Risko, 2008).

While the above outlines the need to address the socio-political determinants of homelessness, it is important to note that structural and systemic explanations account for just part of the picture, and although favoured over individualistic explanations by most academic commentators in the UK (Fitzpatrick, Pawson, Bramley & Wilcox, 2011), should not be considered in isolation. A relational model of homelessness may be best placed to understand the interrelation between systemic and individual circumstances and the needs of this vulnerable population (Giles, 2017). Bramley and Fitzpatrick (2018) found that in UK, "homelessness is not randomly distributed across the population, but rather the odds of experiencing it are systematically structured around a set of identifiable individual, social and structural factors, most of which, it should be emphasized, are outside the control of those directly affected" (pp. 112).

1.6. The Impact of Homelessness

Homelessness is a societal issue and its impacts, like its determinants, are wide-reaching and can be observed at both the systemic and individual level. This issue is pervasive, effecting individuals, their families and social networks, health and social care services, third sector organisations, government policy-making and the national economy. With the effects of homelessness felt so widely, the moral and economic arguments for addressing this issue are strong.

1.6.1. Systemic Impact

Above all, there is a strong moral argument for addressing the impact of homelessness, with the state having responsibility to support all of its citizens, particularly those most marginalised and disadvantaged. Annual homeless mortality rates continue to grow year on year, making homelessness a public health crisis. With 1,731 homeless deaths in England between 2001 and 2009, and those aged 25-34 years five times as likely to die as their housed counterparts (Crisis, 2012), the mortality rates alone provide a compelling argument for the need for action.

While it is not possible to put a price on the health, wellbeing, and lives of individuals, the neoliberal UK society and those that govern it are concerned with issues in which there is significant economic cost involved. The estimated cost of homelessness to the UK economy exceeds £1 billion each year, with the average cost of each homeless person to the public purse estimated to be around £26,000 per year (Pleace, 2015). The economic argument for addressing homelessness is strong, since this issue presents immediate and long-term costs, with preventative strategies and efficient reactive solutions for those who need support capable of reducing the cost to the UK economy (Pleace, 2015). Research suggests that the cost of rough sleeping for 12 months is over £20,000 per person per year (Pleace, 2015). Furthermore, individuals experiencing homelessness for more than three months cost £4298 per person per year to physical health services, and £2,099 per person per year to mental health services (Pleace & Culhane, 2016). Additionally, with the Homeless Link Health Needs Audit (2015) reporting that 94% of individuals experiencing 'core

homeless' were unemployed, the cost to the economy in lost productivity is high. For those homeless individuals with children, particularly street homeless, the involvement of social services can result in children being taken into social care, with the cost of looking after one child in children's social services estimated at around £56,000 per year (Local Government Association, 2019). It is also widely reported that care leavers are at greater risk of becoming homeless (Malvaso & Delfabbro, 2016), and thus the children of homeless adults who enter the social care system, are themselves at risk of homelessness once they leave care, with potential to create a transgenerational vicious cycle of deprivation, disrupted attachment and homelessness.

1.6.2. Individual Impact

The individual impact of homelessness is undeniable, making it paramount to hold onto the notion of homelessness as a violation of fundamental human rights (Lynch & Cole, 2003), and harness this as motivation to intervene. It is stated in Article 25 of the United Nations' (1948) Universal Declaration of human rights that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services". Homelessness not only breaches the right to adequate housing, but also impinges upon a range of other human rights such the "right to liberty and security of the person, the right to freedom from discrimination, the right to privacy, the right to freedom of expression, the right to freedom of association, the right to vote, the right to social security and the right to health" (Lynch & Cole, 2003, pp.1). Homelessness can significantly impinge upon the right to health and, given the way that systems currently operate, can make it extremely difficult for homeless individuals to receive their right to health care. This includes mental health care (Sackville, 2004).

Individuals experiencing homelessness face significant adversity, including extreme poverty, stressful life experiences, and threats to physical safety and psychological wellbeing. The consequences of homelessness can be fatal and are yet often preventable. In 2018, an estimated 726 homeless people died in England and Wales (ONS, 2018), with over half of these deaths due to drug poisoning, liver disease or suicide, and many due to long-term chronic health

conditions that represent multiple missed opportunities for timely intervention (Aldridge et al., 2019). Homelessness is associated with significantly reduced life expectancy, with mean age at death being 45 years for homeless men and 43 years for homeless women; this is contrasted with the general population where mean age at death is 76 years for males and 81 years for females (ONS, 2018). Homeless individuals face higher rates of exposure to health risks including mental health, by virtue of being homeless (Oppenheimer, Nurius & Green, 2016). It is also widely accepted that the homeless population have poorer access to, and utilisation of healthcare, including mental healthcare (Field, Hudson, Hewett & Khan, 2019). Taken together, this evidences that homelessness is a public health crisis (Aldridge, 2019; Donovon & Shinseki, 2013; Patra & Anand, 2008), for which public health prevention measures are required if the fatal consequences are to be avoided.

1.7. Homelessness and Mental Health

With the hallmarks of homelessness including transience, uncertainty, and a lack of safety and security, it is unsurprising that many homeless individuals experience psychological distress. Psychological distress and mental health difficulties can be both a cause of, and a reaction to, becoming homeless (Lee et al., 2010). For some, mental health difficulties create significant disability which can hinder capacity to perform tasks necessary to maintain accommodation arrangements, such as sustaining employment (Hoven, Ford, Wilmot, Hagan & Siegrist, 2016). Homeless people experiencing mental health issues are also more vulnerable to poverty and disaffiliation with social networks and supporting services (Canadian Observatory on Homelessness, 2019), factors which increase susceptibility to homelessness. Furthermore, over one quarter of homeless people in the UK cite mental health difficulties as the reason for becoming homeless (Beaumont, 2011).

Upon becoming homeless, individuals may be exposed to a number of risk factors, such as violence (Petering, Rhoades, Winetrobe, Dent & Rise, 2012), socioeconomic deprivation (Preece & Bimpson, 2019), stigmatisation (Boyd, Bassett & Hoff, 2016; Jensen, 2018), substance misuse as a means of self-

medication (Narendorf, Cross, Santa Maria, Swank & Bordnick, 2017), which can lead to or exacerbate mental health difficulties. The deprivations associated with experiencing homelessness can interact bi-directionally with the disability associated with mental health difficulties, with each serving to compound the effects of the other.

1.7.1. <u>Prevalence of Mental Health Difficulties in the Homeless</u>

Homeless Link (2014a) found that 80% of homeless people in England report having mental health difficulties, 45% of which have a diagnosed condition; this disparity between self-reported and diagnosed difficulties could partly be explained by service underutilisation in this population, with many people experiencing distress not being in contact with services that could provide a diagnosis (Elwell-Sutton, Fok, Albanese, Mathie & Holland, 2016).

Perhaps unsurprisingly, the prevalence of mental health difficulties in the homeless population is significantly higher than that found in the general population. In 2010, Homeless Link conducted a Health Needs Audit of the homeless population and found over 70% of homeless people experience mental distress compared with just 25% of the general population. In addition, 14% of homeless individuals reported a history self-harm compared with just 4% of the general population (Homeless Link, 2010). Homelessness is also associated with increased suicidality (Eynan et al., 2002). These figures highlight the significant impact of homelessness upon psychological wellbeing.

Of 900 individuals using hostels, day services and outreach services, Homeless Link (2011) found that 72% of individuals had one or more mental health needs, with 61% of these considering their needs to be long-term. Over one third of homeless individuals reported wanting more support than was currently being offered to them, while just 10% reported receiving sufficient support from mental health services. Furthermore, around half of those experiencing mental health problems report self-medicating with drugs and alcohol. Substance misuse disorders (62.5%) and mental health problems (53.7%) are the most prevalent health problems among the homeless population, with a high percentage (42.6%)

presenting with a combination of both (Department for Communities and Local Government, 2012).

Serious mental illness (SMI), including schizophrenia and bipolar disorder, is reported to be prevalent in as many as 25–30% in the homeless population (Perry & Craig, 2015; Rees, 2009). Homelessness can exacerbate symptoms of SMI, which in turn can increase an individual's risk for long-term homelessness as a result of SMI impacting individual's engagement with housing services (Fazel, Geddes & Kushel, 2014). A systematic review and meta-regression of twenty-nine surveys of 5,684 homeless individuals from seven Western countries, including the UK, estimated the prevalence of psychotic disorders to range from 3 to 42%, compared with approximately 1% in the general population (Fazel, Khosla, Doll & Geddes, 2008). The estimated lifetime prevalence of schizophrenia in the homeless population (4%) is significantly higher than that of the general population (0.2%), and this is also true for bipolar disorder, where the estimated lifetime prevalence in the general population is 1-2%, compared with the homeless population which has 5% lifetime prevalence (Homeless Link, 2011). Studies have also shown that compared with homeless individuals without SMI, those diagnosed with bipolar disorder or schizophrenia report a significantly greater use of alcohol and illicit substances (Maremmani et al., 2017), potentially attesting the self-medication hypothesis. Moreover, among homeless individuals with and without comorbid substance use, those not using substances had better outcomes on most clinical and social adjustment measures (Gonzalez & Rosenheck, 2002). This emphasises the importance of intervening early in SMI among the homeless population in order to prevent or reduce the effects of substance use and improve outcomes. Homelessness is also associated with higher rates of personality disorder (Rees, 2009), with a meta-analysis estimating the pooled prevalence to be 29.1% (Schreiter et al., 2017).

Regarding diagnoses of anxiety and depression, research consistently points to high rates in the homeless population, with around 40% diagnosed with anxiety, and 60% diagnosed with depression (Archer, Dayson, McCarthy, Pattison & Reeve, 2017; Johnson & Chamberlain, 2011). Though anxiety and depression are common mental health problems, the disability and debilitation caused by

these experiences must not be underestimated. With the aforementioned risk factors for homelessness in mind, which often include trauma histories and disadvantage that predates the homeless state, it comes as little surprise that individuals may experience anxiety and depression as a result of lifelong disempowerment, and the debilitating effects of these mental health difficulties can contribute towards people becoming and remaining homeless. Both anxiety and depression can also be exacerbated by homelessness, with social, economic and physical instability, lack of earnings, low self-esteem, shared living and substance misuse aggravating worry and low mood. Furthermore, exiting homelessness can be hindered by the debilitating effects of these experiences, through self-medication with illicit substances (Soar, Papaioannou & Dawkins, 2016), depletion of cognitive and emotional capacity (Greenberg et al., 2019) and engagement with services aimed at rehabilitation.

Considered to be a subgroup of anxiety-related disorder, the International Classification of Diseases (ICD-10) classifies trauma and stress-related disorders under the broader category of 'Reaction to severe stress and adjustment disorders' (World Health Organisation; WHO, 1992). In order to receive a diagnosis of one of these disorders, the ICD-10 requires the existence of one of two causative influences; an exceptionally stressful life event or a significant life change that has led to continued difficult circumstances. These disorders are particularly prevalent in the homeless population (Torchalla et al., 2014; Votta & Manion, 2004; Winiarski et al., 2020) with Taylor and Sharpe (2008) reported the lifetime prevalence of Post-Traumatic Stress Disorder (PTSD) to be 79% in a sample of homeless adults, and noted that this preceded first episode of homelessness in 59% of cases. Furthermore, in a study of 77 homeless men, Winiarski and colleagues (2020) found that depression (22.1%) and adjustment disorder (16.9%) were the most common presenting mental health difficulties; however, the size of the sample necessitates caution around generalisability. Reaction to severe stress and adjustment disorders can be related to homelessness in at least three ways. First, the stressful event can lead to the development of a stress reaction or adjustment disorder, which can in turn lead to homelessness. An example of this can be seen with war veterans with PTSD who later become homeless. Second a stressful or traumatic event could occur during

the time that the individual is experiencing homelessness; for example, becoming a victim of physical or sexual violence while rough sleeping and developing an acute stress reaction or PTSD as a result. The third, and much less commonly explored, way in which homelessness can be connected to these types of disorders is when the experience of homelessness itself is the causative stressful event that precedes the development of one of the stress or adjustment disorders.

1.7.2. <u>Psychological Understanding of Distress in the Homeless</u>

Bronfenbrenner's (1979) Ecological System's Theory can be helpfully applied to the conceptualisation of distress in homeless individuals. This framework facilitates the examination of an individual's relationships within communities, wider society and systems, acknowledges the impact of several systems interacting with one another, and postulates the impact of each system upon the individual. Ecological systems theory identifies five environmental systems that surround the individual, each of varying proximity to the individual; the microsystem, mesosystem, exosystem, macrosystem and chronosystem. This theoretical framework can be used to formulate and understand the multiple and systemic challenges that an individual experiencing homelessness and psychological distress faces when trying to seek support. Such formulation can serve to identify target areas for intervention (see Figure 1).

1.7.2.1. The individual experiencing homelessness: Any given individual experiencing homelessness may experience hopelessness in the face of multiple and repeated threats to psychological and physical health and wellbeing (Hwang, 2001), alongside isolation or disrupted social networks (Green, Tucker, Golinelli & Wenzel, 2013). They may have trauma histories that inform their relationships with others, including their relationship to professionals and their relationship to help (Reder & Fredman, 1996) more generally. Furthermore, they may be experiencing chaotic lifestyles, which they may or may not attempt to self-medicate with alcohol or illicit substances (Vogel et al., 2019). Taken together these experiences can contribute towards intrapsychic distress.

1.7.2.2. The microsystem: The microsystem is conceptualised as the groups and institutions, which have the most direct impact on the individual, these can include family members and friends, health care services, social services, welfare services, housing services and homeless charities and shelters.

An individual experiencing homelessness may have personal relationships with family members, partners, friends and carers that are characterised by stress, burnout, frustration, sadness, guilt, interpersonal difficulties and communication difficulties. These relationships' difficulties can be a cause, and a result, of the homeless individual's psychological distress and poor mental health.

An individual experiencing homelessness may also have histories of trauma, and experiences of multiple system failures, which may significantly impact upon their relationships with professionals, organisations and to help more generally. There relationships with services providing health care, social care, welfare, housing, shelter and charity may be characterised by lack of trust and hope, communication difficulties, frustration and stress.

1.7.2.3. The mesosystem: According to Bronfenbrenner's (1979) model, the mesosystem consists of interconnections between the microsystems. With each of the entities within the microsystem being distinct structures, each with differing and competing priorities for addressing the problem of homelessness for the individual, there is a clear need for effective communication between each entity if effective multi-agency working and the best outcomes for the individual are to be achieved.

In the context of stretched resources, burnout and frustration for both services and people with direct relationships with the person experiencing homelessness, it is possible that a culture of blame can develop both within and towards the individual entities of the microsystem. Specifically, a culture of blame can arise between family members and carers, the homeless individual, as well as services that support them. A defensive culture of procedures, targets and compliance has grown within care services (Leigh, 2017), and a fear of being punished for mistakes can contribute to individual- and service- level anxieties.

1.7.2.4. The exosystem: Conceptualised as the links between the entities in the microsystem that do not directly involve the individual at the centre, the exosystem considers how relations between systems indirectly affect the individual. In the case of homelessness, it refers to the indirect factors affecting services, or individuals, and how the effects of these filter down and impact upon the care received by the homeless individual. For example, if a family member who usually provides care and support to the homeless individual loses their job, this could indirectly impact the support provided to the individual.

Regarding the exosystem of the services from whom the person experiencing homelessness seeks support, circumstances such as lack of resources, funding cuts and organisational systems affecting interagency communication could all have an indirect impact on the care they receive. This could also include service restructuring, staffing cuts, and the built environment of services. High levels of staff turnover could impact relationships between staff and the person experiencing homelessness (Atkins et al., 2019), and poor interagency communication could make it easy for the individual to get 'lost in the system' (Harrison, 2017).

1.7.2.5. The macrosystem: Bronfenbrenner (1979) described the macrosystem as the overarching culture influencing the individual as well as the microsystems and mesosystems and mesosystems around the individual.

The UK government's austerity programme introduced funding cuts which resulted in services experiencing increased demand, increased workload, and limited resources. Funding cuts to local housing allowance was capped from 2011, and the introduction of universal credit saw delays to payments causing households to fall into larger arrears. Consequently, there was a significant reduction in the availability of social housing which led to a sharp rise in rates of homelessness, and a widening gap between supply and demand for services designed to support individuals experiencing homelessness. This impacted upon the quality of services provided to homeless individuals experiencing distress.

1.7.2.6. The chronosystem: The chronosystem refers to the pattern of societal, economic, political, historical and environmental events and transitions over the life course. For the individual experiencing homelessness and psychological distress, the chronosystem will include cultural discourses and narratives around homelessness and mental health, and will be affected by class, neoliberalism, capitalist ideologies media and societal attitudes.

People who are homeless are either perceived as victims or 'othered', and homelessness is seen as a result of poor choices or misfortune and is often de-contextualised (O'Neil, Gerstein, Pineau, Kendall-Taylor, Volmert & Stevens, 2017). Understandings of homelessness is often influenced by who people 'see', rather than an understanding of social issues or 'hidden' homelessness. Capitalist ideologies prescribe that people who do not work or 'contribute' are viewed as no longer useful (Belcher & Deforge, 2012). Mainstream media produces polarised narratives of homeless people as either "passive or disruptive", and the political and economic factors surrounding homelessness are rarely discussed (De Oliveira, 2018).

1.7.2.7. Strengths and limitations of this model: Bronfenbrenner's (1979) Ecological Systems Theory helpfully positions the individual at the centre of a range of contexts that impact upon their experience of distress, and helps to identify areas for intervention that exist outside of the person.

This strength is held in contrast to other models that can frame distress in the homeless population in a paradoxical and pathologised way, which can in turn come to be internalised by homeless individuals themselves. For example, applying a notion of mental illness, without considering the social context, can serve to locate the problem within the individual and can decontextualize, depoliticise, and neutralise homelessness (Marcuse, 1988). Rimke's (2003; 2010; 2016) critical concept of psycho-centrism can be helpfully applied to critiquing the concepts of pathologisation and notions of individual responsibility of homeless individuals to address the 'internal deficits'. Psycho-centrism describes the ways in which models like the medical model position human emotion exclusively as

artefacts of the individual's mind, which thereby strips distress of its social, political, economic, historical and cultural context.

Chronosystem
Macrosystem
Exosystem
Mesosystem
Microsystem

Individual Experiencing Homelessness

Family and Friends · Social Services · NHS · Work · Housing · Welfare · Homeless Charities

Welfare and Housing · Interagency Working · NHS and Housing · Increased Workload · Housing Demand · Local Authority · Increased service · Funding to each service · Welfare and NHS · Reduced spending and resources

National Law · Ethnicity · Local Policy · Neoliberalism · Poverty · Policy Development · Cultural Discourse · Culture · Changes In Government · Class · Population Growth · Capitalism · Geographical Location · Socioeconomic Status · International Law including human rights law · Economic Events · Mass Media

Figure 1: Using Bronfenbrenner's (1979) Ecological System's Theory to Formulate Psychological Distress in the Homeless

1.7.3. Policy Affecting Mental Health Service Provision to the Homeless

The UK government has rolled out a number of major public policies and political initiatives aimed at tackling homelessness and some of these have had direct implications on mental healthcare provision for homeless individuals. Homelessness is a social and political phenomenon thus in order to gain a full appreciation of the current state of mental healthcare for the homeless

population, it is necessary to understand the political forces that inform and shape such provision.

1.7.3.1. The Homeless Act (2002): The Homeless Act (2002) stipulated new duties to prevent and relieve homelessness across England and Wales. In order to provide a greater number of homeless households with access to advice and assistance, the government introduced Housing Options which focused on prevention-led acceptances and reduced rates of homeless across England and Wales between 2002 and 2010. However, the 2010 welfare reform and the growing housing crisis led to a sharp rise in rough sleeping and Local Authorities saw an increase in homeless acceptances once again.

1.7.3.2. The Homelessness Reduction Act (2017): The rise in homelessness following the government's austerity programme led to the development of The Homelessness Reduction Act (2017). The previous statutory homelessness system prevented many single homeless people from accessing support as they did not meet criteria for 'priority need' status. Under the Homelessness Reduction Act, Local Authorities now have a statutory duty to intervene earlier and prevent homelessness. Duties of Local Authorities under this act include the duty to provide an advisory service to homeless individuals and to those 'threatened with homelessness', as well as a duty to assess all eligible applicants' case, with the aim of widening the pool of people entitled to support, offering support to all eligible homeless applicants irrespective of 'priority need' or 'intentional homelessness'. Those assessed as eligible for support are entitled to a needs-led personalised housing plan which should contain actions necessary to prevent or relieve the applicant's homelessness. The Local Authority has a duty to help the applicant to secure accommodation.

The Homelessness Reduction Act (2017) also outlines a 'duty to refer' requiring public authorities in England, with the person's consent, to notify Local Authorities of individuals who are homeless or threatened with homelessness within 56 days from the initial contact with the individual. This has direct ramifications for NHS services and staff as they have a duty of care to refer any homeless individuals they treat onto the Local Housing Authority for support with homelessness. This

legislation impacts all NHS trusts providing accident and emergency services in a hospital, urgent treatment centres and inpatient treatment of any kind (Department of Health and Social Care, 2018). The duty to refer forms part of health services' safeguarding responsibilities and seeks to extend good practice to ensure that services work collaboratively.

1.7.3.3. Rough Sleeping Strategy (2018): The Ministry of Housing, Communities and Local Government (2018) have published the 'Rough Sleeping Strategy', a policy paper aims to meet the targets to halve rough sleeping by 2022 and ending it altogether by 2027. This policy paper has implications for healthcare service provision with a pledge to provide up to £2 million in health funding to enable those sleeping rough to access mental health and support services. It also provides new training to front line staff to ensure they possess the skills necessary to support people who sleep rough including training on identifying and supporting Lesbian Gay Bisexual and Transgender (LGBT) people, victims of domestic abuse and those affected by modern slavery.

1.7.3.4. Homelessness: Applying All Our Health (2019): Public Health England (2019) produced a guide for health professionals which encourages the development of trusting relationships with patients, families and communities to take action on homelessness. Healthcare professionals must be aware of the individual and structural determinants of homelessness, understand the needs of this population and who has responsibility for meeting those needs. They must adhere to the duty to refer to Local Authorities if working in the relevant health settings, contribute to personalised housing plans where necessary, be pro-active in providing holistic support to individuals and understand the range of interventions to prevent and promote health for people at risk of homelessness. This guidance specifically outlines the need for healthcare professionals to routinely enquire about the household's housing circumstances, support individuals to engage in treatment, ensuring General Practitioner (GP) registration and providing healthcare at the point families seek assistance from Local Authorities. Service managers should work collaboratively with homeless organisations to develop pathways out of homelessness towards improved health and wellbeing, audit homeless access to primary care, commission provision that

is accessible and engages homeless people while being integrated with other services to provide a holistic care that supports people to recovery and obtain accommodation appropriate for their needs.

1.7.3.5. The NHS Long Term Plan (2019): In 2019 NHS England pledged to invest up to £30 million into providing better access to specialist NHS homelessness mental health support across parts of England most affected by rough sleeping. This was in response to findings that while up to half of those sleeping rough has mental health needs, a large proportion of the country does not have specialist mental health support provisions and acknowledging the challenges homeless individuals face in accessing mainstreams services.
In spite of a vast array of policy, effective mental health service provision and utilisation for homeless service users continue to be a significant challenge for health services.

1.7.4. The Policy-Provision Gap

Despite policy in place to guide effective mental health service provision to homeless individuals, evidence from the Survey of Needs and Provision (Homeless Link, 2010) suggests that there is a significant gap between policy and provision. Mainstream mental health services are often inaccessible or unacceptable to the homeless population and as such utilisation of, and engagement with, appropriate services are often sporadic and poor (Elwell-Sutton et al., 2016). Furthermore, when homeless individuals do receive mental health care, their outcomes tend to be less favourable than service users with secure accommodation (Aldridge, 2019). As such, there is a need for continued research investigating the accessibility, acceptability, utilisation and effectiveness of mental health services for the homeless population and for a review to synthesise the findings to build an overall picture of the current state of mental health service provision for this population. This will enable insight into where services fall short of meeting the needs of this population, and could thus inform areas in which a policy review is required and ways in which it could be effectively implemented.

1.8. Approach to the Literature Review

A narrative review of the literature, published up to March 2020, was conducted using Elton B. Stephens Company (EBSCO) electronic databases (see Appendix A for flow diagram of study selection process). A narrative approach was appropriate since it can provide sufficient background information on the current state of the literature, including appraisal and critique of recent developments and key issues surrounding the quality of mental health service provision to the homeless service user population. The purpose of this literature review was to identify research evidence around homelessness and mental health, and the quality of mental health care received by this population. Search terms centred on three broad areas; homelessness (e.g. "UK", "homeless", "homelessness"), mental health (e.g. "mental health", "disorder", "anxiety", "depression"), and mental health care (e.g. "inpatient", "admission", "treatment", "psychotropic medication", "psychological therapy", "discharge", and "follow up"). Narrative and snowballing techniques were then applied to identify further relevant research, including hand-searches of the reference lists of identified articles, and additional searches using Google Scholar. Studies published in English language in peer-reviewed journals were included in the present review. This literature review also includes resources published outside of the academic framework, from which further published resources were identified.

1.9. Secondary Care Mental Health Services and Homelessness

Individuals experiencing homelessness are among the most vulnerable to mental health difficulties, and the mental health service needs of this population are high (Laliberté, Stergiopoulos, Jacob & Kurdyak, 2020). However, need and entitlement to healthcare does not necessarily equate to access and utilisation. People experiencing homelessness often have complex physical and mental health needs yet often experience difficulties in accessing and utilising healthcare services (Moore, Gerdtz & Manias, 2007). The 2014 Homeless Health Needs Audit (Homeless Link, 2014) found 86% of homeless individuals reported a mental health difficulty, and yet over half did not receive any support, and one fifth received support but felt they needed more. Lack of access to timely support

often leads to exacerbated distress (Rees, 2009), and deterioration in mental state reduces homeless individuals' likelihood of accessing mental health services (Kim et al., 2007). This results in a downward spiral and equates to poorer outcomes and health inequalities.

1.9.1. <u>Mental Health Care Accessibility, Acceptability and Utilisation</u>

Mental health service inaccessibility and unacceptability continue to prevent the homeless population from utilising and engaging with appropriate services (Elwell-Sutton et al., 2016). It is well documented in the literature, that people experiencing homelessness have difficulty making and attending appointments (Rae & Rees, 2015). Given that their daily lives are often fraught with significant stressors and threats to their survival, it is understandable that they seek care only when the need is essential. This highlights the need for drop-in services to be made available. People experiencing homelessness also commonly have difficulty registering with a GP due to lack of identification and no fixed address (Aldridge et al., 2018); this represents a further barrier to receiving appropriate, scheduled care. There is a significant need to overcome administrative barriers that are straightforward to resolve and could prevent serious harms (Crane et al., 2018). When homeless individuals are able to register with a GP, they experience services as inflexible; which is counter to the needs of this population (Crisis, 2002). This highlights the need for appropriate out-of-hours services that are better equipped to hold the complexity that homeless individuals often present with. Fragmented services, disjointed working between mental health, social services and homeless services (Marmot, Friel, Bell, Houweling & Taylor, 2008) and a lack of outreach provision (Crisis, 2018) present as further barriers to mainstream mental health care access for homeless individuals.

1.9.1.1. Competing priorities: Given the extreme deprivation experienced by homeless individuals, it is likely that competing priorities impede seeking timely mental health support, and unsurprising that many might prioritise finding food and shelter, for example, over receiving support with mental health needs (Längle, Egerter, Albrecht, Petrasch & Buchkremer, 2005). This may be compounded by a general attitude within society that prioritises physical health problems over mental health problems (Bhui, Shanahan & Harding, 2006) and a

reluctance to acknowledge such difficulties to avoid associated stigmatisation (Kim et al., 2007).

1.9.1.2. Negative prior experiences of services: Homeless individuals often report experiencing staff as having prejudiced attitudes towards them and being unwilling to accommodate their often multiple and complex needs (Crane et al., 2018; Dorney-Smith, Hewett, Khan & Smith, 2016). This can give rise to communication difficulties (Bramley et al., 2015; Davies & Lovegrove, 2016; Håkanson & Öhlén, 2016; Homeless Link, 2017) and culminates in homeless people avoiding services until their need for healthcare becomes essential. In order to remove this barrier to receiving care, it is paramount that staff and services prioritise the development of trusting relationships with clients (Crisis, 2018), and are aware of ways to identify, engage and support homeless individuals (Department of Health and Social Care, 2018), by being respectful (Crisis, 2002) and ensuring regular contact (Cornes et al., 2018). In interviews with homeless youth with mental health difficulties, it was found that access to services was not a significant problem, but rather their concerns regarding the quality of the services they might encounter prevents help-seeking and subsequent service utilisation (Darbyshire, Muir-Cochrane, Fereday, Jureidini & Drummond, 2006).

1.9.2. <u>Emergency Department Over-Utilisation</u>

When homeless individuals do use healthcare services, it tends to be unplanned, during crisis and costly (Perry & Craig, 2015). They often present to inappropriate services such as Emergency Departments (ED), as they perceive they have nowhere else to go, or do not have the resources to access alternative services (Moore et al., 2007).

It is well-documented in the literature that the homeless population frequently use ED as their primary source of care (Lam, Arora & Menchine, 2016); such inappropriate, yet preventable, usage of an already overcrowded healthcare system is significantly costly and represents a major factor contributing to healthcare expenditure. Since homelessness exacerbates mental health difficulties, and individuals are unlikely to seek timely support from primary care

services, they often present to ED in crisis, which can lead to psychiatric hospital admission for conditions that would otherwise be easily managed in the community (Lin, Bharel, Zhang, O'Connell & Clark, 2015). Studies suggest homeless individuals account for around 20% to 30% of all adult ED visits (D'Amore, Hung, Chiang & Goldfrank, 2001).

Furthermore, ED staff consistently report feeling poorly equipped to deal with the complexity of the physical, psychological and social problems that homeless individuals often present with (Hauff & Secor-Turner, 2014); given the time pressure often found in ED, staff must prioritise the treatment of just one of the individual's often many intertwined problems. Since homeless individuals often require a holistic intervention, many of their needs can go unmet through utilising ED as their primary source of care, and at times results in the need for psychiatric hospital admission.

1.9.3. Admission Types and Pathways

Regarding types of admissions into hospital, research shows that homeless individuals are more likely than the general population to be detained under the Mental Health Act (2007). For example, Reeve and colleagues (2018) found that 19% of homeless individuals reported being detained at some point in their lives, and 4% reported being detained in the previous 12 months. This is higher than rates of detention in the general population (NHS Digital, 2019; Timms & Perry, 2016). Qualitative interviews with homeless individuals revealed that many of them make concerted, though unsuccessful, efforts to be detained, as they believe this to be a way to ensure that their mental health needs are met (Reeve et al., 2018).

Similarly, Lauber, Lay and Rossler (2005) found that homeless individuals were often compulsorily admitted to hospital, on an emergency basis, and that planned admissions through GP referral was significantly less common. They also found that pathways into inpatient care differed between homeless and other service user groups, with self-referral, referral via the legal system and compulsory admission being high. It was found that one in three homeless individuals were voluntarily admitted via self-referral, which exceeds self-referral rates in the

general population. The authors concluded that high self-referral rates likely represent the homeless seeking shelter, or alternatively a manifestation of their self-determination to have their mental health needs met.

1.9.4. <u>Length of Stay</u>

When homeless individuals are admitted to psychiatric inpatient services, the research generally points to them having a longer average Length of Stay (LOS) than housed individuals. Homeless Link (2014) estimate that admission duration is three times longer for homeless patients compared with housed patients. In a study comparing homeless people admitted to an acute psychiatric service with a random sample of housed patients admitted during the same period, the LOS was almost four times longer for the homeless group, with 112 days compared to 33 days for the random sample (Abdul-Hamid, Bhan-Kotwal, Kovvuri & Stansfeld, 2017).

However, research findings on LOS are mixed. For example, Lowens, Kellinghaus, Eikelmann and Rekker (2000) found that median LOS was 26 days, with average LOS for homeless service-users not differing significantly from controls matched by mental health diagnosis. Lauber and colleagues (2006) found homeless patients in fact had a shorter LOS than housed patients; however, in these instances individuals were discharged back to homelessness which although shortened the LOS potentially represents adult safeguarding issues (Aldridge, 2019).

Increased LOS in the homeless population can be explained, in part, by delays to discharge caused by unavailability of suitable accommodation (Glasby & Lester, 2004; House of Commons Health Committee, 2002). However, there is also evidence to suggest that increased LOS is not always a result of 'bed blocking', but rather the complexity with which homeless people present with when admitted to psychiatric hospital means they may require more intensive intervention (Hewett & Halligan, 2010). Longer LOS impacts upon resources and increases the risk of institutionalisation of this population and the financial costs of this are significant; however, evidence shows that higher treatment costs for

homeless patients are not fully explained by LOS (Hwang, Weaver, Aubry & Hoch, 2011).

1.9.5. <u>Assessment</u>

Interviews with homeless youth regarding their experiences of mental health assessments reveal that the assessment process often leaves them feeling labelled rather than carefully assessed (Darbyshire et al., 2006). Homeless service users described feeling that their assessments were rushed, provided them little opportunity for discussion or involvement, and failed to provide any counsel for the problems they were experiencing. There was a sense that assessments failed to consider their holistic needs, and were 'done to' them, rather than being a collaborative and useful process.

Similar themes emerged from a study conducting interviews with mental health professionals working with homeless individuals (Arslan, 2013), which revealed that professionals often feel helpless as they assess homeless individuals and learn of the complexity with which they present. Furthermore, professionals felt that while they had awareness of early traumas likely experienced by homeless individuals, they did not feel equipped to assess this effectively. They consequently experienced frustration at the lack of time allocated to assessment within mainstream mental health services, since this often results in trauma going unassessed, or poorly responded to. Hopper, Bassuck and Olivet (2010) highlight that services working with homeless individuals often involve providing care to people with long histories of trauma, yet these services rarely acknowledge or address the impact of the trauma. As Read, Hammersley and Rudegeair (2007) point out, abuse and trauma are frequently observed in the histories of individuals experiencing mental health problems, and this is particularly true of homeless individuals with psychological distress, yet there is a reluctance of both the individual and the assessing professional to ask about such experiences.

1.9.6. <u>Care Planning and Shared Decision-Making</u>

In 2018, The Faculty for Homeless and Inclusion Health joined with Pathway Healthcare for Homeless People to produce a set of standards for commissioners and service providers working with homeless individuals. One such standard

emphasised the need for coordination of the healthcare of homeless individuals as they move between different settings and organisations; it was suggested that this could best be achieved through shared integrated care planning, which should be developed collaboratively with the individual, emphasising their individual goals and strengths.

However, research highlights that such care planning is not frequently performed in collaboration with homeless service users. In focused group commissioned by NHS England, Healthwatch Nottingham and Nottinghamshire (2019) sought to understand how marginalised groups experienced shared decision-making. These focus groups revealed that homeless people felt health professionals often made presumptions about their situations and felt that they were only 'given one' option because of their housing status. They revealed they often found it difficult to challenge health professionals or ask questions and felt open discussions were not always taking place. They rarely felt diagnoses were provided in discussion, and often felt they were prescribed interventions without being given reasons for this decision. Homeless individuals also reported repeatedly being given the same treatment despite its lack of effectiveness. Together this suggests homeless service user involvement in shared decision making is rarely happening. However, this was just one focus group with a small sample of homeless service users in one locality, and as such may not be representative of experiences of all homeless individuals.

1.9.7. Psychotropic Medication

Prescription of psychotropic medication is the mainstay of psychiatric treatment (Bowers et al., 2005; Bowers, 2009), yet the picture around such prescription in the context of homelessness is complex. Hermes and Rosenheck (2016) studied rates of psychotropic medication prescription among 876,989 individuals with SMI using Veterans Health Administration services in 2010. They found that homeless individuals treated in the community had 16.2% fewer psychotropic medication prescriptions than non-homeless individuals, however, greater use of inpatient mental health services by the homeless was associated with receiving more prescriptions than non-homeless inpatients. Furthermore, concerning results from the French Housing First program (Fond et al., 2019) study on 703 homeless

people with SMI revealed that nearly 90% of patients reported at least one potentially inappropriate prescription, with inappropriate prescription associated with low willingness of patients to ask for help.

When homeless individuals are prescribed medication to manage symptoms of mental health difficulties the evidence base suggests that adherence is relatively low (Coe, Moczygemba, Gatewood, Osborn, Matzke & Goode, 2015; Folsom & Jeste, 2002; Zygmunt, Olfson, Boyer & Mechanic, 2002). While non-adherence is associated with poorer outcomes, little is known about why homeless persons so frequently fail to adhere to the medication they are prescribed. Coe and colleagues conducted a qualitative analysis of pharmacist documentation describing patients' reasons for medication non-adherence and found that patient-related factors, such as self-management, forgetfulness, psychosocial stress and anxieties about adverse effects of medication, accounted for around three quarters of medication non-adherence. Similarly, in interviews conducted with homeless individuals, Muir-Cochrane, Fereday, Jureidini, Drummond and Darbyshire (2006) found that frequently cited reasons for non-adherence included unpleasant side-effects, perceived lack of support from relevant agencies and issues with storage or access; these reasons were compounded by everyday stresses experienced by homeless individuals. The authors also found that medication adherence was aided by regular medication supply and consistent contact with mental health services. Difficulty with medication routines, as a result of chaotic lifestyle (Sajatovic et al., 2013), as well as social isolation, medication cost, and failure to alleviate other life stresses (Finkelman, 2000), represent other major obstacles to adherence.

1.9.8. <u>Referrals to Psychology</u>

Despite the significant psychological distress experienced by such a large proportion of the homeless population, this group are less likely than the general population to receive psychological therapy to support them with their difficulties (Sauer-Zavala et al., 2019). As such, the research literature on psychological therapy with the homeless population is scarce. One potential explanation for such low rates of referral to psychological therapy is the substantial comorbidity (Narendorf et al., 2017) and complexity with which homeless individuals present

to services. Such comorbidity creates a high training burden for clinicians who would be required to learn multiple therapeutic protocols to sufficiently address the complex needs of homeless service users (Sauer-Zavala et al., 2019).

There is also a general trend within psychological service policy that stipulates that where there are substance-related disorders as comorbid to mental health difficulties the former should be addressed prior to beginning psychological therapy for mental health difficulties (Baillie et al., 2010; Mangrum, Spence & Lopez, 2006). The rationale for this might be to ensure that talking about difficult experiences during psychological therapy may increase substance misuse after therapy sessions, as a way to cope with such discussions, thus it is necessary to resolve substance dependence before addressing mental health difficulties. However, it is known from the literature that individuals often use substances to self-medicate their mental health difficulties, as well as to deal with difficult emotional experiences (Vogel et al., 2019). As such, engagement with drug and alcohol services is often low in the subsection of the homeless population who use substances (Ibabe et al., 2014), and by consequence, subsequent planned participation in psychological therapy may be lower. Evidence also shows that once in psychological therapy, retention rates are low (Ball et al., 2005).

Homeless individuals also cite experiencing other barriers to engagement in psychological therapy (Chaturvedi, 2016) including resistance to opening up, stigma, negative prior experiences of help-seeking, reluctance to acknowledge that they may need help and not fully understanding what psychological therapy may entail. This study did however also find that facilitators to engagement with psychological therapy included patience and consistency of offer from clinicians, as well as attempts to normalise the need for therapy and reduce the stigma that surrounds it.

1.9.9. Discharge and Follow Up

Preventing individuals from entering, or returning to, homelessness following discharge from inpatient mental health services is a fundamental part of care provision, and effective discharge planning can contribute to such prevention (Tulloch, Fearon & David, 2012). Providing such continuity of care can assist

individuals in securing housing, recovering from mental health difficulties and improving their quality of life in the community.

In 2019 a good practice guideline for the safe and effective discharging of homeless individuals from inpatient mental health services was developed by the Healthy London Partnership. This guidance promotes the need for discharging services to: meet the Homelessness Reduction Act (2017) Duty to Refer; establish links with local homelessness services; conduct safeguarding and mental capacity assessments; seek specialist advice for those with no recourse to public funds; assess whether ongoing care can be provided safely by the accepting service; and notify the patient in advance of discharge. Evidence suggests that in many cases this good practice is not being followed. For example, examining all admissions to psychiatric hospitals in one NHS Trust, Abdul-Hamid and colleagues (2017) found that 27% of the homeless patients were discharged to no fixed abode status. Furthermore, in a Canadian population based cohort study, Laliberté and colleagues (2020) found that more than one in every 50 adult patients was identified as homeless at the point of discharge from a psychiatric hospital. Examining rates of different types of homelessness experienced by patients at the point of discharge, Greenberg, Hoblyn, Seibyl and Rosenheck (2006) found that 13% were literally homeless, 40% were sofa-surfing and 33% were transferred to shelters. Despite evidence that effective discharge planning is crucial if homelessness is to be avoided (Backer et al., 2007), homeless patients often report feeling their housing needs are not considered sufficiently at discharge (Drury, 2008), with one in five homeless individuals citing discharge from inpatient mental health services as their pathway into homelessness (Nielssen et al., 2018).

Regarding follow up, the first month following discharge from inpatient mental health services represents a critical period characterised by high risk and high need (Dixon et al., 2009); this is particularly true for homeless individuals (Greysen, Allen, Rosenthal, Lucas & Wang, 2013). As such, follow up contact with professionals can assess and prevent risk, and meet the persons' needs. However, the evidence suggests homeless individuals are less likely than housed individuals to have follow up appointments following discharge (e.g. Burra et al., 2012). This may be partially a result of homeless individuals being discharged

from hospital back to homelessness; which means their transient lifestyles make them difficult to reach. However, this highlights a failure of mental health services to ensure that homeless service users are discharged to safe situations where effective care can be delivered in the community, as recommended by the Healthy London Partnership (2019) guidelines.

Furthermore, findings indicate that homeless individuals, demonstrate less clinical improvement at discharge (Lauber et al., 2006), and since homeless individuals do not differ significantly from non-homeless individuals on illness severity at admission, Lauber and colleagues argued that reduced clinical improvement is likely an expression of health care inequalities experienced during inpatient treatment. The authors claim that further studies examining, quality of inpatient care for homeless individuals including preparation for their discharge and the post-discharge care they receive are needed.

1.10. Rationale and Aims of the Present Thesis

To the author's knowledge, there is an absence of research that comprehensively examines mental healthcare received by homeless service users from admission to post discharge. Previous research has tended to investigate one or two aspects of mental health care in isolation, which do not provide understanding of the holistic picture of mental health service provision to this marginalised and often excluded faction of the community.

Furthermore, previous research on aspects of treatment received by homeless service users has often examined hospital data from one geographical area or from one particular service or Trust. It is difficult to generalise findings from one particular region to wider population since findings may simply reflect performance of that specific Trust or area. There have been very few population-based cohort studies, particularly in the UK. Research is needed into the care received by homeless service users across the country.

In the absence of such comprehensive research very little is known about the quality of mental health services received by homeless service users from admission to discharge. The present study made use of existing data collected

from 54 NHS Trusts in England, providing inpatient services to those diagnosed with anxiety and/or depression, collected by the NCAAD (RCP, 2019) focusing specifically on a homeless subsample.

With the view to establishing the quality of care received by homeless individuals admitted to hospital for treatment of anxiety and/or depression, the present research aimed to address the following research questions:

1) How do the demographic and clinical profiles of homeless service users diagnosed with anxiety and/or depression compare with those of housed service users?

2) How does the quality of mental health care received by homeless service users compare with that received by housed service users?

3) What proportion of homeless service users are referred for psychological therapy?

4) Which demographic and clinical variables predict referral of homeless service users for psychological therapy?

2. CHAPTER TWO: METHOD

2.1. Chapter Overview

The present study involved a secondary analysis of existing data on the quality of care received by those admitted to secondary mental health services for treatment of anxiety and/or depression. Specifically, it compared data on the demographic and clinical profiles of homeless and housed service users, and the quality of mental healthcare each group received. It also investigated the demographic and clinical factors that predicted referrals of homeless service users to psychological therapy. The data analysed were initially collected as part of the NCAAD (RCP, 2019), a three-year quality improvement programme assessing the performance of secondary care mental health services in England against criteria relating to the care and treatment provided to service users from admission to post-discharge.

This chapter aims to first address the ontological and epistemological foundations of the present thesis, which "by necessity have implications for investigating social phenomena", (Danermark, Ekstrom & Karlsson, 2019, pp. 5) and thus have a decisive role for research. It will then provide a detailed outline of the methodological approach of the NCAAD, including the study design, sampling method, and the process of data collection. The methodological approach applied to the secondary analysis that formed part of the thesis will then be delineated; specifically, the study design, population, ethical considerations, data handling and data analysis.

2.2. Ontological and Epistemological Approach

Ontology is the area of philosophical study concerned with the nature of reality; it endeavours to conceptualise the nature of the existence of entities, concepts, events and structures (Hollway, 2008), and the interactions that take place between them (Willig, 2013). Ontological positioning can be conceptualised on a continuum (Merlo & Pravato, 2020), from relativism at one end, to realism on the other. Relativism posits that reality is constructed from subjective perceptions of

the world, giving way to multiple diverse 'truths' (Baghramian, 2004), while realism assumes that there are structures and objects that exist independently of human perception and which have cause-effect relationships with each other. This study assumed a realist ontological perspective; that is, the studied events occurred independently of influence from the researcher (Baghramian, 2004). As such, this study assumes that data which is documented in the clinical case-notes reviewed in the NCAAD reflects 'real' events observed in the world.

Epistemology is a branch of philosophy concerned with the nature of knowledge and claims around the possession of 'truth' (Fuller, 2002). There are a number of classical epistemological positions on knowledge and truth, ranging from positivism to constructionism. Despite psychology's attempts to align itself with the natural sciences (Pilgrim, 2013), the nature of the social world is in a greater state of flux than the natural world, and this gives rise to difficulties in applying purely positivist epistemologies to the study of human experience (Hughes & Sharrock, 2016). As such, the epistemological approach of the present research was informed by critical naturalism, which prescribes social scientific methods that seek to identify the mechanisms producing social events, and which recognises the complexities of the social world.

In attempt to dance the interface between the natural and social worlds, Bhaskar's (1975; 2013) critical realism combines transcendental realism, a general philosophy of science, with critical naturalism, a philosophy of the human sciences. It claims that distinctions can be made between the 'real' world and the 'observable' world whereby the 'real' is unobservable and exists independently of human perception and construction, while the 'observable' is constructed from human perspectives and experiences (Bal, 2016); unobservable structures produce observable events, thus in order to understand the social world it is necessary to first understand the structures that generate events. As previously stated, the present research was informed by a critical realist epistemology, whereby data on quality of care received by service users were considered to be constructed from subjective perspectives of 'real' events. Given that this study was a secondary analysis of existing data, the methodological approach of the

NCAAD limits the epistemological approach which can be taken by the researcher of the present study.

2.3. Methodological Approach of Primary Audit

2.3.1. <u>Background</u>

The NCAAD was a three-year quality improvement programme with the overarching objective of improving the quality of mental health care received by people admitted to hospital for treatment for anxiety and/or depression. It was commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and was overseen by the College Centre for Quality Improvement (CCQI) at the RCP. Through assessing the performance of secondary care mental health services against criteria relating to the care and treatment provided to service users from admission to post-discharge, the NCAAD aimed to generate examples of best practice, make recommendations for clinicians, commissioners and trusts, and encourage local quality improvement initiatives. The criteria against which services were assessed were derived from 13 healthcare quality standards (Appendix B). These standards were based on National Institute for Health and Care Excellence (NICE) guidelines and a Steering Committee comprising service users, carers and representatives from partner organisations, including Mind, Rethink, the British Psychological Society (BPS) and Anxiety UK. These standards are grouped into seven themes:

i) *Access;*

ii) *Assessment;*

iii) *Shared decision-making;*

iv) *Medication;*

v) *Psychological therapies;*

vi) *Outcome measurement;*

vii) *Discharge and follow up.*

2.3.2. Participating Services and Service Users

All 54 NHS Mental Health Trusts in England that provide inpatient mental health services to people aged 16 years and over with a diagnosis of anxiety and/or depression participated in the NCAAD. Each Trust was required to submit an anonymised list of all eligible service users who received inpatient care for anxiety and/or depression between April and September 2017.

2.3.3. Identification of Case Sample

Once an anonymised list was submitted to the NCAAD team, 100 service users from each NHS Trust were randomly selected to be included in the audit. In instances where there were less than 100 eligible service users identified by the Trust, all were to be included in the audit. A total of 3,795 service users were identified as eligible for inclusion in the NCAAD based on the following criteria:

i)   *Aged 16 years or over, with no upper age limit;*

ii)   *Received inpatient mental health care between 1st April and 30th September 2017;*

iii) *At discharge, service users had a primary diagnosis of an anxiety or a depressive disorder, identified using ICD-10 coding (WHO, 1992);*

iv)   *Did not have a diagnosis of a non-affective (F20, F22, F24, F25, F28, F29) or affective (F30, F31, F32.3) psychosis, or cyclothymia (F34.0), as identified using ICD-10 coding (WHO, 1992);*

v)   *Were admitted to a forensic unit or long stay ward such as a rehabilitation service.*

2.3.4. Data Collection and Quality Assurance

Using data from each sampled service-user's clinical case notes, staff working in the secondary care mental health service completed the Audit of Practice Tool (Appendix C). This provided the NCAAD team with data on service users' demographics, diagnoses, admission, assessment, care planning, medication, psychological therapies, physical health, discharge, readmission, follow up, crisis planning and outcome measures. Using a second auditor, all services re-audited

five case notes from the submitted sample to ensure inter-rater reliability. Three NHS Trusts were selected at random to partake in quality assurance visits, which involved the NCAAD team conducting a random check on ten sets of clinical case notes.

2.4. Methodological Approach of Secondary Analysis

2.4.1. Study Design

The present study was a secondary analysis of cross-sectional data collected as part of the NCAAD and was concerned with examining between-group differences, with the total sample first stratified according to accommodation status, creating 'homeless' and 'housed' groups. Groups were compared on demographic, clinical and quality of care variables. The 'homeless' group was then further stratified according to whether or not they were referred for psychological therapy, and between-groups differences in demographic and clinical variables were examined. The factors that influenced referrals of homeless service users to psychological therapy were also investigated.

2.4.2. Study Population

All 3,795 service users identified in the NCAAD as admitted to hospital for treatment of anxiety and/or depression between April and September 2017 were included in the secondary analysis. The Audit of Practice Tool collected information from clinical case notes regarding accommodation and service users were recorded in one of the following categories; this enabled stratification of the sample into homeless and housed groups:

i) *Mainstream housing;*

ii) *Accommodation with criminal justice support;*

iii) *Accommodation with mental health care support;*

iv) *Accommodation with other (not specialist mental health) care support;*

v) *Acute long-stay healthcare residential facility/hospital;*

vi)   *Homeless;*

vii)   *Sheltered housing;*

viii)   *Other;*

ix)   *Service-user declined to answer;*

x)   *Unknown/not documented.*

The Audit of Practice Tool also collected information on referral for psychological therapy, which allowed stratification of homeless service users into 'referred' and 'not referred' groups.

2.5.   Ethical Considerations

Initial permission to access the data was obtained from the team managing the NCAAD at the RCP (Appendix D). Since this study solely involved access to and analysis of existing data, an application was made to the Ethics Committee at the University of East London's School of Psychology. Ethical approval to analyse data on all homeless service users included in the NCAAD was granted from the Chair of the School's Research Ethics Committee on 1st October 2019 (Appendix E). Approval to amend the application for ethical approval was granted by Chair of the School Research Ethics Committee on 29th January 2020 (Appendix F); this enabled examination of the data on both the homeless and the housed group, since the initial application sought only to examine the homeless group. In the interest of protecting service user's anonymity, all data was fully anonymised and only included participants aged 16 years and over. In line with information governance, and institutional and departmental policies on 'data management, data sharing and data security', data were stored at the RCP site.

2.6.   Data Analysis

Data were analysed using the Statistical Package for Social Sciences (SPSS; version 26). Descriptive statistics and tests of univariate association were used to address hypotheses one to three, and the first part of hypothesis four. Specifically, crosstabulations were performed to obtain frequencies of observed

events occurring in the data. Chi-square tests were then performed to ascertain whether the number of observed events differed significantly from the expected number of events, which would then suggest a significant difference between the independent and dependent variables (Wildemuth, 2009).

To address the first research aim, which sought to outline the demographic and clinical profile of the homeless group, descriptive statistics were obtained on relevant variables for both the homeless and housed groups. The differences between groups on each variable were then assessed using chi-square tests, where the significance level was set to $p<.005$ to account for the number of tests performed.

The second aim, to delineate how the quality of inpatient mental health care received by homeless service users compares with the quality of services, and the third aim, to assess referrals of homeless service users to psychological therapy, were addressed by comparing the homeless and housed groups on a number of variables relating to their care and treatment during admission. Frequency data was analysed using crosstabulations and significance testing was conducted using chi-square tests.

Addressing the fourth aim, which was to examine whether any demographic and clinical variables predicted referral of homeless service users to psychological therapy, it was necessary to compare homeless service users who were referred with those who were not. Frequency data was obtained using crosstabulations and chi-square tests were used to examine statistical significance.

An a priori power analysis using G*Power (version 3.1.9.7; Faul, Erdfelder, Buchner, & Lang, 2009) was performed to calculate the sample size required to achieve sufficient statistical power for the logistic regression. A logistic regression was then performed by entering the dependent variable, referral to psychological therapy, into the model along with each of the following predictor variables: age; gender; ethnicity; and primary diagnosis. Logistic regression is a statistical procedure used to predict a dichotomous outcome or category membership from a number of predictor variables (Brace, Kemp & Snelgar, 2009). Logistic

regression also facilitates the identification of combinations of predictor variables that usefully predict an outcome (Kleinbaum, Dietz, Gail, Klein & Klein, 2002).

3. CHAPTER THREE: RESULTS

3.1. Chapter Overview

This chapter presents the results for each research question addressed in the present study (see Appendix G for SPSS output). The demographic and clinical profiles of homeless service users are compared to housed service users', along with the quality of mental health care received by both groups. Rates of referral to psychological therapy across both homeless and housed groups are compared, and data on the homeless group are then analysed, comparing the demographic and clinical variables of those who were referred to psychological therapy with those who were not referred. A logistic regression model is presented to ascertain whether any demographic and clinical variables predict referral of homeless service users to psychological therapy.

3.2. Service User Sample

The present research analysed data on all 3,795 service users included in the NCAAD; almost 95% of service users were recorded as having some form of accommodation, and were therefore classified as 'housed' (n=3,572), while the remaining 5% of the sample were identified in their clinical case notes as being 'homeless' (n=223).

3.3. Question 1: How Do the Demographic and Clinical Profiles of Homeless Service Users Diagnosed with Anxiety and/or Depression Compare with those of Housed Service Users?

Descriptive statistics were obtained to establish the demographic and clinical characteristics of the homeless group of service users admitted to hospital for treatment for anxiety and/or depression. Comparisons were then made with the housed group to ascertain whether differences exist between the two groups. Pearson chi-square tests were performed to establish whether any observed between-group differences were statistically significant. In cases where variable category membership was unknown or not documented in clinical case notes,

frequency data was reported in the tables, but excluded from percentage calculations and subsequent analyses.

3.3.1. Demographic and Clinical Profile of Homeless Service Users

The homeless service user group ranged in age from 17 to 82 years, but the majority of the group were aged between 25 and 44 years (59.2%). Homeless service users were significantly more likely to be male (79.8%) than female (20.2%). Furthermore, homeless service users tended to be White (75.3%), though disproportionately from BAME backgrounds. Regarding the clinical profile of the homeless service users, over half of this group had a primary diagnosis of stress-related disorders (52.2%), while the second most common primary diagnosis received by homeless service users was depressive episode (28.2%). More than one third of homeless service users had comorbid substance-related disorders (35.4%), while comorbid personality disorder (13.9%) was less common. Formal admission to hospital was infrequent among this group (9.9%) and planned admission pathways were rare (4%). National data on the demographic and clinical profiles of homeless mental health service users is not currently available to act as a comparator for the NCAAD sample analysed herein, thus it is difficult to know whether the homeless group in the present study is representative of the wider homeless mental health service user population.

However, national data exists on the demographics of the homeless population within the UK. Comparing the demographics of the UK homeless population and the homeless service user group studied in the present research reveal that those homeless individuals who come into contact with secondary care mental health services for treatment of anxiety and depression are disproportionately more likely than the wider homeless population to be older, male and White (see Appendix H for national comparator data on the homeless population).

3.3.2. Demographic Profile of Homeless and Housed Service Users

Homeless and housed groups differed significantly across all demographic variables (Table 1). There were significant differences between the homeless and housed groups in terms of age. On average, homeless service users (mean age= 38.9 years, S.D=12.0) were 8.4 years younger than housed service users (mean age= 47.3 years, S.D=19.1). In line with the NCAAD report, and the way in which

age is reported in the homeless literature more generally, service users were then grouped into age bands and groups were subsequently compared. This revealed that just under two thirds of all homeless service users fell into either the 26-35 years' age band or the 36-45 years' age band (58.7%). This is in contrast to under one third of the housed group falling in these age bands (32.5%). Housed service users were significantly more likely than homeless service users to be over 65 years of age. One in five of all housed service users were over 65 years (20.9%), compared with less than one in fifty (1.8%) homeless service users.

Groups differed significantly in terms of gender. Homeless service users were more likely than housed service users to be male. Males accounted for four in five homeless service users (80%), compared with just under half of all housed service users (49.5%). Given so few service users reported non-binary gender identity, frequency data on this were reported in Table 1, but were excluded from subsequent percentage calculations and analyses.

Homeless and housed groups also differed significantly in terms of ethnicity. While both groups had a White majority, ethnic minorities were disproportionately overrepresented in the homeless group. Specifically, just under one fifth of homeless service users were of BAME backgrounds (18.5%), compared with around one tenth of housed service users (9.9%). Focusing on the distribution of ethnicity across the homeless service user group, just less than one in ten identified as Asian (8.3%), around one in twenty were Black (5.3%), and just under one in twenty were of Mixed or Multiple ethnicity (4.9%).

The homeless and housed groups also differed significantly in the type of occupation they undertook. Just under half of all homeless service users were unemployed and seeking work (45.8%), compared with less than one in five housed service users (18.3%). Around one quarter of homeless service users were unemployed and not receiving welfare benefits (23.6%), compared with less than one in twenty housed service users (4.6%). Conversely, around one fifth of housed service users were employed for more than 16 hours per week (21.1%), compared with just over one in twenty homeless service users (6.3%). The

housed group were significantly more likely than the homeless group to be retired, with one in four retired individuals in the housed group (24.7%), compared with around one in fifty in the homeless group (2.5%).

Table 1: Demographic Characteristics of Homeless and Housed Service Users

	Homeless		Housed		Significance
	n	*(%)*	*n*	*(%)*	*p*
Age					
16-17 years	1	(0.4%)	94	(2.6%)	
18-25 years	27	(12.1%)	454	(12.7%)	
26-35 years	64	(28.7%)	607	(17.0%)	
36-45 years	67	(30.0%)	554	(15.5%)	X^2(6, N=3795) = 89.874, *p* < .001
46-55 years	42	(18.9%)	661	(18.5%)	
56-65 years	18	(8.1%)	455	(12.8%)	
66+ years	4	(1.8%)	747	(20.9%)	
Gender					
Male	178	(79.8%)	1766	(49.5%)	
Female	45	(20.2%)	1800	(50.5%)	X^2(1, N=3789) = 77.113, *p* < .001
Other	0	-	5	-	
Unknown	0	-	1	-	
Ethnicity					
White British/Irish/Other	168	(81.6%)	3026	(90.1%)	
Mixed/Multiple/Other	10	(4.9%)	125	(3.7%)	
Asian/Asian British	17	(8.3%)	138	(4.1%)	X^2(3, N=3565) = 18.958, *p* < .001
Black African/Caribbean/Black British	11	(5.3%)	70	(2.1%)	
Unknown/Not recorded	17	-	213	-	
Occupation					
Employed less than 15 hours per week	2	(1.0%)	79	(2.5%)	
Employed more than 15 hours per week	13	(6.5%)	655	(21.1%)	
Homemaker	2	(1.0%)	88	(2.8%)	
Long-term sick or disabled	36	(18.1%)	629	(20.3%)	
Unemployed and not receiving welfare benefits	47	(23.6%)	144	(4.6%)	X^2(8, N=3305) = 256.799, *p* < .001
Retired	5	(2.5%)	766	(24.7%)	
Student	2	(1.0%)	156	(5.0%)	
Unemployed and seeking work	91	(45.7%)	569	(18.3%)	
Unpaid or voluntary work	1	(0.5%)	20	(0.7%)	
Declined to answer or unknown	24	-	466	-	

3.3.3. Clinical Profile of Homeless and Housed Service Users

Homeless and housed groups also differed significantly across all clinical variables with the exception of comorbid diagnosis of personality disorder, which was consistent across both groups. Homeless service users were significantly more likely than housed service users to have a primary diagnosis of a stress-related disorder and a comorbid diagnosis of a substance-related disorder. They were also significantly more likely than housed service users to have unplanned and emergency admissions, to be admitted to hospital following contact with the police, and to be admitted on a voluntary basis (Table 2).

3.3.2.1. Primary and comorbid diagnoses: The original audit found that some diagnoses were recorded infrequently, thus the authors constructed four broad categories of psychiatric diagnoses with certain similarities; these categories were sufficient in size to permit comparisons. As such, the present research made use of the same four broad diagnostic categories.

Homeless and housed groups differed significantly in terms of primary diagnosis. Over half of all homeless service users (52.5%) were diagnosed with 'reaction to severe stress and adjustment disorders' compared with just over one quarter of housed service users (26.1%). Depressive episode was the second most common diagnosis in the homeless group, with over one quarter receiving this diagnosis (28.3%). However, the housed group surpassed the homeless group in this diagnostic category, with over one third of housed service users diagnosed with a depressive episode (34.5%). In contrast, around one in five housed service users (21.7%) were diagnosed with an anxiety disorder, compared with just over one in ten homeless service users (12.1%). Rates of persistent or recurrent mood disorders were low in both groups, though higher in the housed group, with just under one fifth of housed service users (17.9%) receiving this diagnosis, compared with just under one tenth of homeless service users (7.2%).

There were also significant group differences regarding comorbid substance-related disorders, with the homeless group significantly more likely to have this diagnosis than the housed group. Just over one third of all homeless service users (35.4%) were diagnosed with substance-related disorders compared with

just over one in ten housed service users (13.0%). Rates of comorbid diagnosis of personality disorder were consistent across homeless and housed groups.

3.3.2.2. Admission type and pathways: There were significant group differences regarding admission type, with around nine in ten homeless service users (90.1%) admitted to hospital on a voluntary basis compared with around eight in ten housed service users (83%). Accordingly, one tenth homeless service users (9.9%) were formally admitted to hospital, compared with just under one fifth of their housed counterparts (17.0%). When service users were formally admitted under the Mental Health Act (1983), this was most often under section 2.

Pathways to being admitted to hospital for inpatient treatment for anxiety and/or depression differed significantly between housed and homeless groups. Over one third of homeless service users (37.7%) were admitted on an emergency basis via ED compared with around one quarter housed service users (26.5%). Furthermore, a significantly greater proportion of homeless service users (17.1%) were admitted to hospital following contact with the police or via section 135 or 136, compared with housed service users (6.9%). Conversely, more than one in ten housed service users (11.3%) had a planned admission into hospital, compared with less than one in twenty homeless service users (4%).

Table 2: Clinical Characteristics of Homeless and Housed Service Users

	Homeless		Housed		Significance
	n	(%)	*n*	(%)	*p*
Primary Diagnosis					
Depressive episode	63	(28.2%)	1226	(34.3%)	
Recurrent depressive disorder/Persistent mood disorder/Other mood disorder	16	(7.2%)	641	(17.9%)	X^2(3, N=3795) = 78.416, *p* < .001
Phobic anxiety disorder/Other anxiety disorder/Obsessive-compulsive disorder	27	(12.1%)	774	(21.7%)	
Reaction to severe stress and adjustment disorders	117	(52.5%)	931	(26.1%)	
Comorbid Diagnosis					
Mental and behavioural disorder due to psychoactive substance use	79	(35.4%)	464	(13.0%)	X^2(1, N=3795) = 86.173, *p* < .001
Disorder of adult personality and behaviour	31	(13.9%)	365	(10.8%)	X^2(1, N=3795) = 2.098, *p* = .148
Admission Type					
Voluntary basis	201	(90.1%)	2964	(83.0%)	X^2(1, N=3795) = 7.763, *p* < .001
Formal basis	22	(9.9%)	608	(17.0%)	
Formal Admission Basis					
Section 2 of the Mental Health Act	21	(95.5%)	565	(93.0%)	
Section 3 of the Mental Health Act	0	(0.0%)	33	(5.4%)	
Section 4 of the Mental Health Act	0	(0.0%)	9	(1.5%)	-
Section 35 of the Mental Health Act	1	(4.5%)	0	(0.0%)	
Section 36 of the Mental Health Act	0	(0.0%)	1	(0.2%)	
Admission Pathway					
Planned	9	(4.0%)	403	(11.3%)	
Emergency via CRHT	46	(20.7%)	1063	(29.8%)	
Emergency via ED	84	(37.8%)	947	(26.5%)	
Emergency via CMHT	5	(2.2%)	246	(6.9%)	
Transfer from other inpatient mental health service	12	(5.4%)	72	(2.0%)	X^2(8, N=3755) = 75.087, *p* < .001
Transfer from acute hospital service	25	(11.3%)	436	(12.2%)	
Admitted via section 135 or 136 or police custody	38	(17.3%)	245	(6.9%)	
Other	3	(1.3%)	121	(3.4%)	
Unknown/Not recorded	1	-	39	-	

3.4. Question 2: How Does the Quality of Mental Health Care Received by Homeless Service Users Compare with That Received by Housed Service Users?

Descriptive statistics were obtained to establish how the quality of care for homeless service users compares with the quality of inpatient mental health services received by housed service users. Comparisons were made with the housed group of service users to ascertain whether differences exist in the quality of care received by the two groups. Quality of care was defined by a set of standards in each of the following aspects of mental healthcare; assessment, carer support, care planning and shared decision-making, treatment using psychotropic medication, discharge, the use of outcome measures and post-discharge support.

3.4.1. Assessment and Treatment

Pearson chi-square tests revealed homeless and housed service users had significantly different experiences across a large range of assessment and treatment variables, with the exception of care planning and shared decision-making where the proportion of service users with, and involved in developing, care plans were consistent across groups. These tests also revealed that the areas considered in the initial assessment differed between groups. Furthermore, homeless service users were significantly less likely than housed service users to have an identified source of social support, their carers were significantly less likely to be offered support from services and they were significantly less likely to be prescribed psychotropic medication at the point of discharge from hospital (Table 3).

3.4.1.1. Assessment: The areas considered in the initial assessment differed between the homeless and housed groups. Homeless service users were significantly less likely than their housed counterparts to be asked about past response to treatment in the initial assessment. Past treatment response was assessed in around eight in ten housed service users (82.2%) compared with around just two thirds of homeless service users (68.0%). Conversely, a significantly greater proportion of homeless service users (83.9%) were asked

about financial difficulties compared with housed service users (70.6%). Homeless service users were also more likely than housed service users to be asked about employment difficulties and social difficulties, and less likely to be asked about history of trauma, and whether they had dependents; though these differences were not statistically significant.

3.4.1.2. Carer support: Homelessness was associated with a greater likelihood of having no identified source of social support from a family member, friend or carer. Just over one quarter (27.8%) of homeless service users were documented in their clinical case notes as having an identified source of support, in contrast with two thirds of housed services users (63.7%). When service users identified a source of social support, it was found that carers of homeless service users fared less well than carers of housed service users in terms of being signposted to support services or being offered a carers' assessment. Four in ten carers of homeless service users (41.9%) were signposted to carer support services, compared with over six in ten carers of housed service users (62.9%). Similarly, less than one tenth of carers of homeless service users (9.7%) were offered a carers' assessment, compared with over one quarter of those caring for housed service users (25.2%).

3.4.1.3. Care planning and shared decision-making: The results revealed that the proportions of homeless and housed service users receiving adequate care planning, and involvement in shared decision-making, were consistent across groups and that homeless service users fared almost equally as well as their housed counterparts in each variable related to care planning.

3.4.1.4. Psychotropic medication: There were significant between-group differences regarding rates of psychotropic medication prescription, with homeless service users significantly less likely than housed service users to be prescribed this medication at the point of discharge. Around three quarters of homeless service users (78.9%) compared with around nine in ten housed service users (87.9%) were prescribed psychotropic medication at discharge. The proportion of service users receiving written or verbal information about their medication, and the proportion of those having their medication reviewed prior to

discharge, were consistent across groups. When a medication review was conducted, the Pearson chi-square test revealed significant group differences, with side-effects of medication considered for around two thirds of homeless service users (63.3%) compared with three quarters of housed service users (75.3%).

Table 3: Quality of Mental Health Care Received by Homeless Service Users Compared with That Received by Housed Service Users: Assessment and Treatment

	Homeless		Housed		Significance
	n	(%)	n	(%)	p
Assessment					
Assessment of past response to treatment	123	(68.0%)	2553	(82.2%)	X^2(1, N=3287) = 22.918, p < .001
Assessment of employment or education difficulties	176	(86.7%)	2365	(83.4%)	X^2(1, N=3040) = 1.537, p = .215
Assessment of financial difficulties	183	(83.9%)	2152	(70.6%)	X^2(1, N=3266) = 17.768, p < .001
Assessment of social difficulties	222	(99.6%)	3326	(96.6%)	X^2(1, N=3667) = 5.915, p = .015
Assessment of dependents	126	(85.1%)	2102	(89.4%)	X^2(1, N=2500) = 2.576, p = .108
Assessment of history of trauma	151	(75.1%)	2464	(78.7%)	X^2(1, N=3330) = 1.470, p = .225
Carer Support					
Identified source of social support	62	(27.8%)	2277	(63.7%)	X^2(1, N=3794) = 114.67, p < .001
Carer signposted to support	26	(41.9%)	1432	(62.9%)	X^2(1, N=2339) = 11.287, p < .001
Carer assessment offered	6	(9.7%)	573	(25.2%)	X^2(1, N=2339) = 7.772, p < .005
Care Planning and Shared Decision-Making					
Care plan in place	196	(87.9%)	3249	(91.0%)	X^2(1, N=3794) = 2.401, p = .121
Care plan produced in conjunction with service user	155	(79.1%)	2671	(82.2%)	X^2(1, N=3445) = 1.227, p = .268
Care plan copy given to service user	122	(62.2%)	1894	(58.3%)	X^2(1, N=3445) = 1.188, p = .276
Care plan review conducted prior to discharge	121	(61.7%)	2130	(65.6%)	X^2(1, N=3445) = 1.194, p = .275
Psychotropic Medication					
Psychotropic medication prescribed	176	(78.9%)	3141	(87.9%)	X^2(1, N=3795) = 15.478, p < .001
Verbal or written information about medication provided	120	(68.2%)	2296	(73.1%)	X^2(1, N=3317) = 2.036, p = .154
Medication review prior to discharge	143	(81.3%)	2718	(86.5%)	X^2(2, N=3317) = 5.081, p = .079
Medication review considered response to medication	104	(95.4%)	2190	(96.6%)	X^2(1, N=2357) = 0.480, p = .488
Medication review considered side-effects of medication	69	(63.3%)	1706	(75.3%)	X^2(1, N=2357) = 7.911, p < .005

3.4.2. Treatment Evaluation, Discharge and Follow Up

Regarding treatment evaluation, discharge, post-discharge support and follow up care, homeless and housed groups differed significantly across the majority of quality of care indicators, with an exception being treatment evaluation which was consistent across groups. While groups did not differ in terms of overall rates of discharge and readmission, the quality of care around discharge and follow up was comparatively poorer for homeless service users (Table 4).

3.4.2.1. Treatment evaluation and discharge: Regarding treatment evaluation, groups were compared on the use of validated outcome measures to monitor, inform and evaluate treatment; the use of outcome measures was consistently low across groups. Rates of discharge and readmission were also both largely consistent across homeless and housed groups with around nine in ten service users in both groups (90.6% and 86.6%) discharged during the audit period, and around one in ten service users in both groups being readmitted to hospital (11.4% and 12.5%).

Regarding best practice procedures around discharging service users from hospital, there were significant between-group differences in whether care plans were sent to the accepting services, and whether discharge letters were sent to GPs. In both cases, communication between the discharging and accepting service was poorer for homeless compared with housed service users. Care plans were sent for just over one third of discharged homeless service users (35.1%), compared with almost half of discharged housed service users (47.0%), and GP letters were sent for around eight in ten discharged homeless service users (81.2%), compared with almost nine in ten discharged housed service users (86.1%). Proportions of service users whose GP letters were sent within 24 hours were consistent across groups, as were rates of GP letters that included service user risk assessment and contact details of the discharging service. There were however significant between-group differences in the inclusion of service users' medication details in the GP letter, with homeless service users significantly less likely than housed service users to have details of their medication included in the GP letters.

Concerning notification of discharge, a significantly lesser proportion of homeless service users were provided with 24 hours' notice of discharge compared with their housed counterparts; around two thirds of homeless service users (68.8%) compared with over three quarters of housed service users (77.7%) were given at least 24 hours' notice. There were also significant group differences in carer notification of discharge, with carers of homeless service users less likely to have appropriate notice than those caring for housed service users. Of discharged service users with an identified carer, just over one third of carers of homeless service users (37.7%) received 24 hours' prior notification of discharge, compared with over two thirds of carers of housed service users (70.6%).

Compared with the housed group (78.1%), a significantly lesser proportion of homeless service users (63.4%) were discharged with To-Take-Out (TTO) medications. Significant between-group differences were also observed regarding medication review prior to discharge from hospital, with medication reviews taking place for just under half of all discharged homeless service users (47.3%) and almost two thirds of all discharged housed service users (65.4%). There were no statistically significant group differences in consideration of medication response or medication side-effects in the review of medication prior to discharge.

3.4.2.3. Follow Up: With regard to post-discharge support and involvement, there were significant group differences in crisis planning, with homeless service users significantly more likely than housed service users to be discharged without a crisis plan in place; three quarters of housed service users (75.0%) had a crisis plan, compared with under two thirds of homeless service users (62.9%).

Furthermore, around eight in ten homeless service users (81.2%), compared with nine in ten housed service users (90.4%), were followed-up by a professional after being discharged. This difference was also significant. When service users were followed up after discharge, there were significant between-group differences in the method of follow up, with housed service users more likely to be followed-up face-to-face and homeless service users more likely followed up via telephone. Specifically, two in three homeless services users (67.1%) received face-to-face follow up, compared with four in five housed service users

(81.3%), while one in three (32.9%) homeless service users were contacted via telephone, compared with less than one in five of their housed counterparts (17.3%). Homeless services users were significantly less likely than housed service users to be followed up within 48 hours of discharge; under half of all discharged homeless service users (44.9%) were followed up within 48 hours, compared with over half of housed service users (55.7%).

Table 4: Quality of Mental Health Care Received by Homeless Service Users Compared with That Received by Housed Service Users: Evaluation, Discharge and Follow Up

	Homeless		Housed		Significance
	n	(%)	*n*	(%)	*p*
Treatment Evaluation					
Treatment evaluated using any outcome measure	134	(60.1%)	2178	(61.0%)	X^2(1, N=3795) = .078, *p* = .780
Discharge					
Discharged during audit period	202	(90.6%)	3094	(86.6%)	X^2(1, N=3795) = 2.889, *p* =.089
Readmitted during audit period	23	(11.4%)	388	(12.5%)	X^2(1, N=3296) = 0.231, *p* = .630
Care plan sent to accepting service	71	(35.1%)	1455	(47.0%)	X^2(2, N=3301) = 16.256, *p* < .001
GP letter sent upon discharge	164	(81.2%)	2665	(86.1%)	X^2(2, N=3296) = 67.934, *p* < .001
GP letter sent within 24 hours of discharge	74	(45.4%)	1194	(45.2%)	X^2(1, N=2803) = 0.002, *p* = .966
Service contact details included in the GP letter	126	(79.7%)	2140	(81.9%)	X^2(1, N=2772) = 0.449, *p* = .503
Medication details included in the GP letter	137	(86.7%)	2456	(94.0%)	X^2(1, N=2772) = 12.954, *p* < .001
Risk details included in the GP letter	127	(80.4%)	2101	(80.4%)	X^2(1, N=2772) = 0.000, *p* = .999
Service user given at least 24 hours' notice of discharge	139	(68.8%)	2403	(77.7%)	X^2(1, N=3296) = 8.426, *p* = .004
Of those with identified support, carer given 24 hours' notice of discharge	20	(37.7%)	1379	(70.6%)	X^2(1, N=2007) = 26.349, *p* < .001
Psychotropic Medication at Discharge					
Discharged with TTO medication	128	(63.4%)	2419	(78.1%)	X^2(2, N=3301) = 27.296, *p* < .001
Medication reviewed upon discharge	70	(47.3%)	1617	(65.4%)	X^2(1, N=2619) = 20.049, *p* < .001
Medication review considered response to medication	67	(95.7%)	1566	(96.8%)	X^2(1, N=1687) = 0.277, *p* = .598
Medication review considered side-effects of medication	47	(67.1%)	1194	(73.8%)	X^2(1, N=1687) = 1.548, *p* = .213
Post-Discharge Support and Service Involvement					
Crisis plan in place	127	(62.9%)	2319	(75.0%)	X^2(1, N=3794) = 14.525, *p* < .001
Follow up	164	(81.2%)	2798	(90.4%)	X^2(2, N=3296) = 29.020, *p* < .001
Follow up method; face-to-face	108	(67.1%)	2274	(81.3%)	X^2(1, N=2919) = 23.939, *p* < .001
Follow up method; telephone	53	(32.9%)	484	(17.3%)	
Follow up within 48 hours of discharge	70	(44.9%)	1558	(55.7%)	X^2(1, N=2849) = 10.148, *p* < .001

3.5. Question 3: What Proportion of Homeless Service Users Are Referred for Psychological Therapy?

The present research also sought to ascertain whether homeless service users' access to psychological therapy is equal to that of housed service users, and to improve understanding of the circumstances around such referrals being made, accepted and initiated. Descriptive statistics were obtained for both homeless and housed groups, and Pearson chi-square tests were performed to establish whether between-group differences exist in referral to psychological therapy (Table 5).

3.5.1. Referral to Psychological Therapy

Homeless service users were significantly less likely than housed service users to be referred for psychological therapy. Just sixty-two homeless service users were referred, equating to around one quarter of the total homeless group (27.8%). By contrast, four in every ten (39.7%) housed service users were referred for some form of psychological therapy.

Examination of the referrals made to psychological therapy services revealed that homeless service users were also less likely than housed service users to be referred to both individual and group therapeutic modalities, though these differences were not statistically significant. Since so few homeless service users were referred for psychological therapy, the sample size may be insufficient to detect significant differences.

The services to which referrals for psychological therapy were made differed significantly between groups, with homeless service users significantly more likely than housed service users to be referred to Improving Access to Psychological Therapies (IAPT) services, and housed service users significantly more likely to be referred to NHS secondary care services. While just over half of the homeless service users who were referred for psychological therapy (58.1%) were referred to NHS secondary care services, this was the case for over three quarters of referred housed service users (77.5%). By contrast, just under one third of all homeless service users referred for psychological therapy (30.2%)

were referred to IAPT services. This is compared with just over one tenth of housed service users (12.0%).

Once referrals had been made, it was necessary to understand whether such referrals resulted in psychological therapy being initiated. Homeless service users were less likely than housed service users to start either individual or group therapy once referred, though this difference was not statistically significant. Just over one third of referred homeless service users started individual therapy (36.4%), compared with just over half of housed service users (54.4%). Similarly, just over half of all homeless service users referred for group therapy began treatment (58.8%). Less than three quarters of housed service users (72.8%) referred for group therapy started it.

Table 5: Referral to Psychological Therapy

		Homeless		Housed		Significance
		n	(%)	*n*	(%)	*p*
Referred for Psychological Therapies						
Referred for psychological therapy		62	(27.8%)	1416	(39.7%)	X^2(1, N=3794) = 12.394, *p* < .001
Referred for individual therapy		43	(75.4%)	1060	(80.6%)	X^2(1, N=1372) = 0.926, *p* = .336
Referred for group therapy		17	(29.8%)	400	(30.4%)	X^2(1, N=1373) = 0.008, p = .927
Accepting Services of Referrals for Individual Psychological Therapy						
Private		0	(0.0%)	10	(0.9%)	
Third sector		2	(4.7%)	24	(2.3%)	
NHS secondary care		25	(58.1%)	821	(77.5%)	X^2(4, N=1103) = 14.268, *p* < .006
IAPT		13	(30.2%)	127	(12.0%)	
Other		3	(7.0%)	78	(7.4%)	
Psychological Therapy Initiation						
Started individual therapy	Yes	16	(36.4%)	577	(54.4%)	
	No	21	(47.7%)	347	(32.8%)	X^2(2, N= 1105) = 5.687, *p* = .058
	Unknown	7	(15.9%)	136	(12.8%)	
Started group therapy	Yes	10	(58.8%)	291	(72.8%)	
	No	5	(29.4%)	65	(16.2%)	X^2(2, N= 417) = 2.130, *p* = .345
	Unknown	2	(11.8%)	44	(11.0%)	

3.6. Question 4: Which Demographic and Clinical Variables Predict Referral of Homeless Service Users for Psychological Therapy?

Data on the homeless group were then analysed, using Pearson chi-square tests to establish whether there were significant differences in the demographic and clinical profiles of homeless service users who were referred for psychological therapy and those who were not. Specifically, it was of interest to ascertain whether referral for psychological therapy was related to age, gender, ethnicity, and primary diagnosis (Table 6). Since addressing this research question involved examining data for only the homeless group and since so few homeless service users were referred for psychological therapy, it was necessary to re-categorise some of the variables in order to create variable categories with sufficient data to produce meaningful results. All predictor variables were then entered into a logistic regression model.

3.6.1. <u>Demographic Characteristics of Homeless Service Users Referred for Psychological Therapy</u>

Age was previously categorised into six age bands, however some age bands possessed too few cases to produce meaningful results. As such, age was regrouped into three broader age bands. The distribution of homeless service users within each age band was largely consistent across both referred and not referred groups, with the majority in both groups aged between 26-55 years. The gender of homeless service users was also consistent across both groups; with males accounting for around 80% of both referred (79%) and not referred (80.1%) groups. While the distribution of homeless service users within each ethnic category was consistent across both referred and not referred groups, there were too few service users in each minority ethnic category to produce meaningful results if each category were to be entered individually into the logistic regression. From a statistical analysis perspective, it was possible to regroup the minority ethnic categories into one overarching BAME category and then compare the referral rates of White service users with those of BAME service users. However, doing this would have problematic connotations and say very little about the impact of ethnicity on rates of referral to psychological therapy. As such, it was decided to exclude ethnicity from the logistic regression

model rather than trying to crudely group together experiences of, for example, Black and Asian service users experiencing homelessness.

3.6.2. Clinical Characteristics of Homeless Service Users Referred for Psychological Therapy

Homeless service users who were referred for psychological therapy did not differ significantly from homeless service users who were not referred in terms of primary diagnosis. The proportion of service users in each diagnostic category was consistent across both groups. In terms of comorbid diagnosis of personality disorder, a greater proportion of homeless service users referred for psychological therapy were diagnosed with comorbid personality disorder, compared with those who were not referred. However, this difference was not statistically significant. Similarly, those referred for psychological therapy were more likely than those who were not to have a comorbid diagnosis of a substance-related disorder, though these group differences were not statistically significant.

Table 6: Demographic and Clinical Characteristics of Homeless Service Users Referred for Psychological Therapy Compared With Those Who Were Not

	Referred		Not Referred		Significance
	n	(%)	*n*	(%)	*p*
Age					
16-25 years	8	(12.9%)	20	(12.4%)	
26-55 years	48	(77.4%)	125	(77.6%)	X^2 (2, N=223) = 0.012, *p* = .994
56+ years	6	(9.7%)	16	(9.9%)	
Gender					
Male	49	(79.0%)	129	(80.1%)	X^2 (1, N=223) = 0.033, *p* = .856
Female	13	(21.0%)	32	(19.9%)	
Ethnicity					
White British/Irish/Other	49	(79.0%)	119	(73.9%)	
Mixed/Multiple/Other	1	(1.6%)	9	(5.6%)	X^2 (4, N=223) = 3.032
Asian/Asian British	3	(4.8%)	14	(8.7%)	
Black African/Caribbean/Black British	4	(6.5%)	7	(4.3%)	, *p* = .553
Unknown/Not recorded	5	(8.1%)	12	(7.5%)	
Primary Diagnosis					
Depressive episode	14	(22.6%)	49	(30.4%)	
Recurrent depressive disorder/Persistent mood disorder/Other mood disorder	8	(12.9%)	8	(5.0%)	X^2 (3, N=223) = 4.962, *p* = .175
Phobic anxiety disorder/Other anxiety disorder/Obsessive-compulsive disorder	8	(12.9%)	19	(11.8%)	
Reaction to severe stress and adjustment disorders	32	(51.6%)	85	(52.8%)	
Comorbid Diagnoses					
Mental and behavioural disorders due to psychoactive substance use	19	(30.6%)	60	(37.3%)	X^2 (1, N=223) = 0.858, *p* = .354
Disorders of adult personality and behaviour	11	(17.7%)	20	(12.4%)	X^2 (1, N=223) = 1.058, *p* = .304.

3.6.3. Logistic Regression Model

Before carrying out the logistic regression, an a priori power analysis was performed using a two-tailed test, with a medium effect size (d= .5), and an alpha of .05. It revealed that a total sample of 124 service users was required to achieve a power of .80. Since there were 223 homeless service users in total, the sample size had sufficient statistical power to produce meaningful results.

Logistic regression is used to predict a nominal dependent variable, given one or more independent variables, when the dependent variable has two possible outcomes (Lund Research, 2018). To ascertain whether age, gender, and primary diagnosis have a predictive effect on referral of homeless service users to psychological therapy, in which all independent variables were nominal level data, logistic regression was an appropriate method of analysis.

Before conducting the logistic regression, it was necessary to ensure that the data met the four assumptions required to produce a valid result. The first three assumptions were met; that is, the dependent variable was dichotomous nominal level of measurement; that there were one or more independent variables of nominal, ordinal or continuous level of measurement; and that the dependent variable comprised mutually exclusive categories. The fourth assumption, that there is a linear relationship between any continuous independent variables and the logit transformation of the dependent variable, was not applicable since all of the independent variables were of nominal level of measurement.

The logistic regression model (Table 7) yielded that none of the four demographic and clinical variables included in the model had a statistically significant predictive effect on referral of homeless service users to psychological therapy. Interactions between the three variables were tested, and none were found to be significant.

Table 7: Logistic Regression Model of Predictive Factors for Referral of Homeless Service Users to Psychological Therapy

Variable	Categories	B(SE)	Exp B (OR)	95% CI for Exp(b)		Significance
				Lower	Upper	
Age bands	18-25 years					p = .980
	26-45 years	.032 (.643)	1.033	.293	3.643	p = .960
	55 years+	.090 (.513)	1.094	.400	2.990	p = .861
Gender	Male					
	Female	.128 (.375)	1.137	.545	2.370	p = .733
Primary diagnosis	Depressive episode					
	Recurrent mood disorder	.284 (.368)	1.328	.645	2.731	p = .441
	Anxiety disorder	-.995 (.545)	.370	.127	1.077	p = .068
	Stress-related disorder	-.107 (.472)	.899	.357	2.265	p = .821
Constant		.800 (.586)	2.226			p = .172

4.   CHAPTER FOUR: DISCUSSION

4.1.   Chapter Overview

This chapter summarises the key findings from the present thesis and considers these in relation to the existing empirical and theoretical literature. The novel contributions of this thesis are highlighted and the clinical implications of the findings are considered. The methodological strengths and limitations of this thesis are discussed, directions for future research are outlined and conclusions are drawn.

4.2.   Summary of Key Findings

In summary, this research highlighted that homeless and housed service user groups differed significantly in terms of both demographic and clinical profiles. The homeless group were significantly more likely than the housed group to be male, aged between 26-45 years, White though disproportionately from BAME groups, unemployed but seeking work, or unemployed and not receiving benefits. They were also more likely to be diagnosed with stress-related disorders, have comorbid diagnoses of substance-related disorders, be admitted to hospital on a voluntary basis and have unplanned, emergency admissions.

Furthermore, findings revealed that homeless service users were disadvantaged on nearly all quality of care variables, when compared with housed service users. This was particularly evident in terms of receiving comprehensive assessment, carer support, prescription of psychotropic medication, adequate communication around discharge, follow up care and referral for psychological support. The logistic regression revealed that no demographic or clinical variables predicted referral to psychological therapy in the homeless group, though this may be due to the unequal sized groups resulting in an inability to detect significant predictive effects or a result of homeless status overshadowing all other variables in predicting referral. It remained clear that homeless service users are underserved by psychological services.

4.3. Question 1: How Do the Demographic and Clinical Profiles of Homeless Service Users Diagnosed with Anxiety and/or Depression Compare with those of Housed Service Users?

4.3.1. <u>Demographic Profile of Homeless and Housed Service Users</u>

The findings on the demographic profile of homeless service-users were largely in keeping with the existent literature on the demographics of the UK homeless population. The present research found that homeless service users admitted to hospital for anxiety or depression were, on average, 8.4 years younger than housed service users. Furthermore, around 60% of the homeless group fell into the 26-45 years' age band, compared with just one third of the housed group. Similarly, studies examining homeless inpatients have found that homeless inpatients tended to be younger than inpatients with secured accommodation (Adams, Rosenheck, Gee, Seibyl & Kushel, 2007; Lauber et al., 2006). UK government data sources reflect similar age distributions in the homeless population more generally, with 62% of homeless individuals aged between 25 and 44 years (ONS, 2019). Moreover, investigations specifically focused on rough sleeper demographics also demonstrate that those who are literally roofless most frequently occupy the 26-45 years' age category (Greater London Authority, 2019). Taken together and considered in relation to the average life expectancy of UK general population, these findings could suggest that homelessness is an issue of 'middle' adulthood. However, it is important to consider that homeless average life expectancy is 44 years (ONS, 2018), some 33 years less than the general population. Since the age distribution among the homeless service user group in the present study reflects the age distribution in the homeless population more generally, it could be argued that anxiety and depression among the homeless are not disproportionately experienced by certain age groups; rather homeless individuals are vulnerable to both anxiety and depression across the lifespan.

The homeless group was a male majority, with 80% of homeless service users being male. This male majority reflects the gender split in the rough sleeping homeless population more generally (Greater London Authority, 2019; Homeless Link, 2013). Furthermore, these findings are reflective of previous research

finding higher rates of males among homeless inpatient populations (Lauber et al., 2006). However, considering Slesnick and Prestopnik's (2005) finding that homeless females were more likely to be diagnosed with anxiety and affective disorders (42% and 28% respectively) than homeless males (21% and 12%, respectively), it is surprising that homeless females were not slightly overrepresented in the present sample.

This research also found that while both homeless and housed groups were a White majority, the homeless service user group were more likely than the housed group to be of BAME backgrounds. Specifically, one fifth of the homeless service users were of BAME backgrounds, compared with one tenth of the housed service users.

As is the case in the homeless population more generally (Greater London Authority, 2019), this study found that while the homeless service users were a White majority, ethnic minorities were disproportionately represented in the homeless group compared with rates of ethnic minorities in the general population (Ministry of Housing, Communities and Local Government, 2019b). Considering the intersectionality of racial discrimination, low socioeconomic status and homelessness, it is unsurprising that many homeless individuals from BAME communities experience mental health difficulties. A study examining mental health in BAME homeless individuals found that young homeless people with a history of racial or ethnic discrimination experienced more emotional distress than homeless individuals without such a history (Milburn et al., 2010).

Regarding occupation status, this research found that homeless service users were more likely than housed service users to be unemployed and seeking work, or unemployed and not receiving welfare benefits, and these categories of occupation status were the two most frequently occupied by the homeless group. This corroborates previous findings that mental health and disability substantially impact upon the ability of homeless people to remain in employment and participation in income support programmes (Zuvekas & Hill, 2000). Focus-group data from a group of homeless young people regarding their challenges in obtaining and maintaining employment revealed that mental illness, addiction,

previous involvement with the criminal justice system, prior experience of homelessness and geographic transience present significant barriers to employment for this population (Ferguson, Bender, Thompson, Maccio & Pollio, 2012). Psychological distress and mental health difficulties not only impact upon an individual's ability to secure and sustain employment, but a lack of employment and therefore a lack of regular and reliable income represents another source of stress that can impinge upon, and in turn exacerbate existing mental health difficulties.

4.3.2. Clinical Profile of Homeless and Housed Service Users

4.3.2.1. Primary diagnosis: This research found that over half of the homeless group were diagnosed with 'reaction to severe stress and adjustment disorders', which includes acute stress reaction, PTSD, adjustment disorder and other or unspecified reactions to severe stress.

Regarding PTSD in the homeless population, given the aforementioned postulation of traumatic experiences being one of three pathways into homelessness, it is perhaps unsurprising to learn that psychological trauma and PTSD are so prevalent in this population. In a study on 70 homeless men and women, Taylor and Sharpe (2008) found that 98% had experienced at least one traumatic event in their lifetime, with six being the mean number of traumatic events per person. They also found that in the 12 months prior to participation in the study, 41% of the sample had experienced PTSD, which is compared to 1.5% of the general population. The generalisability of these finding is limited by the relatively small sample size.

The finding of high rates of diagnosis of stress-related disorders in the homeless group is unsurprising considering homeless individuals' likelihood of exposure to the risk factors associated with the development of such disorders. Risk factors include low socioeconomic status, unemployment, no educational qualifications, renting rather than owning a home, being divorced, separated or widowed, and urbanicity (Puri & Treasaden, 2009). Furthermore, the finding that homeless service users were more likely than housed service users to be diagnosed with adjustment disorder, is supported in the literature. Votta and Farrell (2009) found

that homeless individuals were significantly more likely than housed individuals to report increased suicidality, depressive symptoms and internalising and externalising behaviour problems, as well as lower self-worth and a disengagement coping style; all of which are indicative of adjustment disorder. However, this study had a small sample size and is based on self-report data rather than standardised clinical assessment of adjustment disorder.

The ICD-10 states that these disorders can be conceptualised as 'maladaptive responses' to severe acute or ongoing stress which interferes with the individuals' ability to employ 'successful coping mechanisms' and therefore 'lead to problems of social functioning'. While on the one hand, the argument for the usefulness of these diagnostic categories would include that they allow individuals with such experiences to access treatment, enable clinicians to identify the appropriate course for intervention, and give words, labels or understandings to experiences; but on the other hand it could be said that such diagnostic labels obscure and depoliticise the social causes of misery (Pilgrim, 2007). To apply such diagnoses to homeless individuals who are likely experiencing significant stressors in their everyday lives, which remain largely out of their control, serves to medicalise their understandable misery (Pilgrim & Bentall, 1999) and imply that there is a healthy way in which one should adapt to a constant threat to their personal safety (Pilgrim, 2007), and fight for their survival against social injustice (Moncrieff, 2010). The application of adjustment disorder diagnoses to this population raises questions about what is conceptualised as 'healthy' ways of coping and adjusting to destitution, significant social stresses and repeated threats to one's survival. Nonetheless, these diagnoses are the current modus operandi within NHS services at present and although problematic they arguably have some utility for homeless individuals in seeking the appropriate support from services. Taken together the finding of substantially higher rates of diagnosis of stress-related disorders in the homeless group raises questions about the function and utility of this diagnosis, as well as how these diagnoses are being applied in clinical practice. While this may enable an individual to meet certain criteria necessary to access services, the pathologisation of understandable responses to extraordinarily stressful circumstances arguably have moral implications.

With over one quarter of the homeless group admitted to hospital for treatment of depressive episode, this was the second most frequently occurring diagnosis in this group. However, the rates of depressive episode among the homeless group were lower than the 40-60% prevalence rate found in other studies (e.g. Archer et al., 2017). It could be that homeless individuals diagnosed with stress-related disorders had low mood or depression prior to experiencing the stressful event, but did not come into contact with services until the experience of a stressful event caused a stress-related disorder. The present study also found that rates of anxiety disorders, which included phobic disorders, obsessive compulsive disorders and other anxiety disorders, were lower than reported elsewhere in the literature. This may be an artefact of the categorisation of PTSD and other stress-related disorders as a subcategory within neurotic/anxiety disorders. In other words, the present study separated stress-related disorders from anxiety disorders, while other research may be including stress-related disorders when investigating the prevalence anxiety disorders in the homeless population.

4.3.2.2. *Comorbid diagnoses:* Compared with housed service users, those in the homeless group had markedly higher rates of comorbid substance-related disorders. Given prior findings that these are the most common type of disorders in homeless populations (Fazel, Khosla, Doll & Geddes, 2008) with some meta-analyses reporting pooled prevalence rates of over 60% (e.g. Schreiter et al., 2017), and findings that history of unhealthy alcohol and drug use are more common among homeless than housed individuals (Doran et al., 2018), the findings of high rates of substance-related comorbidity in the present study might have been predicted. This has important consequences for services, since such comorbidity warrants attention.

Regarding comorbid diagnosis of personality disorder, it was initially predicted that rates of comorbidity would be higher in the homeless group than in the housed, given findings in the existing literature supporting this prediction (e.g. Rees et al., 2009). However, this study did not find significant between group differences in prevalence of comorbid diagnoses of disorders of adult personality and behaviour. While there were slightly higher rates in the homeless group this was not reflective of findings from previous studies (e.g. Ball, Cobb-Richardson,

Connolly, Bujosa & O'Neall, 2005; Fazel et al., 2008; Salavera, Tricás & Lucha, 2013; Whitbeck, Armenta & Welch-Lazoritz, 2015). This might be explained by the nuances of the homeless population in the present study and the way in which NHS services are delivered. It is well documented that individuals with personality disorder are often excluded from mainstream services (Kealy & Ogrodniczuk, 2010), as it is arguably felt that services specially designed to manage the complexities associated with personality disorder are better equipped (Murphy & McVey, 2010), and the low rates of comorbid personality disorder in both homeless and housed groups supports this hypothesis. Alternatively, lower rates of diagnosis of personality disorder in the present study may reflect the fact that the present study was looking at comorbid diagnoses, while previous research (e.g. Ball et al., 2005; Salavera et al., 2013) finding high rates of personality disorder among the homeless has been concerned with personality disorder as a primary diagnosis.

The homeless as compared to other psychiatric inpatients had higher rates of substance use disorders, equal rates of psychotic and personality disorders, (Lauber et al., 2005)

4.3.2.3. Admission type and pathway: It was found that homeless service users were significantly more likely to be admitted to hospital on a voluntary basis and less likely to be detained on a formal basis, when compared with housed service users. This was surprising given previous findings of higher rates of formal detention among the homeless population compared with the general population (NHS Digital, 2019). Furthermore, in a survey of 540 psychiatric inpatients, 17.7% of the homeless inpatients had a compulsory admission, compared with 13% of housed inpatients (Schreiter et al., 2019). However, the present study demonstrated homeless service users' willingness or agreement to be hospitalised, which could, at least for rough sleepers, reflect an attempt at securing temporary accommodation while in hospital (Lauber et al., 2005). Alternatively, considering the relative powerlessness of the homeless population, this demonstration of agreement with hospitalisation may reflect a reduced capacity to resist professional suggestions for admission (Dej, 2016).

Regarding admission pathway, the findings of this research support the substantial body of evidence in the literature regarding the overuse of ED by the homeless population. Over one third of homeless service users in the present study were admitted to inpatient hospital for treatment of anxiety or depression on an emergency basis via ED. As previously discussed, prior research has highlighted similar patterns of ED use in this population (Lam et al., 2016; Moore et al., 2007) which underscores that mainstream primary healthcare services continue to be inappropriate, inaccessible and underutilised by this marginalised population; emphasising the need for consideration and implementation of better ways to reach a vulnerable faction of the population who are currently being underserved by the system.

Given what is known from the literature around homeless service users under-utilising preventative or primary care, often due to barriers to access and GP registration (Aldridge et al., 2018) and no recourse to public funds (Farmer, 2017), and only accessing care once unmanaged symptoms have exacerbated, it might have been predicted that more homeless service users would have required formal admissions into hospital.

The present study also found that homeless service users were more likely than housed service users to be admitted to hospital following contact with the police. This may be an artefact of homeless individuals, who are literally roofless, having very limited privacy, and thus their psychological distress may be more visible to the public, including police patrolling the streets (Dej, 2016). This would indicate a need for increased outreach provision that could serve to catch and contain psychological distress in the homeless population before custodial action is deemed necessary; experiences which may serve to traumatise homeless individuals further and reduce their willingness to engage with services.

4.4. Question 2: How Does the Quality of Mental Health Care Received by Homeless Service Users Compare with That Received by Housed Service Users?

4.4.1. Assessment

Regarding initial assessment, this research demonstrated that homeless were more likely to be asked about employment, social and financial difficulties, and less likely to be asked past response to treatment, whether they had any dependents and history of trauma. However, group differences were only significant regarding financial issues and past response to treatment. These trends suggest a lack of standardised assessment within services, and highlights that assessments are likely informed by clinician bias and assumptions about homelessness rather than based on objective, standardised information gathering. This could result in important information being missed, prevents a truly person-centred approach, and perhaps reflects earlier findings that homeless service users feel that mental health assessments do not consider their holistic needs (Darbyshire et al., 2006).

There were a considerable number of cases in the data where it was documented on the Audit of Practice Tool that asking about certain areas in the assessment was deemed 'not applicable'. Given the substantial evidence of the association between, for example, trauma and homelessness (Winiarski et al., 2020), it is concerning that there are occasions where it is felt not applicable to consider potential history of trauma when assessing homeless individuals. This avoidance of assessing trauma perhaps reflects services' incapacity to hold, contain and manage the complexity that homeless service users often bring and require support with (Hopper et al., 2010). Similarly, with the avoidance of assessing whether homeless service users have dependents suggests an unwillingness of services to engage with painful discussions of possible family separation and displacement, but also represents a safeguarding issue, since there is a need to consider the implications of homelessness on children (Malvaso & Delfabbro, 2016). Taken together, results on assessment highlight the need for assessments of homeless service users admitted to hospital to be standardised, comprehensive attempts at information gathering.

4.4.2. Carer Support

This study found homeless service users were significantly less likely than housed service users to have a family member, friend or carer which they identified as a source of support; less than one third of homeless service users identified a source of social support, compared with just under two thirds of housed service users. This is in line with previous research highlighting the social isolation experienced by homeless individuals (Finfgeld-Connett, 2010), and also attests the notion that interpersonal relationship breakdown can be a contributing factor in the pathway to homelessness (Tessler et al., 2001). However, this finding may also reflect possible assumptions made by healthcare professionals that homeless service users have a lack of contact with family members, friends or carers, with such assumptions preventing important questions regarding sources of support from being asked.

However, of the homeless service users who did have an identified source of support, it was found that these identified individuals received significantly less carer support from services, including signposting to appropriate support services and being offered a carer's assessment. Supporting a loved one who is experiencing homelessness can be a significant source of stress for carers (Polgar, 2009), and since social isolation and relationship breakdown is such a significant factor in the lives of many homeless people, it is imperative to support the existing relationships that people have. One aspect of supporting such relationships involves supporting carers and alleviating the burden of care which they may experience. Polgar (2009) highlights that carers of homeless people feel less carer stress when they receive support and that supportive interventions can empower carers, increase family support and improve outcomes for the homeless individual. Furthermore, research shows that having family, friends or mentors from home upon which homeless individuals can rely is associated lowered risk for depressive symptoms and anxiety (Tyler, Schmitz & Ray, 2018).

Since family support supplements the care provided by mental health services and since supporting a homeless relative with a mental health problem is more stressful for carers than supporting a homeless relative without such difficulties

(Polgar, 2011), there is a significant need for services to be doing more to support carers.

4.4.3. Care Planning and Shared Decision-Making

This research revealed no group differences with regard to involvement in care planning and joint decision-making. While rates of care planning were consistently high across both groups, service user involvement in the care planning process and joint decision-making was poor for both groups. The current literature on care planning with homeless service users is limited; however, findings suggest that shared decision-making that involves service users by offering choices, encouraging open conversation, explaining reasons why certain decisions are needed and considering prior treatment response, is rarely happening in practice (Healthwatch Nottingham & Nottinghamshire, 2019). The proportion of service users receiving a copy of the care plan, and having the care plan reviewed prior to discharge was low across both groups; this could have particularly detrimental implications for homeless service users since it is argued that coordination between healthcare settings and organisations is crucial and best achieved through collaborative care planning which is then communicated to various services involved (Faculty for Homeless and Inclusion Health, 2018).

4.4.4. Psychotropic Medication Prescription

Homeless service users were significantly less likely than housed service users to be prescribed psychotropic medication at the point of discharge, which is in accordance with previous research looking at treatment measures during inpatient stay (Lauber, Lay & Rossler, 2006b) which found homeless patients less often received psycho-pharmacotherapy. It is unclear from the data analysed in the present study whether low rates of psychotropic medication prescription in the homeless at the point of discharge reflects lower rates of prescription more generally, or whether it reflects non-adherence and therefore discontinuation of medication during admission. However, there is a wealth of previous research highlighting significant rates of medication non-adherence among homeless individuals (e.g. Coe et al., 2015), thus it could be possible that for some,

medication was an unacceptable form of treatment which led to non-adherence and subsequent discontinuation by the time the service-user was discharged.

There were no significant group differences in terms of whether verbal or written information about medication was provided to service users, whether medication was reviewed prior to discharge or whether such medication review entailed consideration of response to the prescribed medication. Yet, medication review was significantly less likely to consider side effects of medication for homeless service users than housed service users. This reflects previous findings from the Healthwatch Nottingham and Nottinghamshire (2019) focus group which revealed that service users felt they were often prescribed the same treatment for years despite limited or no effect.

4.4.5. Discharge

Regarding discharge from hospital, there were no statistically significant differences in rates of discharge and readmission among homeless and housed service users. However, it is difficult to draw conclusions or inferences about this finding in the absence of LOS data. Thus it remains unclear whether housed and homeless service users are being discharged at equal rates or whether they are receiving different amounts of input from services.

However, the findings around the quality of care that homeless service users received around discharge were interesting. Homeless service users were significantly less likely to have their care plans sent to accepting services or to have a discharge letter sent to their GP. While the latter finding may be a reflection of lower rates of GP registration among homeless service users, a well-documented issue among this population (Aldridge et al., 2018). However, even when GP letters and care plans were sent, the letters for homeless service users' GPs tended to have contained less relevant information, including information regarding the patient's medication or risk assessment. Together, this highlights that there is less communication between the discharging and accepting services for homeless service user. This goes against the guidance published by Healthy London Partnership (2019) on the safe and effective discharging of homeless patients. It also goes against the Faculty of Homeless and Inclusion Health

(2018) guidance stipulating the need for care plans to act as an effective way of ensuring continuity of care as homeless service user's move between services and organisations. Such a lack of detail contained in GP letters has problematic implications for the ability of accepting services to provide successful continuity of care for homeless service users. This could result in poorer outcomes for these individuals who are potentially discharged to services who have very little information about their current mental state, their previous treatment or associated risks.

With regard to receiving 24 hours' notice of discharge, homeless service users and their carers fared significantly worse than housed service users and their carers. This raises important questions around how well-planned the discharge procedure is for homeless people and how supported they feel through the transition from hospital back to the community. It also raises questions around whether those who are literally roofless are being discharged back to the streets, if they are frequently being discharged with less than 24 hours' notice. As Aldridge (2019) points out, if this is the case, it represents a vulnerable adults safeguarding issue, since discharging patients to unsuitable places or back to homelessness is unsafe and inappropriate. It is pertinent that the discharging patients from hospital needs to be structured, planned and supported (Healthy London Partnership, 2019), and this is arguably more important for homeless service users with mental health difficulties than any other patient group, if 'revolving door' readmission rates are to minimised and homelessness is to be reduced. However, the fact that so few homeless service users received appropriate notification of discharge could also have been a result of self-discharging or discharge against medical advice. While it is not possible to identify reason for discharge from the data of the present study, it is well-documented in the literature that rates of self-discharge against medical advice are higher in homeless inpatients than housed inpatients (Brook, Hilty, Liu, Hu & Frye, 2006). This raises questions about what is leading to such high rates of self-discharge in this population and whether it reflects their dissatisfaction with the inpatient mental health care they receive.

Results also show that homeless service users were significantly less likely than their housed counterparts to be discharged from hospital with TTO medication, and when they were discharged with TTO medication this was less likely to be reviewed upon discharge. The reasons for this are unclear, though one possible hypothesis may be that clinician's hold biases around homeless service users misusing substances and thus may feel less comfortable about prescribing upon discharge psychotropic medication which could potentially be misused (Rhoades, Winetrobe & Rice, 2014). An alternative explanation may also be related to homeless service users self-discharging against medical advice (Brooke et al., 2006), which means they may be less likely to have TTO medications in place.

4.4.6. Follow Up

The period after discharge represents a critical period for all patients discharged from psychiatric inpatient services (Hunt et al., 2009; Tomita & Herman, 2012). This period is particularly critical for homeless patients (Herman et al., 2011) since returning to homelessness could result in a relapse in mental health problems and require readmission, creating a 'revolving door' scenario that represents "the missed opportunity to capture and build on the benefits of a hospital stay, to address underlying problems and to support the wider reduction of homelessness" (Healthy London Partnership, 2019, pp. 1). Despite this, the present study found that homeless service users were significantly less likely to be followed up by a professional after discharge; this may represent professionals experiencing problems with making contact with homeless individuals at follow up due to their transient lifestyles. However, if this is the case, it suggests that homeless service users are being discharged either back to homelessness, no fixed abode status, or to temporary, insecure accommodation such as shelters. Such accommodation types are inappropriate places to recover from a mental health difficulty so significant to require hospitalisation (Forchuk et al., 2006).

4.5. Question 3: What Proportion of Homeless Service Users are Referred for Psychological Therapy?

The present research found that homeless service users were significantly less likely than housed service users to be referred for psychological therapy. Previous research echoes the findings, concluding that this group are less likely than the general population to receive psychological therapy to support them with their difficulties (Sauer-Zavala et al., 2019).

However, analyses of the data did not reveal significant differences between homeless and housed groups with regard to referral to either individual or group psychological therapy. Furthermore, while there were differences between the homeless and housed groups in terms of rates of referred service users initiating therapy, with the homeless group less likely than the housed group to start therapy, these differences were not statistically significant. Failure to detect significant group differences in referral to, and initiation of, both individual and group therapy may be a result of the sample size being insufficient to detect statistically significant differences. However, the trends identified are in line with previous research findings. Using interviews with homeless individuals to attempt to understand their perspectives around accessing psychological therapy, Chaturvedi (2016) found that there are a number of barriers at the individual-level that suggest a reluctance in this population to engage with psychological therapy. This reluctance was related to stigmatisation, denial of difficulties, resistance in asking for help, self-determination and lack of understanding around what psychological therapy entails. This may explain the trend in low therapy initiation rates observed in the homeless group of service users in the present study who were referred for psychological therapy.

Significant group differences were detected with regards to the type of psychology service that the referrals were made to. Homeless service users were more likely than housed service users to be referred to IAPT services, while the housed group were significantly more likely than the homeless group to be referred to NHS secondary care psychological services. This finding was of interest since IAPT services are less likely to be equipped to deal with the

complexity of the problems often brought by homeless service users. IAPT services are designed to deliver short-term, low-intensity interventions for common mental health problems such as anxiety and depression, within primary care (NHS England, 2016). Given what is known about the broad array of complexly interconnected difficulties, coupled with long histories of trauma, experienced by the homeless population, it seems that IAPT services are unlikely to be appropriate services to hold, manage and address such complexities, and rather NHS secondary care teams may be far more suited to this. One potential hypothesis that might explain these findings could be that IAPT services tend to have shorter waiting times than NHS secondary care services (NHS England, 2015) thus rationale for referral of homeless service users to IAPT may be that homeless service users are more likely to have their needs met in a timely manner if seen through IAPT. However, if referrals are deemed by the accepting service to be inappropriate, this could lead to the referral being rejected and homeless service user referred back to their GP with recommendations to refer to a more appropriate service. Such instances could lead to increased risk of homeless service users 'slipping through the net' or 'becoming lost in the system', particularly if they do not have a GP, which is often the case.

4.6. Question 4: Which Demographic and Clinical Variables Predict Referral of Homeless Service Users for Psychological Therapy?

The present study did not find any significant demographic or clinical differences between those homeless service users who were referred for psychological therapy and those who were not. Furthermore, the logistic regression did not reveal any significant predictive effects of age, gender, ethnicity or primary diagnosis on referral of homeless service users for psychological therapy. This has rarely been discussed in the literature and therefore warrants further investigation.

Logistic regression typically requires a large sample size to accommodate the number of independent variables entered into the model (Brace et al., 2009). It is generally recommended that for each independent variable there must be at least 10 cases with the least frequent outcome in order to ensure the logistic

regression model is viable. The present study accounted for this by using a more conservative significance value. Since only 62 homeless service users were referred for psychological therapy, and data for only 223 homeless service users were analysed in total, the sample size may have been insufficient to detect significant findings. Alternatively, the findings may be better explained by the homeless label overshadowing other demographic and clinical variables in the prediction of referral for psychological therapy. However, given what is known about intersectionality and the compounding effects of multiple layers of disadvantage created by the possession of intersecting discriminated characteristics (Collins & Bilge, 2020), it is probable that a larger sample size would detect significant demographic and clinical predictors of referral of homeless service users for psychological therapy.

4.7.   Clinical Implications of the Findings

The findings from this study indicate a need for a number of steps to be taken by services to ensure that the mental health care provision gap between housed and homeless service users is bridged and the consequential health inequalities and human rights violations experienced by the homeless population are addressed. This research firstly echoes the guidance from the Department of Health and Social Care (2018), in response to the Homelessness Reduction Act's (2017) 'duty to refer'. That is, there is a fundamental need for NHS services to routinely enquire about service users' housing status. Such routine enquiry enables not only the identification of a marginalised population at risk of receiving inadequate and unequal care, but also facilitates the potential to identify the 'hidden homeless' who might be less 'visible'. Following identification, thorough documentation of housing status is required. In the event of identifying a service user who is homeless or 'at risk of homelessness', documentation around the circumstances surrounding it, such as the type of homelessness experienced, the duration of homelessness and the catalytic factors for entering homelessness, is warranted. Services should then take adequate steps to ensure appropriate care is provided from the first initial contact through to follow up. In light of the findings from the present study, services should pay particular attention to conducting comprehensive assumption-free mental health assessments, providing their

carers with adequate support and signposting, ensuring appropriate NICE recommended treatments are offered, making the necessary referrals to psychological therapies where indicated, involving service users in decisions about their care, and engaging in best practice around planned discharge and follow up care.

In line with the 'duty to refer', it is also necessary for services to make referrals to other appropriate agencies with the person's consent. Services should also endeavour to engage in ongoing monitoring of service delivery to this population. Services should be held accountable for providing appropriate, accessible and inclusive services for all, including the most vulnerable and marginalised groups in society. Such detailed enquiry, documentation and monitoring can also facilitate useful research endeavours, which can serve to improve the state of the literature and lead to continued service improvements and better clinical outcomes for homeless individuals. Research on the homeless population has traditionally been difficult to achieve, in part due to this population being 'hard-to-reach' and in part due to the lack of adequate and accurate reporting by services that this population come into contact with.

Findings of disproportionately high rates of homeless individuals from BAME groups has implications for mental health services who will need to aware of how racial and ethnic discrimination could contribute to increased distress. Increased attention is needed to how institutional racism and structural inequalities filter down to BAME service users and how this adds a layer of disadvantage to homeless service users from these backgrounds. This will also apply for other frequently excluded groups, such as those from LGBT communities, migrants and sex workers. Services should refer to the guidance published by the Faculty of Homeless and Inclusion Health (2018) when considering how to deliver inclusive, acceptable treatment and interventions to individuals who typically occupy the margins of society.

There is also a need to ensure that comorbid diagnoses of 'mental and behavioural disorders due to psychoactive substance use' are addressed instead of being used a gatekeeping factor from psychological therapy. It is often a policy

in psychological therapy services that substance use disorders are addressed before psychological therapy for a mental health issue can commence. With such high rates of comorbidity in this population, it is fundamental to ensure that if using alcohol or substances represent barriers to referral to psychological therapy, then referrals to drug and alcohol services are made and that psychological therapy commences once these issues are addressed.

The findings also point to the need to improve homeless service user's pathways into secondary care. It was found that a large majority of homeless service users are admitted to hospital for treatment for anxiety and/or depression via emergency services, and that rates of unplanned admissions are high. Together these attest the underutilisation of primary care services among homeless individuals and call for greater service flexibility; including increased outreach services and greater accessibility of primary care services, in order to better engage this 'hard-to-reach' population. Such adjustments could reduce the usage of emergency and secondary care services by this population and could serve to improve outcomes.

The results also suggest that services need to do significantly more to ask homeless service users about sources of social support, and when they identify a member of family, a friend or a carer, services should be consistently signposting carers to sources of support and offering a carer's assessment. With homeless individuals often having precarious support networks and interpersonal relationships, and yet social support playing such a key role in mental health recovery, it is paramount that services do more to support the existing relationships that homeless individual's rely on, which can include reducing the burden of care felt by the carer's of homeless service users.

The need for consistent referral of homeless service users to psychological therapy, when it is deemed an appropriate course of intervention, also emerged from the findings. This study showed that homeless service users are disproportionately under-referred compared with housed service users, highlighting the need to document the reason guiding the decision not to refer, in order to ensure that gatekeeping to services as a result of underlying prejudicial

attitudes about this population is not occurring. There are also implications for psychology services, and for those clinicians making referrals of homeless individuals to such services. The present study identified that when homeless service users were referred for psychological therapy, this was most frequently to IAPT which, given the nature of these services, are unlikely to be equipped to meet the complex needs that homeless individuals often present with. This has implications for psychological therapy services as psychological therapists need to be aware of the issues contributing to, and arising from homelessness as well as have an understanding of the specific vulnerabilities of this population and be equipped with the skills necessary to address these.

A further clinical implication of the findings regards the process of discharge of homeless service users from hospital. There is a need for services to take action to ensure a streamlined discharge from hospital back into the community, with service users and their carers having adequate notice of discharge to ensure a smooth transition and to prevent individuals from re-entering homelessness. It is paramount that services demonstrate joined-up multi-agency working to ensure that homeless individuals are discharged to secure accommodation as opposed to being discharged to no fixed abode. This will serve to prevent 'revolving door patients', since homelessness is known to exacerbate mental health difficulties. If homeless service users are discharged back to the precarious social circumstances they found themselves in prior to hospital admission, maintaining recovery will be increasingly difficult and it would be unsurprising should they would require a further admission to hospital.

Since the days and weeks following discharge from hospital represent a critical period for any service user, and in particular homeless service users, the findings of the present study demonstrate that services need to prioritise the follow up of homeless service users in order to prevent them re-entering homelessness or requiring a subsequent admission to hospital. While it may be argued that there are challenges to following-up homeless service users, given their tendency toward chaotic and transient lifestyles, if their discharge from hospital is well managed and they are discharged to stable accommodation, the challenge of follow up is significantly reduced.

In order to prevent discharging a psychiatrically stable patient before appropriate housing has been obtained, in order to free up a bed to admit another patient who is in crisis, clinicians should assess accommodation status at admission to ensure ample opportunity for services to make appropriate accommodation arrangements prior to discharge (Greysen, Allen, Rosenthal, Lucas & Wang, 2013).

These clinical implications affect mainstream services providing inpatient care to homeless individuals admitted for treatment for anxiety and/or depression, as well as other forms of psychological distress and psychiatric disorder. While it will be good practice for mainstream services to make the following adjustments to their service delivery, these wide-reaching clinical implications could represent the need for a service reform, towards developing specialist homeless mental health care services that can become embedded within established teams in each locality.

Such a model was piloted in South London and Maudsley (SLAM) NHS Trust between December 2014 and December 2017 (Khan, Koehne, Haine & Dorney-Smith, 2018). This inter-professional Pathway Homeless team comprised a Mental Health Practitioner, a Housing Worker, a GP, a Business Manager and Clinical Academics. The aim of this pilot was to develop an integrated service capable of improving health and housing outcomes for homeless inpatients. Other key outcomes were to reduce rates of unscheduled admissions and an increase access to scheduled care and community services. The team also ensure that service users are registered with a GP and liaise with other services in the community to ensure effective communication between services and care planning. The outcomes of this pilot were impressive, with improved housing status observed for 74% of service users, and where housing solutions were not achieved; service users were signposted to relevant services and were provided with a key worker to support them in the community post-discharge. Results also suggested a reduction in unscheduled care, and improved use of scheduled care in the community. The findings from this pilot are highly promising and exemplify ways in which services can be designed in an integrated and holistic way to best meet the needs of a population with complex needs.

4.7.1. <u>Conceptualising the Wider Implications of the Findings</u>

The findings from the present study highlight the various ways in which NHS secondary care mental health services across England fail to provide an equal service to homeless and housed service user populations. In order to address the health inequalities faced by homeless service users, the quality of secondary care services they receive needs to be at least on par with that received by housed service users. Though as denoted by the concept of 'Proportionate Universalism' (Marmot et al., 2010), reducing health inequalities experienced by marginalised and underserved groups requires action that is proportionate to their needs and level of disadvantage. As such, there is a need for service providers and policy makers to consider how to adjust service delivery to ensure that the disparities in quality of care received by homeless and housed service user groups are remedied.

Bronfenbrenner's (1979) Ecological System's Theory was previously employed to formulate how psychological distress may *develop* for an individual experiencing homelessness (section 1.7.2). As previously stated, this framework can also be used to identify avenues through which supportive interventions can be targeted in order to *address* the factors contributing to that individual's psychological distress. This section explores how Ecological System's Theory (Bronfenbrenner, 1979) can be used by mental health service providers and policy-makers to map service delivery adjustments based on this study's findings of gaps in provision to homeless service users. This model can help service providers and policy-developers to conceptualise where adjustments to service planning and delivery can be made at each concentric system level to ensure that the quality of care provided to homeless service users is able to adequately meets their needs. The present study was based on data from an audit on secondary mental health services, and as such, secondary care services are placed centrally within the formulation (Figure 2).

4.7.1.1. Secondary care mental health services: The present study revealed that secondary mental health services are currently failing to deliver care of an appropriate and acceptable quality to meet the needs of its' homeless service user population. Furthermore, homeless service users receive a poorer quality of

care compared to housed service users. When planning to address these inequalities, services should consider the immediate service delivery context including funding, targets, management structures and staff capacity. Taken together, these contextual factors can be usefully understood as impacting upon the ability of the service to provide appropriate care to homeless service users.

4.7.1.2. The microsystem: The microsystem surrounding secondary mental health services can include those responsible for creating the service's policies and those responsible for training frontline staff. It also includes the frontline staff themselves who are employed by the service to work directly with the homeless service users, and who are therefore responsible for delivering the care commissioned by the service, to the homeless service user.

Based on the present findings, those creating the service's policies may need to consider developing a service-wide policy for enquiring about, and recording, service user's housing status so as to ensure that homeless service users are being identified and that their specific needs are to be met. This policy should detail the necessary steps to be taken once a homeless service user is identified, including how staff must respond in accordance with the Homelessness Reduction Act's (2017) 'duty to refer'. There is also a need for the development of a policy that outlines the safe discharging of homeless service users, and this could be guided by the recommendations published by the Healthy London Partnership (2019).

The findings from the present study also highlight the need for mandatory training to all frontline staff on how to effectively assess the needs of service users who have been identified as homeless. The findings suggest that homeless service users are not currently receiving holistic, assumption-free assessment, with certain areas of assessment often neglected and other areas often emphasised due to the assumptions of the assessor. The assessment is the first step to engaging a person and thus this process should feel collaborative and therapeutic, and is of increased importance for homeless service users who experience additional barriers to engagement. Such training should raise awareness of the importance of engaging homeless service users with services,

and of fostering the relationships that homeless individuals have with their carers. Training should also emphasise the importance of supporting carers of homeless individuals so as to reduce carer stress and burden. There will also therefore be a need to raise staff awareness of services available to support carers of individuals experiencing homelessness, and the need for signposting carers to these services.

The findings from the present study also show that frontline staff should be trained in safe and effective discharge planning, and this should be in line with the service's discharging policy, which in turn should be guided by The Healthy London Partnerships' (2019) discharging guidance. The findings of this study highlight the need for improved multiagency communication via discharge letters and care plans being sent to relevant services and for appropriate notice of discharge to be given to homeless service users and their carers. Training staff on the importance of safe and effective discharge and crisis planning, and the need for efficient follow up of homeless service users is fundamental if secondary care services are to improve the post-discharge outcomes of homeless service users and reduce the provision gap between them and housed service users.

While developing policies and delivering training to frontline staff in the microsystem may help to address some of the inequalities found in the present study, targeting interventions in the microsystem alone will unlikely suffice. This is because the success of these interventions often rely on the effectiveness of external agencies conceptually located in the mesosystem surrounding the microsystem. For example, developing a policy and delivering training to staff on how to effectively discharge homeless service users back to the community relies heavily on there being effective links between the secondary care service and community services.

4.7.1.3. The mesosystem: The mesosystem surrounding secondary care mental health services can include those agencies with which the service may have working relationships. The effectiveness of these multiagency relationships indirectly impact upon the ability of the service to deliver care to homeless service

users. These agencies may include local authorities, housing and employment services and homeless charities.

Based on the findings from the present study homeless service users are less likely to have a planned route into secondary care services. As such, there may be a need to increase awareness among primary care services, such as GP practices, to improve accessibility, acceptability and utilisation of primary care services among this population. This is with the aim of firstly preventing the need for secondary care admission, and if it is not possible to prevent admission, to at least increase rates of planned admissions for homeless service users.

The findings also showed that safe and effective discharging of homeless service users was happening less often than it should be, and communication between discharging and accepting services was poor. This highlights the need for more effective links between secondary care services and external agencies to be fostered in order to improve discharge planning and provision for this population.

However, circumstances and constraints existing in the exosystem may impact upon the effectiveness of multiagency partnership working necessary to first prevent the need for admission of homeless individuals to secondary services and second ensure the safe discharge of admitted homeless service users back into the community. Policy development at the regional or national level may be required in order to ensure that joined-up, multiagency working is possible.

4.7.1.4. The exosystem: The exosystem is conceptualised here as the ways in which the relationships between systems indirectly affect the secondary care service at the centre. For example, if GP services experience increased demand or decreased funding, their ability to make primary care services available and accessible to the homeless population will be reduced, and this will indirectly impact upon the admission pathways of homeless service users into secondary care services. Another example might be the relationship between housing services and welfare services; if these services do not have a good working partnership, and the systems do not work effectively to accommodate the needs of homeless individuals, this will impact upon the ability of secondary care

services to provide a smooth discharge of homeless service users back into the community. Circumstances such as service restructuring, staffing cuts, the built environment of services, lack of resources, funding cuts and organisational systems affecting interagency communication could all have an indirect impact on the ability of secondary care services to provide appropriate quality of care to homeless service users.

The findings from the present study revealed the need for regional and national level policy development to ensure integrated systems and communication between agencies, as well as ensuring that ways of working within agencies are complimentary so that individuals do not fall between the gaps. The effectiveness of such policy development and implementation will be impacted by the circumstances occurring in the macrosystem.

4.7.1.5. The macrosystem: The macrosystem surrounding NHS secondary care mental health services that may have an indirect effect on the ability of such services to improve the quality of care they are able to provide to homeless service users may include changes to government and the policies that are emphasised and enforced both within the NHS as well as across other public sector services such as housing and welfare.

The funding cuts introduced as part of the UK government's austerity programme could continue to impact upon the ability of mental health services to provide high quality services to homeless individuals experiencing distress. This could continue to impact on services through increased demand, increased workload, and limited resources. With increased demand, hospital bed management could see that homeless service users are discharged unsafely without adequate support in the community, and indeed even discharged back to homelessness. National policy implementation is required to ensure that it is not possible for services to discharge homeless service users back to homelessness or unstable accommodation, since this represents a safeguarding issue.

4.7.1.6. An overview: This framework highlights that in order for an intervention at one level to be successful, it is necessary to consider the context of the

surrounding levels. Since each level impacts upon the other, targeting an intervention at one level alone is unlikely to be effective without having a ripple effect on other connected entities. As such, there is a need for services and policy makers to consider the wider context and take a holistic approach to ensuring that interventions are well-integrated and that all stakeholders are able to work cohesively and collaboratively towards meeting the needs of homeless individuals.
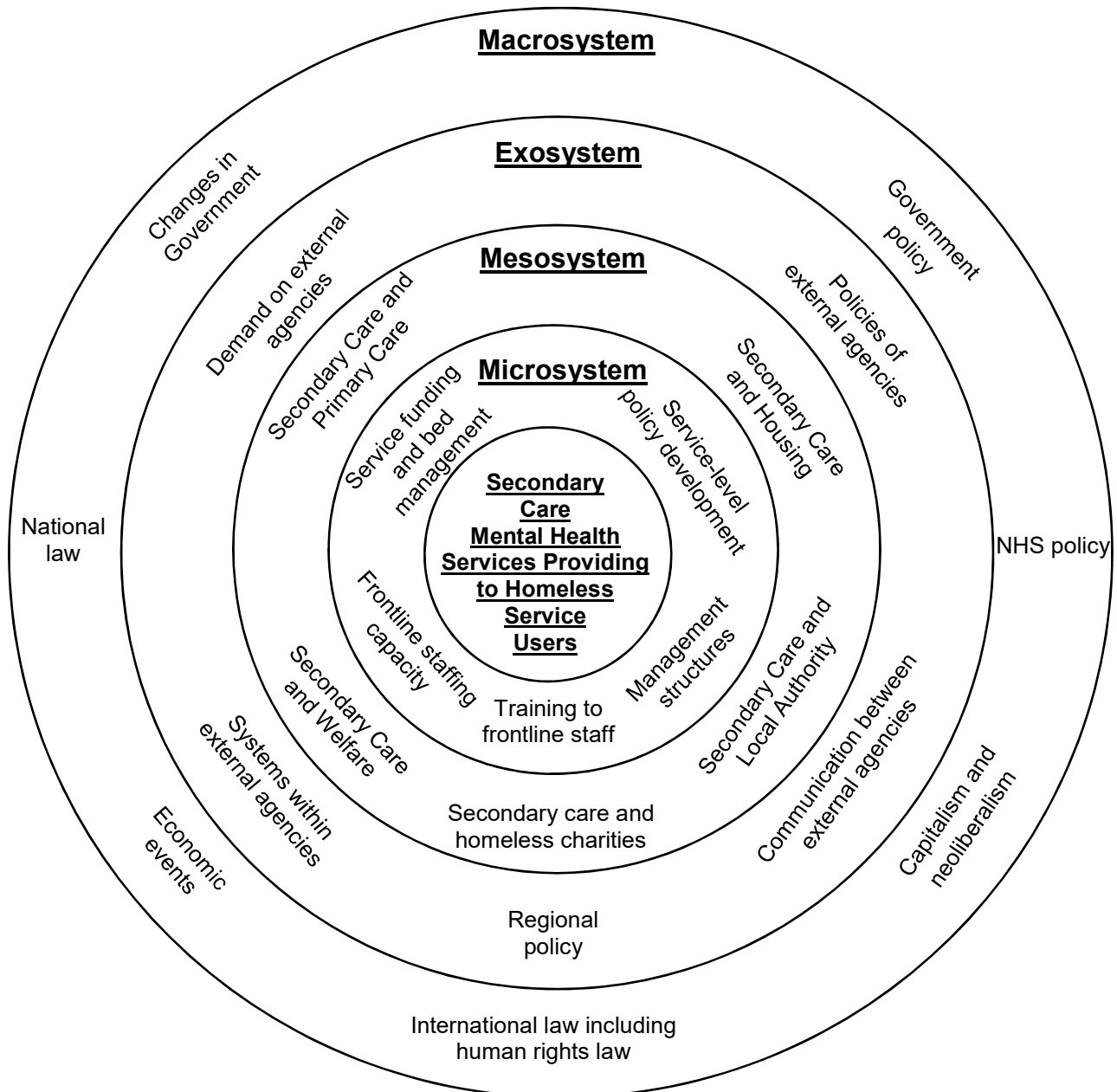
Figure 2: Using Bronfenbrenner's (1979) Ecological System's Theory to Implement Delivery of Secondary Mental Health Services to Homeless Service Users in the Context of the Findings of the Present Research

4.8.   Research Strengths and Limitations

To the researcher's knowledge, this is the first comprehensive study to review the quality of mental health care received by an extensive sample of homeless individuals using services across all NHS mental health trusts providing inpatient care. Furthermore, while previous studies have generally tended to focus on isolated aspects of care, this study reviewed all elements of treatment from admission to post-discharge. Together this allows for a holistic picture of the current state of mental health service provision for homeless service users in England to emerge, and has underscored some of the unacceptable, yet perhaps unsurprising, health inequalities experienced by the homeless population accessing mainstream services.

However, since this study was based on existing data from a national clinical audit not designed with the homeless population in mind, there are limitations with the quality of the data specifically relating to homelessness. First, while the Audit of Practice Tool used in the original audit assesses the accommodation status of service users, with 'homeless' as one category, it insufficiently defines homelessness and therefore fails to capture a range of important factors that would contribute to a more detailed and sophisticated view. As previously discussed, homelessness encompasses a broad array of experiences from single-person rooflessness to families housed in temporary accommodation, and the failure of the tool to operationalise homelessness leaves the recording of a service-user as 'homeless' open to the interpretation of the clinician completing the tool. Future research designed specifically to assess quality of mental health care received by the homeless population would benefit from using a tool that assesses the type of homelessness experienced, the duration of, and circumstances around, homelessness.

A further strength of the present study was the large total sample size, which included a substantial group of homeless service users. However, since so few homeless service users were referred for psychological therapy, the non-significant findings in research questions three and four may have been a result

of small sample referred to psychological therapy; this highlights a potential avenue for future research.

A further methodological limitation of the present study was the unequal group sizes studied. Since the present study examined clinical data, there was a natural variation in the number of homeless and housed service-users within the patient population studied in the NCAAD, thus creating unequal group sizes in the present study (homeless n= 223; housed n=3572). This was also the case when comparing those homeless service-users who were and those were not referred for psychological therapy (referred n=62; not referred n=161). Examining groups of unequal sizes can result in unequal variances between samples which can in turn lead to a loss of statistical power and increased risk of Type I error rates (Rusticus & Lovato, 2014). While it was possible to create equal group sizes using a matched pairs design, this would have entailed excluding valuable data from the housed group, and thus the decision was made to retain all data and compare groups of unequal sizes since it is not necessary to have equal-sized groups to compute accurate statistics (Rusticus & Lovato, 2014).

Another methodological issue with the present study regards the way in which the data was collected in the original audit. The NCAAD required NHS secondary care staff to examine clinical case notes retrospectively and enter data into the audit of practice tool. Data entered into this tool was subject; firstly, to the interpretation of the staff completing the tool but also, secondly, to interpretation of the clinicians who wrote the original clinical case notes; clinical case notes by their very nature do not capture all aspects of treatment and care. However, data quality assurance checks were completed by the NCAAD team, which increases confidence that data were not overly influenced by individual subjectivity. Another limitation is that the data relies on clinical case-notes being complete; it is not possible to know if an aspect of care was not carried out on the basis that such aspect was not recorded in the case-notes.

In summary, while there are a number of methodological limitations associated with the present and primary study, the novel contributions of the findings as well as the reflections on the limitations, provide good grounding of what future

research is needed and how best that can be achieved in order to avoid facing similar methodological issues in future research.

4.9. Directions for Future Research

With the findings from this study clearly demonstrating that homeless service users experience inequalities in the mental health care they receive while admitted to hospital for anxiety and/or depression, future research should focus on developing an audit of practice, similar to that of the NCAAD but which is designed specifically with the homeless population in mind. Such an audit could provide a more detailed examination of the homeless-specific variables, such as type of homelessness experienced and duration of homelessness. It would also facilitate examination of quality of care from admission to post-discharge for all homeless service users admitted to hospital for treatment of any mental health diagnosis across the country. This would allow for a larger sample of homeless service users than was captured in the present thesis, and this could serve to address some of the limitations found in the study as a result of sample size, such as rates and predictors of referral of homeless service users for psychological therapy, and reasons for decisions not to refer homeless service users.

A further avenue of research would be to understand quality of mental healthcare provision to the homeless population from their own perspectives. The voice of this marginalised population is not frequently heard, and their perspectives and opinions are often missed in research. In order to empower homeless service users, it is vital that their voices are heard and responded to.

A further implication for research derived from the findings of this thesis is the need for academic review of the use of the diagnosis 'reaction to severe stress and adjustment disorders' within this population. At present it is necessary, according to the medical model under which mental health services currently operate, for homeless individuals experiencing distress to have a diagnosis in order to receive care (see Rapley, Moncrieff & Dillon, 2011). However, it is necessary to ascertain whether such diagnoses are helpfully and correctly

applied, or whether they serve to medicalise understandable misery experienced in response to stressful social determinants and therefore decontextualize homelessness as a socio-political issue. It is the ethical duty of clinicians, academics and the institutions for which they work to ensure that diagnostic categories are applied accurately, and to ensure individuals can receive support for distress in order to attain their human right to health.

Owing to low numbers of homeless service users in minority ethnic categories it was not possible to include ethnicity in the logistic regression to establish whether the ethnicity of homeless service users predicts referral to psychological therapy. This highlights the need for future research to include larger sample sizes to enable to the study of homeless service users from BAME backgrounds. Future research should focus on how ethnicity impacts on the quality of mental health care received by homeless people from BAME backgrounds compared with that received by White service users experiencing homelessness; it might be predicted that the former fares less well given what is known about institutional racism within mental health services (McKenzie & Bhui, 2007; Sashidharan, 2001). There is a need to disentangle the effects of ethnicity as an additional layer of intersectionality on the quality of mental healthcare received.

Another area where further research is warranted concerns the prescription of psychotropic medication, and discharge of homeless service users from mental health inpatient services. More research is needed to understand the reasons for lower rates of medication prescribed to homeless service users at the point of discharge.

4.10. Conclusion

This research provides a comprehensive review of the quality of mental health care, from admission to post-discharge, received by the homeless population using NHS inpatient services for anxiety and depression treatment in England. It underscores and builds upon previous research findings that the homeless population consistently fares worse than the rest of society in a wide array of

mental health treatment domains. The findings are testament to the fact that homeless individuals experience health inequalities that represent a violation of their basic human rights. This evidences the need to be fundamentally clear that the state of service provision for homeless individuals is a poignant example of extreme social injustice (Lowe & Dybicz, 2019).

This also highlights the moral obligation for more to be done this marginalised and vulnerable faction of our human community. As The Marmot Review (Marmot et al., 2010) rightly points out, addressing this injustice requires proportionate universalism, where action to target and narrow the gap in health inequality is proportionate to the needs and level of disadvantage of priority populations. While it may be argued that specialist mental health services for homeless individuals, such as those modelled by the Pathway Homeless team in SLAM NHS Trust (Khan et al., 2018) and emphasised in the NHS Long Term Plan (NHS England and NHS Improvement 2019), may require economic investment, the human-level returns are indisputable and can no longer be ignored.

REFERENCES

Abdul-Hamid, W. K., Bhan-Kotwal, S., Kovvuri, P., & Stansfeld, S. (2017). Homelessness and the length of stay in psychiatric wards. *MOJ Addict Med Ther*, *3*(6), 195-197. https://doi.org/10.23937/24743631/1510024

Adams, J., Rosenheck, R., Gee, L., Seibyl, C. L., & Kushel, M. (2007). Hospitalized younger: a comparison of a national sample of homeless and housed inpatient veterans. *Journal of health care for the poor and underserved*, *18*(1), 173-184. https://doi.org/10.1353/hpu.2007.0000

Aldridge, R. (2019). Homelessness: A barometer of social justice. *The Lancet Public Health*, *5*(1), e2-e3. https://doi.org/10.1016/S2468-2667(19)30240-3

Aldridge, R. W., Menezes, D., Lewer, D., Cornes, M., Evans, H., Blackburn, R. M., ... & Hewett, N. (2019). Causes of death among homeless people: A population-based cross-sectional study of linked hospitalisation and mortality data in England. *Wellcome open research*, *4* (49), 1-17. https://doi.org/10.12688/wellcomeopenres.15151.1

Aldridge, R. W., Story, A., Hwang, S. W., Nordentoft, M., Luchenski, S. A., Hartwell, G., ... & Hayward, A. C. (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), 241-250. https://doi.org/10.1016/S0140-6736(17)31869-X

Archer, T., Dayson, C., McCarthy, L., Pattison, B., & Reeve, K. (2017). The mental health needs of Nottingham's homeless population: An exploratory research study. Project Report. Sheffield: Sheffield Hallam University. https://doi.org/10.7190/cresr.2017.9288742283

Arslan, S. (2013). "The experiences of professionals working with homeless people in a clinical setting": a qualitative study. *Housing, Care and Support, 16*(3/4)*, 145-153. https//:doi.org/10.1108/HCS-08-2013-0010

Atkins, G., Davies, N., Wilkinson, F., Pope, T., Guerin, B., & Tetlow, G. (2019). *Institute for Government Performance Tracker 2019: A data* https://www.instituteforgovernment.org.uk/sites/default/files/publications/performance-tracker-2019_0.pdf

Backer, T. E., Howard, E. A., & Moran, G. E. (2007). The role of effective
  discharge planning in preventing homelessness. *The Journal of Primary
  Prevention, 28*(3-4), 229-243. https://doi.org/10.1007/s10935-007-0095-7

Baghramian, M. (2004). *Relativism*. Oxfordshire: Routledge.

Baillie, A. J., Stapinski, L., Crome, E., Morley, K., Sannibale, C., Haber, P., &
  Teesson, M. (2010). Some new directions for research on psychological
  interventions for comorbid anxiety and substance use disorders. *Drug and
  alcohol review, 29*(5), 518-524. https://doi.org/10.1111/j.1465-
  3362.2010.00206.x

Bal, H. (2016). Warwick Education Studies: What is critical realism? Retrieved
  from https://warwick.ac.uk/fac/soc/ces/research/current/socialtheory/maps
  /criticalrealism/

Ball, S. A., Cobb-Richardson, P., Connolly, A. J., Bujosa, C. T., & O'Neall, T. W.
  (2005). Substance abuse and personality disorders in homeless drop-in
  center clients: Symptom severity and psychotherapy retention in a
  randomized clinical trial. *Comprehensive psychiatry, 46*(5), 371-379.
  https://doi.org/10.1016/j.comppsych.2004.11.003

Beaumont, J. (2011). Population. In J. Beaumont (Ed). *Social Trends 41*. London:
  Office for National Statistics

Belcher, J. R., & DeForge, B. R. (2012). Social stigma and homelessness: The
  limits of social change. *Journal of Human Behavior in the Social
  Environment, 22*(8), 929-946. https://doi.org/10.1080/10911359.2012.
  707941

Benjaminsen, L. & Bastholm-Andrade, S. (2015). Testing a typology of
  homelessness across welfare regimes: Shelter use in Denmark and the
  USA, *Housing Studies, 30*(6), 858–876. https://doi.org/10.1080/02673037.
  2014.982517

Bhaskar, R. (1975). *A realist theory of science [RTS].* Leeds: Leeds Books.

Bhaskar, R. (2009). *Scientific realism and human emancipation*. London:
  Routledge.

Bhaskar, R. (2013). *A realist theory of science*. London: Routledge.

Bhui, K., Shanahan, L., & Harding, G. (2006). Homelessness and mental illness: A literature review and a qualitative study of perceptions of the adequacy of care. *International Journal of Social Psychiatry*, *52*(2), 152-165. https://doi.org/ 10.1177/0020764006062096

Bowers, L. (2009). Association between staff factors and levels of conflict and containment on acute psychiatric wards in England. *Psychiatric services*, *60*(2), 231-239. https://doi.org/10.1176/ps.2009.60.2.231

Bowers, L., Simpson, A., Alexander, J., Hackney, D., Nijman, H., Grange, A., & Warren, J. (2005). The nature and purpose of acute psychiatric wards: The Tompkins Acute Ward Study. *Journal of Mental Health*, *14*(6), 625-635. https://doi.org/10.1080/09638230500389105

Boyd, J. E., Bassett, E. D., & Hoff, R. (2016). Internalized stigma of mental illness and depressive and psychotic symptoms in homeless veterans over 6 months. *Psychiatry research*, *240*(6), 253-259. https://doi.org/10.1016/j.psychres.2016.04.035

Brace, N., Kemp, R., & Snelgar, R. (2009). *SPSS for Psychologists 4th ed.* Hampshire: Palgrave Macmillian.

Bramley, G. (2017). *Homelessness projections: Core homelessness in Great Britain, summary report.* Crisis. Retrieved from https://www.crisis.org.uk/media/237582/crisis_homelessness_projections_ 2017. pdf.

Bramley, G., Fitzpatrick, S., Edwards, J., Ford, D., Johnsen, S., Sosenko, F., & Watkins, D. (2015). *Hard edges: Mapping severe and multiple disadvantage in England.* London: Lankelly Chase Foundation.

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

Brook, M., Hilty, D. M., Liu, W., Hu, R., & Frye, M. A. (2006). Discharge against medical advice from inpatient psychiatric treatment: A literature review. *Psychiatric services*, *57*(8), 1192-1198. https://doi.org/10.1176/ps.2006.57.8.1192

Bronfenbrenner, U. (1979). *The ecology of human development*. London: Harvard University Press.

Brown, K., Keast, R. L., Waterhouse, J., Murphy, G., & Mandell, M. (2012). Co-management to solve homelessness: wicked solutions for wicked problems. In V. Pestoff., T. Brandsen., & B. Verschuere., (eds). *New public governance, the third sector and co-production:* Routledge critical studies in public management (pp. 229-244). New York: Routledge.

Burra, T. A., Hwang, S. W., Rourke, S. B., & Stergiopoulos, V. (2012). Homeless and housed inpatients with schizophrenia: Disparities in service access upon discharge from hospital. *International Journal of Mental Health and Addiction*, *10*(5), 778-789. https://doi.org/10.1007/s11469-012-9392-3

Cabinet Office. (2017). *Race disparity audit: Summary findings from the ethnicity facts and figures website*. Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/686071/Revised_RDA_report_March_2018.pdf

Canadian Observatory on Homelessness. (2019). Homeless Hub: About homelessness - supporting communities to prevent and end homelessness - Mental health. Retrieved from https://homelesshub.ca/about-homelessness/topics/mental-health

Caton, C. L., Hasin, D., Shrout, P. E., Opler, L. A., Hirshfield, S., Dominguez, B., & Felix, A. (2000). Risk factors for homelessness among indigent urban adults with no history of psychotic illness: A case-control study. *American Journal of Public Health*, *90*(2), 258-263. https://doi.org/10.2105/ajph.90.2.258

Chaturvedi, S. (2016). Accessing psychological therapies: Homeless young people's views on barriers and facilitators. *Counselling and Psychotherapy Research*, *16*(1), 54-63. https://doi.org/10.1002/capr.12058

Clarke, A. (2016). The prevalence of rough sleeping and sofa surfing amongst young people in the UK. *Social Inclusion*, *4*(4), 60-72. https://doi.org/10.17645/si.v4i4.597

Coe, A. B., Moczygemba, L. R., Gatewood, S. B., Osborn, R. D., Matzke, G. R., & Goode, J. V. R. (2015). Medication adherence challenges among patients experiencing homelessness in a behavioral health clinic. *Research in Social and Administrative Pharmacy*, *11*(3), e110-e120. https://doi.org/10.1016/j.sapharm.2012.11.004

Collins, P. H., & Bilge, S. (2020). *Intersectionality*. Great Britain: John Wiley & Sons.

Cornes, M., Whiteford, M., Manthorpe, J., Neale, J., Byng, R., Hewett, N., ... & Tinelli, M. (2018). Improving hospital discharge arrangements for people who are homeless: A realist synthesis of the intermediate care literature. *Health & social care in the community*, *26*(3), e345-e359. https://doi.org/10.1111/hsc.12474

Crane, M., Cetrano, G., Joly, L., Coward, S., Daly, B., Ford, C., ... & Williams, P. (2018). *Mapping of specialist primary health care services in England for people who are homeless: Summary of findings and considerations for health service commissioners and providers.* Retrieved from https://www.housinglin.org.uk/_assets/Resources/Housing/OtherOrganisati on/Homelessness-mapping-report_SUMMARY.PDF

Crisis. (2002). *Critical condition: Vulnerable single homeless people and access to GPs.* Retrieved from http://opinion-former-resources.politics.co.uk /microsites2/364304/ graphics/gppolicybrief.pdf

Crisis. (2012, March 3). *Homelessness kills: An analysis of the mortality of homeless people in early twenty-first century England* [Press release]. Retrieved from https://www.crisis.org.uk/ending-homelessness/homelessness-knowledge-hub/health-and-wellbeing/homelessness-kills-2012/

Crisis. (2018, December 14). *More than 24,000 people facing Christmas sleeping rough or in cars, trains, buses and tents, Crisis warns* [Press release]. Retrieved from https://www.crisis.org.uk/about-us/media-centre/more-than-24-000-people-facing-christmas-sleeping-rough-or-in-cars-trains-buses-and-tents-crisis-warns/

D'Amore, J., Hung, O., Chiang, W., & Goldfrank, L. (2001). The epidemiology of the homeless population and its impact on an urban emergency department. *Academic Emergency Medicine*, *8*(11), 1051-1055. https://doi.org/10.1111/j.1553-2712.2001.tb01114.x

Danermark, B., Ekström, M., & Karlsson, J. C. (2019). *Explaining society: Critical realism in the social sciences*. London: Routledge.

Darbyshire, P., Muir-Cochrane, E., Fereday, J., Jureidini, J., & Drummond, A. (2006). Engagement with health and social care services: Perceptions of homeless young people with mental health problems. *Health & social care in the community*, *14*(6), 553-562. https://doi.org/10.1111/j.1365-524.2006.00643.x

Davies, J. & Lovegrove, M. (2016). *'Inclusion Health: Education and Training for Health Professionals'.* Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/490870/NIHB-Inclusion_Health_education__Report.pdf

Dej, E. (2016). Psychocentrism and homelessness: The pathologization/responsibilization paradox. *Studies in Social Justice*, *10*(1), 117-135. https://doi.org/10.26522/ssj.v10i1.1349

De Oliveira, B. (2018). On the news today: Challenging homelessness through participatory action research. *Housing, Care and Support, 21*(1), 13-25. https://doi.org/10.1108/HCS-01-2018-0002

Department for Communities and Local Government. (2012). *Evidence review of the costs of homelessness.* Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/7596/2200485.pdf

Department of Health and Social Care. (2018). *Guidance for NHS trusts and foundation trusts providing emergency departments, urgent treatment centres and inpatient services.* Retrieved from https://www.gov.uk/government/publications/homelessness-duty-to-refer-for-nhs-staff/guidance-for-nhs-trusts-and-foundation-trusts-providing-emergency-departments-urgent-treatment-centres-and-inpatient-services

Dixon, L., Goldberg, R., Iannone, V., Lucksted, A., Brown, C., Kreyenbuhl, J., ... & Potts, W. (2009). Use of a critical time intervention to promote continuity of care after psychiatric inpatient hospitalization. *Psychiatric Services*, *60*(4), 451-458. https://doi.org/10.1176/ps.2009.60.4.451

Donovan, S., & Shinseki, E. K. (2013). Homelessness is a public health issue. *American journal of public health*, *103*(2), S180. https://doi.org/10.2105/AJPH.2013.301727

Doran, K. M., Rahai, N., McCormack, R. P., Milian, J., Shelley, D., Rotrosen, J., & Gelberg, L. (2018). Substance use and homelessness among emergency department patients. *Drug and alcohol dependence*, *188*, 328-333. https://doi.org/10.1016/j.drugalcdep.2018.04.021

Dorney-Smith, S., Hewett, N., Khan, Z., & Smith, R. (2016). Integrating health care for homeless people: Experiences of the KHP pathway homeless team. *British Journal of Healthcare Management*, *22*(4), 215-224. https://doi.org/10.12968/bjhc.2016.22.4.215

Drury, L. (2008). From homeless to housed: Caring for people in transition. *Journal of Community Health Nursing*, *25*(2), 91-105. https://doi.org/10.1080/07370010802017109

Ellison, N. (2016). The coalition government, public spending and social policy. In H. Bochel & M. Powell (Eds), *The coalition government and social policy: Restructuring the welfare state* (pp. 27-52). Bristol: Policy Press.

Elwood, S., & Lawson, V. (2017). Neutralizing homelessness: Federal policy and the depoliticization of poverty. *Urban Geography*, *38*(3), 329-331. https://doi.org/ 10.1080/02723638.2016.1247597

Elwell-Sutton, T., Fok, J., Albanese, F., Mathie, H., & Holland, R. (2016). Factors associated with access to care and healthcare utilization in the homeless population of England. *Journal of Public Health*, *39*(1), 26-33. https://doi.org/10.1093/pubmed/fdw008

Employment Related Services Association. (2015). *Supporting homeless people into work: recommendations for the future of Government-led employment support.* Retrieved from https://www.homeless.org.uk/sites/default/ files/site-attachments/Supporting%20homeless%20people%20into%20 work.pdf

Eynan, R., Langley, J., Tolomiczenko, G., Rhodes, A. E., Links, P., Wasylenki, D., & Goering, P. (2002). The association between homelessness and suicidal ideation and behaviors: Results of a cross-sectional survey. *Suicide and life-threatening behavior*, *32*(4), 418-427. https://doi.org/10.1521/suli.32.4.418.22341

Faculty for Homeless and Inclusion Health. (2018). *Homeless and Inclusion Health standards for commissioners and service providers.* Retrieved from https://www.pathway.org.uk/wp-content/uploads/Version-3.1-Standards-2018-Final.pdf

Farmer, N. J. (2017). 'No Recourse to Public Funds', insecure immigration status and destitution: the role of social work?. *Critical and Radical Social Work*, *5*(3), 357-367. https://doi.org/10.1332/204986017X15029697778471

Faul, F., Erdfelder, E., Buchner, A., & Lang, A. G. (2009). Statistical power analyses using G*Power 3.1: Tests for correlation and regression analyses. *Behavior Research Methods*, *41*, 1149-1160. https://doi.org/10.3758/BRM.41.4.1149

Fazel, S., Geddes, J. R., & Kushel, M. (2014). The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. *The Lancet, 384*(9953), 1529-1540. https://doi.org/10.1016/S0140-6736(14)61132-6

Fazel, S., Khosla, V., Doll, H., & Geddes, J. (2008). The prevalence of mental disorders among the homeless in western countries: Systematic review and meta-regression analysis. *PLoS medicine, 5*(12), e225. https://doi.org/10.1371/journal.pmed. 0050225

European Federation of National Organisations Working with the Homeless, FEANTSA. (2011). *Impact of anti-crisis austerity measures on homeless services across the EU: FEANTSA Policy Paper.* Retrieved from https://www.feantsa.org/download/impact_20of_20austerity_20measures_20on_20homeless_20services_policy_20paper_en39378897677279840 83.pdf

Ferguson, K. M., Bender, K., Thompson, S. J., Maccio, E. M., & Pollio, D. (2012). Employment status and income generation among homeless young adults: Results from a five-city, mixed-methods study. *Youth & Society, 44*(3), 385-407. https://doi.org/10.1177/0044118X11402851

Field, H., Hudson, B., Hewett, N., & Khan, Z. (2019). Secondary care usage and characteristics of hospital inpatients referred to a UK homeless health team: A retrospective service evaluation. *BMC health services research, 19*(1), 1-15. https://doi.org/10.1186/s12913-019-4620-1

Finfgeld-Connett, D. (2010). Becoming homeless, being homeless, and resolving homelessness among women. *Issues in Mental Health Nursing, 31*(7), 461-469. https://doi.org/10.3109/01612840903586404

Finkelman, A. W. (2000). Psychopharmacology: an update for psychiatric home care. *Home care provider, 5*(5), 170-177. https://doi.org/10.1067/mhc.2000.110687

Fitzpatrick, S., Pawson, H., Bramley, G. & Wilcox, S. (2011). *The homelessness monitor.* London: Crisis.

Fitzpatrick, S., Pawson, H., Bramley, G., Wood, J., Watts, B., Stephens, M., & Blenkinsopp, J. (2019). *The homelessness monitor: England 2019.* Retrieved from https://www.crisis.org.uk/media/240419/the_homelessness_monitor_england_2019.pdf

Folsom, D., & Jeste, D. V. (2002). Schizophrenia in homeless persons: A systematic review of the literature. *Acta Psychiatrica Scandinavica*, *105*(6), 404-413. https://doi.org/10.1034/j.1600-0447.2002.02209.x

Fond, G., Tinland, A., Boucekine, M., Girard, V., Loubière, S., Auquier, P., & Boyer, L. (2019). Prescription of potentially inappropriate psychotropic drugs in homeless people with schizophrenia and bipolar disorders: Results from the French Housing First (FHF) program. *Progress in Neuro-Psychopharmacology and Biological Psychiatry*, *89(4)*, 84-89. https://doi.org/ 10.1016/j.pnpbp.2018.08.024

Forchuk, C., Russell, G., Kingston-MacClure, S., Turner, K., & Dill, S. (2006). From psychiatric ward to the streets and shelters. *Journal of Psychiatric and Mental Health Nursing*, *13*(3), 301-308. https://doi.org/10.1111/j.1365-2850.2006.00954.x

Fransham, M., & Dorling, D. (2018). Homelessness and public health. *British Medical Journal*, *360*(2341), 1-5. https://doi.org/10.1136/bmj.k214

Fuller, S. (2002). *Social epistemology*. Bloomington, IN: Indiana University Press.

Giles, D. B. (2017). Neutralizing homelessness, 2015: The story to date. *Urban Geography*, *38*(3), 332-340. https://doi.org/10.1080/02723638.2016.1247598

Glasby, J., & Lester, H. (2004). Delayed hospital discharge and mental health: The policy implications of recent research. *Social Policy & Administration*, *38*(7), 744-757. https://doi.org/10.1111/j.1467-9515.2004.00416.x

Gonzalez, G., & Rosenheck, R. A. (2002). Outcomes and service use among homeless persons with serious mental illness and substance abuse. *Psychiatric Services*, *53*(4), 437-446. https://doi.org/10.1176/appi.ps.53.4.437

Greater London Authority. (2019). *CHAIN Annual Report Greater London: April 2018-March 2019*. Retrieved from https://data.london.gov.uk/dataset/chain-reports

Greenberg, G. A., Hoblyn, J., Seibyl, C., & Rosenheck, R. (2006). Housing outcomes for hospitalized homeless veterans. *Journal of health care for the poor and underserved*, *17*(2), 425-440. https://doi.org/10.1353/hpu.2006.0061

Greenberg, J. M., Wynn, J. K., Lee, J., Hellemann, G., Gabrielian, S., & Green, M. F. (2019). Resilience in homeless veterans: Clinical and cognitive correlates. *Psychiatric rehabilitation journal*, *42*(3), 314-322. https://doi.org/10.1037/prj0000333

Green, H. D., Tucker, J. S., Golinelli, D., & Wenzel, S. L. (2013). Social networks, time homeless, and social support: A study of men on Skid Row. *Network Science*, *1*(3), 305-320. https://doi.org/10.1017/nws.2013.18

Greysen, S. R., Allen, R., Rosenthal, M. S., Lucas, G. I., & Wang, E. A. (2013). Improving the quality of discharge care for the homeless: A patient-centered approach. *Journal of health care for the poor and underserved*, *24*(2), 444-455. https://doi.org/10.1353/hpu.2013.0070.

Håkanson, C., & Öhlén, J. (2016). Illness narratives of people who are homeless. *International journal of qualitative studies on health and well-being*, *11*(1), 1-12. https://doi.org/10.3402/qhw.v11.32924

Harper, D., McGrath, L., Mundy, E., Curno, T., Thompson, S., Wood, K., & Buhagiar, J. (2015). Psychologists against austerity. *The Psychologist*, *28*(3), 172. https://doi.org/10.1865/J.653.8.439

Harrison, N. (2017). *Moving on up: Pathways of care leavers and care-experienced students into and through higher education.* Retrieved from https://www.nnecl.org/resources/moving-on-up-report?topic=guides-and-toolkits

Hauff, A. J., & Secor-Turner, M. (2014). Homeless health needs: Shelter and health service provider perspective. *Journal of Community Health Nursing*, *31*(2), 103-117. https://doi.org/10.1080/07370016.2014.901072

Head, B. W. (2008). Wicked problems in public policy. *Public policy*, *3*(2), 101-118. https://doi.org/10.1180/s.53.4.495

Healthwatch Nottingham and Nottinghamshire. (2019). *Shared decision making focus group report.* Retrieved from https://hwnn.co.uk/wp-content/uploads/2019/10/NHSE-Shared-Decision-Making-Final-Report-111019.pdf

Healthy London Partnership. (2019). *Safe and effective discharge of homeless hospital patients.* Retrieved from https://www.healthylondon.org/wp-content/uploads/2019/01/190124-GUIDANCE-Safe-and-effective-discharge-of-homeless-hospital-patients.pdf

Herman, D. B., Conover, S., Gorroochurn, P., Hinterland, K., Hoepner, L., & Susser, E. S. (2011). Randomized trial of critical time intervention to prevent homelessness after hospital discharge. *Psychiatric services*, *62*(7), 713-719. https://doi.org/10.1176/ps.62.7.pss6207_0713

Hermes, E., & Rosenheck, R. (2016). Psychopharmacologic services for homeless veterans: comparing psychotropic prescription fills among homeless and non-homeless veterans with serious mental illness. *Community mental health journal*, *52*(2), 142-147. https://doi.org/10.1007/s10597-015-9904-2

Hewett, N., & Halligan, A. (2010). Homelessness is a healthcare issue. *Journal of the Royal Society of Medicine. 103(8), 306-307.* https://doi.org/10.1258/jrsm. 2010.10k028

Hollway, W. (2008). The importance of relational thinking in the practice of psycho-social research: Ontology, epistemology, methodology and ethics. In S.Clarke, P. Hoggett & H. Hahn (eds) *Object relations and social relations: The implications of the relational turn in psychoanalysis* (pp. 137-162). London: Karnac.

Holmqvist, M. (2009). Medicalization of unemployment: Individualizing social issues as personal problems in the Swedish welfare state. *Work, employment and society*, *23*(3), 405-421. https://doi.org/10.1177/0950017009337063

Homeless Link. (n.d.). Impact of homelessness. Retrieved from https://www.homeless.org.uk/facts/understanding-homelessness/impact-of-homelessness

Homeless Link. (2010). *The health and wellbeing of people who are homeless: Evidence from a national audit.* Retrieved from https://www.homeless.org.uk/sites/default/files/site-attachments/Health%20Audit%20Findings_National%20evidence_2010.pdf

Homeless Link. (2010). *Survey of Needs & Provision 2010: Services for Homeless Single People and Couples in England*. Retrieved from https://www.homeless.org.uk/sites/default/files/site-attachments/ SNAP2010_Full_Report.pdf

Homeless Link. (2011). *Homelessness, mental health and wellbeing guide.* Retrieved from https://www.homeless.org.uk/sites/default/files/site-attachments/Mental_Health_Guide.pdf

Homeless Link. (2013). *Survey of needs and provision 2013: Homelessness services for single people and couples without dependents in England.* Retrieved from https://www.homeless.org.uk/sites/default/files/site-attachments/ SNAP2013_Full_Report.pdf

Homeless Link. (2015). Health Needs Audit– Explore the data. Retrieved from: https://homeless.org.uk/facts/homelessness-in-numbers/health-needs-audit-explore-data

Homeless Link. (2014a). *The unhealthy state of homelessness: Health audit results 2014.* Retrieved from https://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf

Homeless Link. (2014b). *Support for Single Homeless People in England: Annual Review.* Retrieved from https://www.homeless.org.uk/sites/default/files/ site-attachments/Support%20for%20Single%20Homeless%20People.pdf

Homeless Link. (2017) *Support for single homeless people in England Annual Review 2017.* Retrieved from: https://www.homeless.org.uk/sites/default/ files/site-attachments/Annual%20Review%202017_0.pdf

Homeless Link. (2018a). *Statutory homelessness data January-March 2018.* Retrieved from https://www.homeless.org.uk/sites/default/files/site-attachments/Statutory%20Homelessness%20Q1%202018%20Analysis.pdf

Homeless Link. (2018b). *Support for single homeless people in England: Annual Review 2018.* Retrieved from https://www.homeless.org.uk/sites/defaults/ files/site-attachments/Annual%20Review2018.pdf

Homeless Link. (2019). *Annual review of single homelessness support in England.* Retrieved from https://www.homeless.org.uk/connect/blogs/ 2019/aug/29/launching-survey-for-annual-review-2019-support-for-single-homeless-people

Homelessness Act 2002 (c.7). Retrieved from
https://www.legislation.gov.uk/ukpga/2002/7/contents

Homelessness Reduction Act 2017 (c.13). Retrieved from
https://www.legislation.gov.uk/ukpga/2017/13/contents/enacted

Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The open health services and policy journal*, *3*(2), 80-100.
https://doi.org/10.2174/187492400100302008

House of Commons Health Committee. (2002). Delayed discharges (third report). *London: TSO*.

Hoven, H., Ford, R., Willmot, A., Hagan, S., & Siegrist, J. (2016). Job coaching and success in gaining and sustaining employment among homeless people. *Research on social work practice*, *26*(6), 668-674. https://doi.org/10.1177/1049731514562285

Huey, L., Fthenos, G., & Hryniewicz, D. (2012). "I Need Help and I Know I Need Help. Why Won't Nobody Listen to Me?" Trauma and Homeless Women's Experiences with Accessing and Consuming Mental Health Services. *Society and mental health*, *2*(2), 120-134.
https://doi.org/10.1177/2156869312445287

Hughes, J. A., & Sharrock, W. W. (2016). *The philosophy of social research*. London: Routledge.

Hunt, I. M., Kapur, N., Webb, R., Robinson, J., Burns, J., Shaw, J., & Appleby, L. (2009). Suicide in recently discharged psychiatric patients: A case-control study. *Psychological medicine*, *39*(3), 443-449.
https://doi.org/10.1017/S0033291708003644

Hwang, S. W. (2001). Homelessness and health. *Canadian medical association journal*, *164*(2), 229-233. https://doi.org/10.1007/BF03405025.

Hwang, S. W., Weaver, J., Aubry, T., & Hoch, J. S. (2011). Hospital costs and length of stay among homeless patients admitted to medical, surgical, and psychiatric services. *Medical care*, *46*(3), 350-354.
https://doi.org/10.1097/MLR.0b013e318206c50d.

Ibabe, I., Stein, J. A., Nyamathi, A., & Bentler, P. M. (2014). Predictors of substance abuse treatment participation among homeless adults. *Journal of substance abuse treatment, 46*(3), 374-381. https://doi.org/10.1016/j.jsat.2013.10.008

Jainchill, N., Hawke, J., & Yagelka, J. (2000). Gender, psychopathology, and patterns of homelessness among clients in shelter-based TCs. *The American journal of drug and alcohol abuse*, *26*(4), 553-567. https://doi.org/10.1081/ADA-100101895

Jensen, P. R. (2018). Undignified dignity: Using humor to manage the stigma of mental illness and homelessness. *Communication Quarterly*, *66*(1), 20-37. https://doi.org/10.1080/01463373.2017.1325384

Johnson, G., & Chamberlain, C. (2011). Are the homeless mentally ill?. *Australian Journal of Social Issues*, *46*(1), 29-48. https://doi.org/10.1002/j.1839-4655.2011.tb00204.x

Johnson, G., Scutella, R., Tseng, Y., & Wood, G. (2015). *Entries and exits from homelessness: a dynamic analysis of the relationship between structural conditions and individual characteristics (248)*. Retrieved from https://www.ahuri.edu.au/__data/assets/pdf_file/0013/2155/AHURI_Final_Report_No248_Entries-and-exits-from-homelessness.pdf

Kim, M. M., Swanson, J. W., Swartz, M. S., Bradford, D. W., Mustillo, S. A., & Elbogen, E. B. (2007). Healthcare barriers among severely mentally ill homeless adults: Evidence from the five-site health and risk study. *Administration and Policy in Mental Health and Mental Health Services Research*, *34*(4), 363-375. https://doi.org/10.1007/s10488-007-0115-1

Kealy, D., & Ogrodniczuk, J. S. (2010). Marginalization of borderline personality disorder. *Journal of Psychiatric Practice*, *16*(3), 145-154. https://doi.org/10.1097/01.pra.0000375710.39713.4d

Khan, Z., Koehne, S., Haine, P., & Dorney-Smith, S. (2018). Improving outcomes for homeless inpatients in mental health. *Housing, Care and Support*, 22(1), 77-90. https://doi.org/10.1108/HCS-07-2018-0016

Kleinbaum, D. G., Dietz, K., Gail, M., Klein, M., & Klein, M. (2002). *Logistic regression*. New York: Springer-Verlag.

Laliberté, V., V. Stergiopoulos, B. Jacob, & Kurdyak, P. (2020). Homelessness at discharge and its impact on psychiatric readmission and physician follow up: A population-based cohort study. *Epidemiology and psychiatric sciences, 29*(1), e21, 1-8. https://doi.org/10.1017/S2045796019000052

Lam, C. N., Arora, S., & Menchine, M. (2016). Increased 30-day emergency department revisits among homeless patients with mental health conditions. *Western Journal of Emergency Medicine*, *17*(5), 607-612. https://doi.org/10.5811/westjem.2016.6.30690

Längle, G., Egerter, B., Albrecht, F., Petrasch, M., & Buchkremer, G. (2005). Prevalence of mental illness among homeless men in the community. *Social Psychiatry and Psychiatric Epidemiology*, *40*(5), 382-390. https://doi.org/ 10.1007/s00127-005-0902-5

Lauber, C., Lay, B., & Rossler, W. (2005). Homelessness among people with severe mental illness in Switzerland. *Swiss medical weekly*, *135*(3-4) 50-56. https://doi.org/10.4414/smw.2005.10815

Lauber, C., Lay, B., & Rössler, W. (2006). Homeless people at disadvantage in mental health services. *European Archives of Psychiatry and Clinical Neuroscience*, *256*(3), 138-145. https://doi.org/10.1007/s00406-005-0616-4

Lee, S., Castella, A. D., Freidin, J., Kennedy, A., Kroschel, J., Humphrey, C., ... & Kulkarni, J. (2010). Mental health care on the streets: An integrated approach. *Australian & New Zealand Journal of Psychiatry*, *44*(6), 505-512.
https://doi.org/10.3109/00048670903555120

Leigh, J. (2017). Blame, culture and child protection. London: Palgrave Macmillan.

Lin, W. C., Bharel, M., Zhang, J., O'Connell, E., & Clark, R. E. (2015). Frequent emergency department visits and hospitalizations among homeless people with Medicaid: implications for Medicaid expansion. *American journal of public health*, *105*(5), 716-722. https://doi.org/10.2105/AJPH.2015.302693

Local Government Association. (2019). *Children's social care budgets: A survey for lead members for children's services.* Retrieved from https://www.local.gov.uk/sites/default/files/documents/Children%27s%20social%20care%20budget%20survey%20FINAL_0.pdf

Lowe, S., & Dybicz, P. (2019). Veteran Homelessness: Examining the Values of Social Justice Guiding Policy. *Journal of Veterans Studies*, *4*(1), 15-33. https://doi.org/10.21061/jvs.v4i1.91

Lowens, S., Kellinghaus, C., Eikelmann, B., & Reker, T. (2000). Homeless men in inpatient psychiatric treatment: A controlled study. Effects of treatment. *Psychiatrische Praxis*, *27*(1), 24-27. https://doi.org/10.23937/2474-3631/1510024

Lurie, K., Schuster, B., & Rankin, S. (2015). *Discrimination at the margins: The intersectionality of homelessness & other marginalized groups.* Retrieved from https://digitalcommons.law.seattleu.edu/hrap/8

Lynch, P., & Cole, J. (2003). Homelessness and human rights: Regarding and responding to homelessness as a human rights violation. *Melbourne Journal of International Law*, 4(1) 139-176. https://doi.org/10.1680341

Malvaso, C., & Delfabbro, P. (2016). Leaving care and service engagement: Lessons from the homelessness sector. *Parity*, *29*(1), 12-13. https://doi.org/10.1032-6170

Mangrum, L. F., Spence, R. T., & Lopez, M. (2006). Integrated versus parallel treatment of co-occurring psychiatric and substance use disorders. *Journal of substance abuse treatment*, *30*(1), 79-84. https://doi.org/10.1016/j.jsat.2005.10.004

Marcuse, P. (1988). Neutralizing homelessness. *Socialist Review, 18*(1), 69-96.

Maremmani, A. G., Bacciardi, S., Gehring, N. D., Cambioli, L., Schütz, C., Jang, K., & Krausz, M. (2017). Substance use among homeless individuals with schizophrenia and bipolar disorder. *The journal of nervous and mental disease*, *205*(3),173-177. https://doi.org/10.1097/NMD.0000000000000462

Marmot, M., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M., & Geddes, I. (2010). *The Marmot review: Fair society, healthy lives.* Retrieved from https://www.parliament.uk/globalassets/documents/fair-society-healthy-lives-full-report.pdf

Marmot, M., Friel, S., Bell, R., Houweling, T. A., & Taylor, S. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. *The Lancet*, *372*(9650), 1661-1669. https://doi.org/10.1016/S0140-6736(08)61690-6

Marsh, S. (2016, March 10). 'I am well-spoken and not an addict': How homelessness can happen to anyone. *The Guardian*. Retrieved from https://www.theguardian.com/commentisfree/2016/mar/10/i-am-wellspoken-and-not-an-addict-how-homelessness-can-happen-to-anyone

Mcgrath, L., Griffin, V., & Mundy, E. (2015). The psychological impact of austerity: A briefing paper. *EducationalPsychology Research and Practice, 2*(2), 46-57. https://doi.org/10.15123/uel.885xw

McKenzie, K., & Bhui, K. (2007). Institutional racism in mental health care. *British Medical Journal*, 334(7595), 649–650. https://doi.org/10.1136/bmj.39163.395972.80

Mental Health Act 2007. (c.12). Retrieved from https://www.legislation.gov.uk/ukpga/2007/12/contents

Merlo, G., & Pravato, G. (2020). Relativism, realism, and subjective facts. *Synthese, 4*(1), 1-17. https://doi.org/10.1007/s11229-020-02562-x

Milburn, N. G., Batterham, P., Ayala, G., Rice, E., Solorio, R., Desmond, K., ... & Rotheram-Borus, M. J. (2010). Discrimination and mental health problems among homeless minority young people. *Public health reports, 125*(1), 61-67. https://doi.org/10.1177/003335491012500109

Ministry of Housing, Communities & Local Government. (2018). *Rough sleeping strategy.* Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/733421/Rough-Sleeping-Strategy_WEB.pdf

Ministry of Housing Communities & Local Government. (2019a). *Rough sleeping in England: Annual statistical release evaluating the extent of rough sleeping.* Retrieved from https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness#rough-sleeping-tables

Ministry of Housing, Communities and Local Government. (2019b). *Statutory homelessness.* Retrieved from https://www.ethnicity-facts-figures.service.gov.uk/housing/homelessness/statutory-homelessness/latest

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & Prisma Group. (2009). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *PLoS med, 6*(7), e1000097. https://doi.org/10.1371/journal.pmed.1000097

Moncrieff, J. (2010). Psychiatric diagnosis as a political device. *Social Theory & Health*, *8*(4), 370-382. https://doi.org/10.1057/sth.2009.11

Moore, G., Gerdtz, M., & Manias, E. (2007). Homelessness, health status and emergency department use: An integrated review of the literature. *Australasian Emergency Nursing Journal*, *10*(4), 178-185. https://doi.org/10.1016/j.aenj.2007.07.003

Muir-Cochrane, E., Fereday, J., Jureidini, J., Drummond, A., & Darbyshire, P. (2006). Self-management of medication for mental health problems by homeless young people. *International Journal of Mental Health Nursing*, *15*(3), 163-170. https://doi.org/10.1111/j.1447-0349.2006.00420.x.

Murphy, N., & McVey, D. (2010). *Treating personality disorder: Creating robust services for people with complex mental health needs*. London: Routledge.

Narendorf, S. C., Cross, M. B., Santa Maria, D., Swank, P. R., & Bordnick, P. S. (2017). Relations between mental health diagnoses, mental health treatment, and substance use in homeless youth. *Drug and alcohol dependence*, *175* (1),1-8. https://doi.org/10.1016/j.drugalcdep.2017.01.028

National Audit Office. (2017). *Homelessness.* Retrieved from https://www.nao. org.uk/wp-content/uploads/2017/09/Homelessness.pdf

NHS Digital. (2019). *Mental Health Act Statistics, Annual Figures 2018-19.* Retrieved from https://digital.nhs.uk/data-and-information/publications/ statistical/mental-health-act-statistics-annual-figures/2018-19-annual-figures

NHS Digital. (2019). *Psychological Therapies: reports on the use of IAPT services, England September 2019 Final including reports on the IAPT pilots and Quarter 2 2019-20 data.* Retrieved from https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-report-on-the-use-of-iapt-services/september-2019-final-including-reports-on-the-iapt-pilots-and-quarter-2-2019-20-data

NHS England. (2015). *Improving Access to Psychological Therapies (IAPT) Waiting Times Guidance and FAQ's.* Retrieved from https://www.england.nhs.uk/wp-content/uploads/2015/02/iapt-wait-times-guid.pdf

NHS England. (2016). *Implementing the five year forward view for mental health.* Retrieved from https://www.england.nhs.uk/wp-content/uploads/ 2016/07/fyfv-mh.pdf

NHS England and NHS Improvement. (2019). *The NHS Long Term Plan.* Retrieved from https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

Nielssen, O. B., Stone, W., Jones, N. M., Challis, S., Nielssen, A., Elliott, G., ... & Large, M. M. (2018). Characteristics of people attending psychiatric clinics in inner Sydney homeless hostels. *Medical Journal of Australia*, *208*(4), 169-173. https://doi.org/10.5694/mja17.00858

Nilsson, S. F., Nordentoft, M., & Hjorthøj, C. (2019). Individual-level predictors for becoming homeless and exiting homelessness: A systematic review and meta-analysis. *Journal of urban health*, *96*(5), 741-750. https://doi.org/10.1007/s11524-019-00377-x

Office for National Statistics. (2018) *Deaths of Homeless People in England and Wales: 2013-2017.* London, England: ONS. Retrieved from https://www.ons.gov.uk/ peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletin s/deathsofhomelesspeopleinenglandandwales/2013to2017

Office for National Statistics (2019). *UK homelessness 2005 to 2018: Assessment of the comparability and coherence of existing UK government data sources on homelessness.* London, England: ONS. Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/housing/articles/u khomelessness/2005to2018

O'Neil, M., Gerstein Pineau, M., Kendall-Taylor, N., Volmert, D., & Stevens, A. (2017). Finding a better frame: How to create more effective messages on homelessness in the United Kingdom. *A FrameWorks Strategic Report Sponsored by Crisis. Washington, DC: FrameWorks Institute*. Retrieved from https://www.crisis.org.uk/media/237700/ finding_a_better_frame_2017.pdf

Oppenheimer, S. C., Nurius, P. S., & Green, S. (2016). Homelessness history impacts on health outcomes and economic and risk behavior intermediaries: New insights from population data. *Families in Society*, *97*(3), 230-242. https://doi.org/10.1606/1044-3894.2016.97.21

Ortiz-Ospina, E., & Roser, M. (2017). Our world in data: Homelessness. Retrieved from https://ourworldindata.org/homelessness

Patra, S., & Anand, K. (2008). Homelessness: A hidden public health problem. *Indian J Public Health*, *52*(3), 164-170. https://doi.org/10.1043/Iph.445

Petering, R., Rhoades, H., Winetrobe, H., Dent, D., & Rice, E. (2017). Violence, trauma, mental health, and substance use among homeless youth Juggalos. *Child Psychiatry & Human Development*, *48*(4), 642-650. https://doi.org/10.1007/s10578-016-0689-5

Perry, J., & Craig, T. K. (2015). Homelessness and mental health. *Trends in Urology & Men's Health*, *6*(2), 19-21. https://doi.org/10.1002/tre.445

Pilgrim, D. (2007). The survival of psychiatric diagnosis. *Social Science & Medicine*, *65*(3), 536-547. https://doi.org/10.1016/j.socscimed.2007.03.054

Pilgrim, D. (2013). The failure of diagnostic psychiatry and some prospects of scientific progress offered by critical realism. *Journal of Critical Realism*, *12*(3), 336-358. https://doi.org/10.1179/1476743013Z.0000000004

Pilgrim, D., & Bentall, R., (1999). The medicalisation of misery: A critical realist analysis of the concept of depression. *Journal of mental health*, *8*(3), 261-274. https://doi.org/10.1080/09638239917427

Pleace, N. (2015) *At what cost? An estimation of the financial costs of single homelessness in the UK*. Retrieved from https://www.crisis.org.uk/media/237022/costsofhomelessness_finalweb.pdf

Pleace, N. & Culhane, D.P. (2016). *Better than Cure? Testing the case for Enhancing Prevention of Single Homelessness in England*. Retrieved from https://www.crisis.org.uk/ending-homelessness/ homelessness-knowledge-hub/cost-of-homelessness/better-than-cure-2016/

Polgar, M. (2009). How are people empowered to help a homeless relative?. *Human Organization, 68*(4), 431-438. https://doi.org/10.17730/humo.68.4.803h34 66711l4q73

Polgar, M. (2011). Families help homeless and disabled relatives providing support is more stressful with "Double Troubles". *Journal of Applied Social Science*, *5*(1), 37-49. https://doi.org/10.1177/193672441100500103

Preece, J., & Bimpson, E. (2019). *Housing insecurity and mental health in Wales.* Retrieved from https://housingevidence.ac.uk/wp-content/uploads/2019/ 03/190327-Housing-insecurity-and-mental-health-in-Wales_final.pdf

Public Health England. (2019). *Homelessness: Applying all our health.* Retrieved from https://www.gov.uk/government/publications/homelessness-applying-all-our-health/homelessness-applying-all-our-health

Puri, B., & Treasaden, I. (2009). *Psychiatry: An evidence-based text*. London: CRC Press.

Rae, B. E., & Rees, S. (2015). The perceptions of homeless people regarding their healthcare needs and experiences of receiving health care. *Journal of advanced nursing*, *71*(9), 2096-2107. https://doi.org/10.1111/jan.12675

Rapley, M., Moncrieff, J., & Dillon, J. (2011). *De-medicalizing misery: Psychiatry, psychology and the human condition*. Hampshire, UK: Palgrave Macmillan

Read, J., Hammersley, P., & Rudegeair, T. (2007). Why, when and how to ask about childhood abuse. *Advances in Psychiatric Treatment*, *13*(2), 101-110. https://doi.org/10.1192/apt.bp.106.002840

Reder, P., & Fredman, G. (1996). The relationship to help: Interacting beliefs about the treatment process. *Clinical Child Psychology and Psychiatry*, *1*(3), 457-467. https://doi.org/10.1177/1359104596013012

Rees, S. (2009). *Mental ill health in the adult single homeless population: A review of the literature*. Retrieved from https://www.crisis.org.uk/media/20611/crisis_mental_ill_health_2009.pdf

Reeve, K., & Batty, E. (2011). *The hidden truth about homelessnesss: Experiences of single homelessness in England*. Retrieved from https://www.crisis.org.uk/media/236815/the_hidden_truth_about_homelessness.pdf

Reeve, K., Mccarthy, L., Pattison, B., Parr, S., Batty, E., Maye-Banbury, A., ... & Dayson, C. (2018). *The mental health needs of Nottingham's homeless population: An exploratory research study.* Retrieved from http://shura.shu.ac.uk/21958/1/ mental-health-nottinghams-homeless-population.pdf

Rhoades, H., Winetrobe, H., & Rice, E. (2014). Prescription drug misuse among homeless youth. *Drug and alcohol dependence*, *138*(6), 229-233. https://doi.org/10.1016/j.drugalcdep.2014.02.011

Rimke, H. (2003). Constituting transgressive interiorities: 19th century psychiatric readings of morally mad bodies. In A. Arturo (Ed.), *Violence and the body: Race, gender and the state* (pp. 403-428). Bloomington, IN: Indiana University Press.

Rimke, H. (2010). Consuming fears: Neoliberal in/securities, cannibalization, and psychopolitics. In J. Shantz (Ed.), *Racism and borders: Representation, repression, resistance* (pp. 95- 113). New York: Algora Publishing

Rimke, H. (2016). Pathologizing resistance and promoting anthropophobia: The violent extremism risk assessment (VERA) as case study. In H. Ramadan & J. Shantz (eds.) *Manufacturing phobias: The political production of fear in theory and practice* (pp. 17-26). Toronto: University of Toronto Press.

Royal College of Psychiatrists. (2019). *National clinical audit of anxiety and depression: Technical report for the core audit 2017-2018.* Retrieved from https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/national-clinical-audits/ncaad-documents-technical-report.pdf

Rusticus, S. A., & Lovato, C. Y. (2014). Impact of sample size and variability on the power and type I error rates of equivalence tests: A simulation study. *Practical Assessment, Research, and Evaluation, 19*(1), 1-10. https://doi.org/10.7275/4s9m-4e81

Sacks, J. Y., McKendrick, K., & Banks, S. (2008). The impact of early trauma and abuse on residential substance abuse treatment outcomes for women. *Journal of substance abuse treatment*, *34*(1), 90-100. https://doi.org/ 10.1016/j.jsat.2007.01.010

Sackville, R. J. (2004). Homelessness, human rights and the law. *Australian Journal of Human Rights*, *10*(2), 11-26. https://doi.org/10.1080/1323238X.2004. 11910780

Sajatovic, M., Levin, J., Ramirez, L. F., Hahn, D. Y., Tatsuoka, C., Bialko, C. S., ... & Williams, T. D. (2013). A prospective trial of customized adherence enhancement plus long-acting injectable antipsychotic medication in homeless or recently homeless individuals with schizophrenia or schizoaffective disorder. *The journal of clinical psychiatry*, *74*(12), 1249-1255.https://doi.org/10.4088/JCP.12m08331

Salavera, C., Tricás, J. M., & Lucha, O. (2013). Personality disorders and treatment drop out in the homeless. *Neuropsychiatric disease and treatment*, *9(4)*, 379-387. https://doi.org/10.2147/NDT.S38677

Sashidharan, S. P. (2001). Institutional racism in British psychiatry. *Psychiatric Bulletin*, *25*(7), 244-247. https://doi.org/10.1192/pb.25.7.244

Sauer-Zavala, S., Ametaj, A. A., Wilner, J. G., Bentley, K. H., Marquez, S., Patrick, K. A., Starks, B., Shtasel, D., & Marques, L. (2019). Evaluating transdiagnostic, evidence-based mental health care in a safety-net setting serving homeless individuals. *Psychotherapy, 56*(1), 100–114. https://doi.org/10.1037/pst0000187

Schreiter, S., Bermpohl, F., Krausz, M., Leucht, S., Rössler, W., Schouler-Ocak, M., & Gutwinski, S. (2017). The prevalence of mental illness in homeless people in Germany: A systematic review and meta-analysis. *Deutsches Ärzteblatt International*, *114*(40), 665-672. https://doi.org/10.3238/arztebl.2017.0665

Schreiter, S., Heidrich, S., Zulauf, J., Saathoff, U., Brückner, A., Majic, T., ... & Bäuml, J. (2019). Housing situation and healthcare for patients in a psychiatric centre in Berlin, Germany: A cross-sectional patient survey. *BMJ open*, *9*(12), e032576, 1-11. https://doi.org/10.1136/bmjopen-2019-032576

Shelter. (2018). Over half of homeless families in England are in work, shock new figures show [Press release]. Retrieved from https://england.shelter.org.uk/media/press _releases/articles/over_half_of_homeless_families_in_england_are_in_wo rk,_shock_new_figures_show

Slesnick, N., & Prestopnik, J. (2005). Dual and multiple diagnosis among substance using runaway youth. *The American journal of drug and alcohol abuse*, *31*(1), 179-201. https://doi.org/10.1081/ADA-47916

Soar, K., Papaioannou, G., & Dawkins, L. (2016). Alcohol gel ingestion among homeless eastern and central Europeans in London: Assessing the effects on cognitive functioning and psychological health. *Substance use & misuse*, *51*(10), 1274-1282. https://doi.org/10.3109/10826084.2016.1168441

Somerville, P. (2013). Understanding homelessness. *Housing, Theory and Society*, *30*(4), 384-415. https://doi.org/10.1080/14036096.2012.756096

Steen, A., Mackenzie, D., & McCormack, D. (2012). *Homelessness and unemployment: understanding the connection and breaking the cycle.* Swinburne Institute for Social Research, Hawthorn. Retrieved from https://www.sheltertas.org.au/wp-content/uploads/2015/03/Homelessness-and-unemployment_Final-Report-20121.pdf

Stuckler, D., Reeves, A., Loopstra, R., Karanikolos, M., & McKee, M. (2017). Austerity and health: The impact in the UK and Europe. *European journal of public health*, *27*(4), 18-21. https://doi.org/10.1093/eurpub/ckx167

Taylor, K., & Sharpe, L. (2008). Trauma and PTSD among homeless adults in Sydney. *Australian and New Zealand Journal of Psychiatry*, *42*(3), 206-213. https://doi.org/10.1080/00048670701827218

Tessler, R., Rosenheck, R., & Gamache, G. (2001). Gender differences in self-reported reasons for homelessness. *Journal of Social Distress and the Homeless*, *10*(3), 243-254. https://doi.org/10.1023/A:1016688707698

Thompson, R. G., & Hasin, D. (2012). Psychiatric disorders and treatment among newly homeless young adults with histories of foster care. *Psychiatric services*, *63*(9), 906-912. https://doi.org/10.1176/appi.ps.201100405

Timms, P., & Perry, J. (2016). Sectioning on the street–futility or utility?. *BJPsych bulletin*, *40*(6), 302-305. https://doi.org/10.1192/pb.bp.115.052449

Tomita, A., & Herman, D. B. (2012). The impact of critical time intervention in reducing psychiatric re-hospitalization after hospital discharge. *Psychiatric services*, *63*(9), 935-937. https://doi.org/10.1176/appi.ps.201100468

Torchalla, I., Strehlau, V., Li, K., Aube Linden, I., Noel, F., & Krausz, M. (2014). Posttraumatic stress disorder and substance use disorder comorbidity in homeless adults: Prevalence, correlates, and sex differences. *Psychology of Addictive Behaviors*, *28*(2), 443-452. https://doi.org/10.1037/a0033674

Tulloch, A. D., Fearon, P., & David, A. S. (2012). Timing, prevalence, determinants and outcomes of homelessness among patients admitted to acute psychiatric wards. *Social psychiatry and psychiatric epidemiology*, *47*(7), 1181-1191. https://doi.org/10.1007/s00127-011-0414-4.

Tyler, K. A., Schmitz, R. M., & Ray, C. M. (2018). Role of social environmental protective factors on anxiety and depressive symptoms among Midwestern homeless youth. *Journal of Research on Adolescence*, *28*(1), 199-210. https://doi.org/10.1111/jora.12326

United Nations General Assembly. (1948). *Universal declaration of human rights 302(2).* Retrieved from https://www.un.org/ en/universal-declaration-human-rights/

Vichta, R., & Husband, A. (2017). Intimate partner violence and homelessness: Young women lost in the intersectionality. *Parity*, *30*(9), 113-115. https://doi.org/10.1032-6170

Vogel, M., Nikoo, M., Nikoo, N., Schütz, C. G., Walter, M., Somers, J., & Krausz, M. (2019). Association of substance use patterns with psychiatric disorders in homeless persons with psychiatric disorders in Vancouver. *International Journal of Mental Health and Addiction*, *17*(5), 1200-1213. https://doi.org/ 10.1007/s11469-018-0040-4

Votta, E., & Farrell, S. (2009). Predictors of psychological adjustment among homeless and housed female youth. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, *18*(2), 126-132.https://doi.org/10.1016/ s0012

Votta, E., & Manion, I. (2004). Suicide, high-risk behaviors, and coping style in homeless adolescent males' adjustment. *Journal of adolescent health*, *34*(3), 237-243. https://doi.org/10.1016/j.jadohealth.2003.06.002

Walker-Dalhouse, D., & Risko, V. J. (2008). Homelessness, poverty, and children's literacy development. *The Reading Teacher*, *62*(1), 84-86. https://doi.org/10.1598/RT.62.1.11

Whitbeck, L. B., Armenta, B. E., & Welch-Lazoritz, M. L. (2015). Borderline personality disorder and Axis I psychiatric and substance use disorders among women experiencing homelessness in three US cities. *Social psychiatry and psychiatric epidemiology*, *50*(8), 1285-1291. https://doi.org/ 10.1007/s00127-015-1066-6.

Wildemuth, B. M. (2009). *Applications of social research methods to questions in information and library science*. California: Libraries Unlimited.

Williams, M. (2010). Can we measure homelessness?: A critical evaluation of 'Capture-Recapture'. *Methodological Innovations Online*, *5*(2), 49-59. https://doi.org/10.4256/mio.2010.0018

Willig, C. (2013). *Introducing qualitative research in psychology*. UK: McGraw-hill education.

Winiarski, D. A., Rufa, A. K., Bounds, D. T., Glover, A. C., Hill, K. A., & Karnik, N. S. (2020). Assessing and treating complex mental health needs among homeless youth in a shelter-based clinic. *BMC Health Services Research*, *20*(1), 1-10. https://doi.org/10.1186/s12913-020-4953-9

World Health Organization. (1992). *International classification of mental and behavioural disorders (ICD-10)*. Retrieved from https://www.who.int/classifications/icd/icdonlineversions/en/

Zhang, M. (2003). Links between school absenteeism and child poverty. *Pastoral Care in Education*, *21*(1), 10-17. https://doi.org/10.1111/1468-0122.00249

Zuvekas, S. H., & Hill, S. C. (2000). Income and employment among homeless people: the role of mental health, health and substance abuse. *The journal of mental health policy and economics*, *3*(3), 153-163. https://doi.org/10.1002/mhp.94

Zygmunt, A., Olfson, M., Boyer, C. A., & Mechanic, D. (2002). Interventions to improve medication adherence in schizophrenia. *American Journal of Psychiatry*, *159*(10), 1653-1664. https://doi.org/10.1176/appi.ajp.159.10.1653

APPENDICES

Appendix A: Flow Diagram of Study Selection Process

Appendix B: The NCAAD Standards of Practice

Appendix C: The Audit of Practice Tool

Appendix D: Permission from the RCP

Appendix E: Approved ethics application for research involving secondary analysis of existing data

Appendix F: Approved request for amendment to an ethics application

Appendix G: SPSS Output

Appendix H: National Demographic Data on Homeless Population

Appendix A: Flow Diagram of Study Selection Process
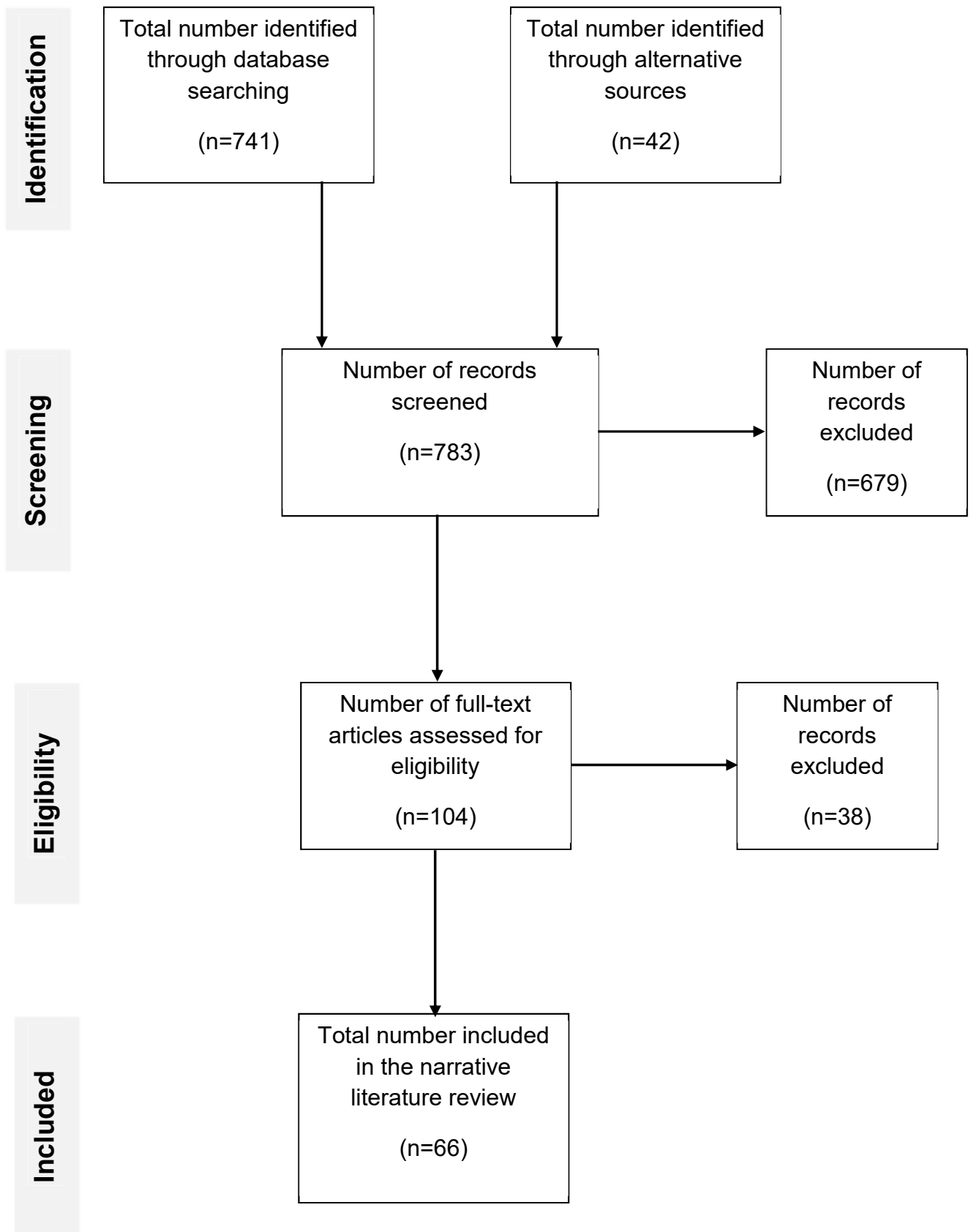
Adapted from Moher, Liberati, Tetzlaff, Altman & Prisma Group (2009).

Appendix B: The NCAAD Standards of Practice

THE STANDARDS

The standards are a way to measure how well a mental health service is performing

🔓 ACCESS

1. The Trust routinely collects data to assess equity of access.

   Guidance: This includes age, gender, ethnicity, employment and accommodation status.

2. Service users have timely access to inpatient care when required.

📋 ASSESSMENT

3. Service users' assessments are comprehensive and include consideration of:
   - Identification of social support and/or stressors in relation to finance, education/employment and relationships;
   - Previous traumatic experiences or associated symptoms;
   - Previous treatments and response to them (if applicable);

4. Service users' physical health is considered as part of their assessment and treatment, with support, advice or onward referral offered where appropriate.

   Guidance: This includes blood pressure, heart and respiratory rates; BMI; blood tests, and lifestyle factors (e.g. diet, exercise, smoking, drug and alcohol use).

💬 SHARED DECISION MAKING

5. The needs of service user's family members, friends or carers are considered as part of the assessment process and they are offered an assessment of their needs.

6. Care plans are jointly developed with service users and their family member, friend or carer (if applicable), and they are given a copy with an agreed date for review.

➕ MEDICATION

7. Psychotropic medication is provided in line with the relevant NICE and BNF guidance for the service user's diagnosis/condition.

💭 PSYCHOLOGICAL THERAPIES

8. Psychological therapies are provided in line with relevant NICE guidance for the service user's diagnosis/condition.

🧳 DISCHARGE

9. Within 24 hours of discharge a discharge letter is sent to the service user's GP and a copy of the service user's care plan is sent to the accepting service (if applicable).

10. The service user and their family member, friend or carer (if applicable), receives at least 24 hours' notice of discharge and this is documented.

11. Service users discharged from an inpatient setting receive a follow-up within 48 hours of discharge.

12. Service users have a crisis plan agreed and in place prior to discharge from an inpatient service.

⚖️ OUTCOME MEASUREMENT

13. Assessments include the use of an appropriately validated outcome measure(s) (e.g. symptoms, level of functioning and/or disability) which are used to monitor, inform and evaluate treatment.

Appendix C: The NCAAD Audit of Practice Tool

National Clinical Audit of Anxiety and Depression (NCAAD)

Please login using your unique username and password:

Username

Password

DASHBOARD

Please follow the links below to enter the data for each of the service users identified in your sample:

Service User ID: {subject} {status}

If you have any issues or queries, please contact your local NCAAD Audit Lead or the NCAAD project team via email (ncaad@rcpsych.ac.uk) or telephone (020 3701 2745/2649).

AUDIT OF PRACTICE TOOL

This audit of practice tool reviews the assessment, care, treatment, and discharge planning for service users with a primary diagnosis of an anxiety and/or depressive disorder over a six-month period, beginning with their admission to an inpatient mental health service.

This tool has been developed to assess standards derived from national and professional guidance. A list of the NCAAD standards is available on the audit website (www.rcpsych.ac.uk/ncaad) and the *Audit Implementation Guide*.

When completing this tool, please keep the *Audit of Practice Guidance* to hand for reference.

Service User Inclusion Criteria:

- Admitted to an inpatient mental health service between **01 April 2017** and **30 September 2017**;
- Aged 16 years or over (no upper age limit);
- Primary diagnosis of an anxiety and/or depressive disorder as identified using the ICD-10 coding at discharge (for a full list of eligible ICD-10 codes, please see the *Audit Implementation Guide*).

Please note that service users with the following characteristics are EXCLUDED from the audit:
- Psychosis based diagnoses (incl. F32.3 Severe depressive disorder with psychotic symptoms);
- Bipolar affective disorder (F31), cyclothymia (F34.0) or mania (F30);
- Admitted to a forensic service or long stay ward such as a rehabilitation service.

Entering the Data

One audit of practice tool should be completed for each service user.

Please note that all information entered should be based on the service user's clinical records/casenotes and NOT clinician knowledge.

Questions shaded in grey are not applicable to every service user. Please note the guidance at the beginning of the question to identify whether or not you need to complete the question.

If you have any issues or queries, please contact your local NCAAD Audit Lead or the NCAAD project team via email (ncaad@rcpsych.ac.uk) or telephone (020 3701 2745/2649).

TRUST/ORGANISATION INFORMATION

Trust/Organisation Code

Data Collector Name
We will use this information to contact you should there be any queries with this submission

Service User ID

Responsible CCG's ODS Code

SERVICE USER INFORMATION

1 Age on admission

[   ]

2 Gender

- ( ) Male
- ( ) Female
- ( ) Non-binary/other
- ( ) Unknown/not documented

3 Ethnicity

- ( ) White British
- ( ) White Irish
- ( ) Any other white background
- ( ) White and Black Caribbean
- ( ) White and Black African
- ( ) White and Asian
- ( ) Any other mixed background
- ( ) Indian
- ( ) Pakistani
- ( ) Bangladeshi
- ( ) Any other Asian background
- ( ) Caribbean
- ( ) African
- ( ) Any other Black background
- ( ) Chinese
- ( ) Any other ethnic group
- ( ) Service user declined to answer
- ( ) Unknown/not documented

4 Employment status at time of admission

- ( ) Employed - less than 16 hours per week
- ( ) Employed - 16 or more hours per week
- ( ) Homemaker
- ( ) Long-term sick leave/disabled and receiving incapacity benefit, income support etc.
- ( ) Not receiving benefits and not working or actively seeking work
- ( ) Retired
- ( ) Student
- ( ) Unemployed and seeking work
- ( ) Unpaid voluntary work, who are not working or actively seeking work
- ( ) Service user declined to answer
- ( ) Unknown/not documented

5 Accommodation status at time of admission

- ( ) Mainstream housing
- ( ) Accommodation with criminal justice support
- ( ) Accommodation with mental health care support
- ( ) Accommodation with other (not specialist mental health) care support
- ( ) Acute/long stay healthcare residential facility/hospital
- ( ) Homeless
- ( ) Sheltered housing
- ( ) Other
- ( ) Service user declined to answer
- ( ) Unknown/not documented

6 Is there an identified family member, friend or carer, who is the main source of support for the service user?

- ( ) Yes
- ( ) No

DIAGNOSIS

7 **Primary diagnosis/condition at discharge**
Please select ONE only. The numbers in brackets relate to the associated ICD-10 diagnoses.

- ○ **Diagnosis unknown/not documented**
- ○ Mild depressive episode (F32.0)
- ○ Moderate depressive episode (F32.1)
- ○ Severe depressive episode without psychotic symptoms (F32.2)
- ○ Other depressive episode (F32.8, F32.9)
- ○ Recurrent depressive disorder, current episode mild (F33.0)
- ○ Recurrent depressive disorder, current episode moderate (F33.1)
- ○ Recurrent depressive disorder, current episode severe without psychotic symptoms (F33.2)
- ○ Recurrent depressive disorder, currently in remission (F33.4)
- ○ Other recurrent depressive disorders (F33.8, F33.9)
- ○ Dysthymia (F34.1)
- ○ Other persistent mood [affective] disorders (F34.8, F34.9)

- ○ Other mood [affective] disorders (F38, F39)
- ○ Agoraphobia (F40.0)
- ○ Social phobias (F40.1)
- ○ Other phobic anxiety disorders (F40.2, F40.8, F40.9)
- ○ Panic disorder (F41.0)
- ○ Generalized anxiety disorder (F41.1)
- ○ Mixed anxiety and depressive disorder (F41.2)
- ○ Other mixed anxiety disorders (F41.3)
- ○ Other anxiety disorders (F41.8, F41.9)
- ○ Obsessive-compulsive disorder (F42)
- ○ Acute stress reaction (F43.0)
- ○ Post-traumatic stress disorder (F43.1)
- ○ Adjustment disorders (F43.2)
- ○ Other reactions to severe stress (F43.8, F43.9)

8 **Additional diagnoses/conditions at discharge**
Please select ALL that apply. The numbers in brackets relate to the associated ICD-10 diagnoses.
*Items in red include diagnoses which may be excluded from the audit - please check Appendix 2: EXCLUDED ICD-10 Codes in the guidance document to ensure the service user is eligible.

- ☐ **No additional diagnoses OR Diagnoses unknown/not documented**
- ☐ Organic, including symptomatic, mental disorders (F00 - F09)
- ☐ Mental and behavioural disorders due to psychoactive substance use (F10 - F19)
- ☐ Schizophrenia, schizotypal and delusional disorders (F20 - F29)
- ☐ Mood [affective] disorders (F30 - F39)
- ☐ Neurotic, stress-related and somatoform disorders (F40 - F48)
- ☐ Behavioural syndromes associated with physiological disturbances and physical factors (F50 - F59)

- ☐ Disorders of adult personality and behaviour (F60 - F69)
- ☐ Mental retardation [learning disabilities] (F70 - F79)
- ☐ Disorders of psychological development (F80 - F89)
- ☐ Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F90 - F98)
- ☐ Unspecified mental disorder (F99)
- ☐ Long term physical health disorder (e.g. motor neuron disease, multiple sclerosis, COPD)

ADMISSION

9   Date and time hospital was notified of need for a bed

◯ Unknown/not documented

Date (DD/MM/YYYY)

Time (HH:MM, 24hr)

If the time in NOT available, please enter 'Unknown'

10   Date of admission (DD/MM/YYYY)

11   Time of admission

◯ Unknown/not documented

(HH:MM, 24hr)

12   Type of admission

◯ Planned

◯ Emergency via Crisis Resolution/Home Treatment Team (CRHT)

◯ Emergency via Emergency Department

◯ Emergency via Community CAMHS or Community Mental Health Team (CMHT)

◯ Transfer from another inpatient mental health service

◯ Transfer from acute hospital service

◯ Admitted via Section 136/135 from a Health Based Place of Safety (HBPoS)

◯ Police custody

◯ Unknown/not documented

◯ Other

If 'Other', please state:

13   Was the admission voluntary?

◯ Yes

◯ No - Service user was admitted under the Mental Health Act

14   [ONLY ANSWER IF THE SERVICE USER WAS ADMITTED UNDER THE MENTAL HEALTH ACT]Mental Health Act classification

◯ Section 2: Admission to hospital for assessment

◯ Section 3: Admission to hospital for treatment

◯ Section 4: Admission for assessment in an emergency

◯ Section 35: Accused person remanded to hospital for a report

◯ Section 36: Accused person remanded to hospital for treatment

◯ Other

ASSESSMENT

Please answer the following questions based on all the information in the service user's casenotes until the point of discharge from the inpatient service

15   Did the assessment include details about the service user's past response to treatment?

    ○ Yes   ○ No

    ○ N/A

16   Did the assessment include information about the service user's difficulties in relation to their:

	Yes	No	N/A
Employment and/or education	○	○	○
Financial situation	○	○	○
Social situation	○	○	○

17   Did the assessment include information about the service user's dependents (e.g. children, elderly relatives etc.)?

    ○ Yes   ○ No

    ○ N/A - This was considered and not applicable to the service user

18   Did the assessment consider whether the service user had a history of trauma?

    ○ Yes   ○ No

    ○ N/A - This was considered and not applicable to the service user

19   [ONLY ANSWER IF THE SERVICE USER HAS AN IDENTIFIED FAMILY MEMBER, FRIEND OR CARER]Was the identified family member, friend or carer provided with information about available support services and/or a support plan?

    ○ Yes   ○ No

20   [ONLY ANSWER IF THE SERVICE USER HAS AN IDENTIFIED FAMILY MEMBER, FRIEND OR CARER]Was the identified family member, friend or carer offered a carer's assessment?

    ○ Yes   ○ No

CARE PLANNING

Please answer the following questions based on all the information in the service user's casenotes until the point of discharge from the inpatient service

21   Did the service user have a care plan?

◯ Yes   ◯ No

22   [ONLY ANSWER IF THE SERVICE USER HAS A CARE PLAN]Is there evidence that the care plan was jointly developed between the service user and clinician?

◯ Yes   ◯ No

23   [ONLY ANSWER IF THE SERVICE USER HAS A CARE PLAN]Was the service user given a copy of their care plan?

◯ Yes   ◯ No

24   [ONLY ANSWER IF THE SERVICE USER HAS A CARE PLAN]Did the care plan include an agreed date for a review?

◯ Yes   ◯ No

MEDICATION

Please answer the following questions based on all the information in the service user's casenotes until the point of discharge from the inpatient service

25 Was the service user being prescribed psychotropic medication at the point of discharge?

◯ Yes   ◯ No

[ONLY ANSWER IF THE SERVICE USER WAS BEING PRESCRIBED PSYCHOTROPIC MEDICATION]Please specify the DAILY/PRN dosage for ALL psychotropic medication being prescribed at the point of discharge:
Please complete only the relevant fields. You can leave the rest blank.

Antidepressants

	Regular DAILY Dosage
Agomelatine (mg)	
Amitriptyline hydrochloride (mg)	
Buspirone hydrochloride (mg)	
Bupropion hydrochloride (mg)	
Citalopram (mg)	
Clomipramine hydrochloride (mg)	
Dosulepin hydrochloride (mg)	
Doxepin (mg)	
Duloxetine (mg)	
Escitalopram (mg)	
Fluoxetine (mg)	
Fluvoxamine maleate (mg)	
Imipramine hydrochloride (mg)	
Isocarboxazid (mg)	
Mianserin hydrochloride (mg)	
Mirtazapine (mg)	
Moclobemide (mg)	
Nortriptyline (mg)	
Paroxetine (mg)	
Phenelzine (mg)	
Reboxetine (mg)	
Sertraline (mg)	

	Regular DAILY Dosage
Tranylcypromine (mg)	
Trazodone hydrochloride (mg)	
Trimipramine (mg)	
Venlafaxine (mg)	
Vortioxetine (mg)	

Hypnotics and Anxiolytics

	Regular DAILY Dosage
Alprazolam (mg)	
Chlordiazepoxide hydrochloride (mg)	
Clomethiazole (Chlormethiazole) (mg)	
Clonazepam (mg)	
Diazepam (mg)	
Flurazepam (mg)	
Loprazolam (mg)	
Lorazepam (mg)	
Lormetazepam (mg)	
Melatonin (mg)	
Meprobamate (mg)	
Nitrazepam (mg)	
Oxazepam (mg)	
Promethazine (mg)	
Temazepam (mg)	
Zolpidem tartrate (mg)	
Zopiclone (mg)	

PRN

Antipsychotics

Regular DAILY Dosage

	Regular DAILY Dosage
Amisulpride (mg)	
Aripiprazole (mg)	
Asenapine (mg)	
Benperidol (mg)	
Chlorpromazine hydrochloride (mg)	
Clozapine (mg)	
Flupenthixol (mg)	
Haloperidol (mg)	
Levomepromazine (Methotrimeprazine) (mg)	
Lurasidone hydrochloride (mg)	
Olanzapine (mg)	
Paliperidone (mg)	
Pericyazine (mg)	
Perphenazine (mg)	
Prochlorperazine (mg)	
Promazine hydrochloride (mg)	
Quetiapine (mg)	
Risperidone (mg)	

Sulpiride (mg)	
Trifluoperazine (mg)	
Zuclopenthixol (mg)	

PRN

Other

	Regular DAILY Dosage
Pregabalin (mg)	
Lithium (mg)	
Gabapentin (mg)	
Lamotrigine (mg)	

PRN

[ ]
[ ]
[ ]
[ ]

153

Medication Name

[ ]
[ ]
[ ]

Regular DAILY Dosage (mg)

[ ]
[ ]
[ ]

PRN (mg)

[ ]
[ ]
[ ]

26	[ONLY ANSWER IF THE SERVICE USER WAS BEING PRESCRIBED PSYCHOTROPIC MEDICATION]Was the service user given verbal and/or written information about their medication prior to discharge?

○ Yes   ○ No

27	[ONLY ANSWER IF THE SERVICE USER WAS BEING PRESCRIBED PSYCHOTROPIC MEDICATION]Did a review of the service user's medication(s) take place prior to discharge?

○ Yes   ○ No

○ N/A - service user has NOT been discharged

If 'Yes': Did the review include the following:
Please select ALL that apply

☐ Response to medication

☐ Side effects of medication

☐ Unknown/not documented

PSYCHOLOGICAL THERAPIES

28 Was the service user referred to psychological therapy?

○ Yes ○ No

○ Unknown/not documented

If this information in NOT available, please enter 'unknown'

Date of referral (DD/MM/YYYY)

Date of assessment (DD/MM/YYYY)

29 [ONLY ANSWER IF THE SERVICE USER WAS REFERRED TO PSYCHOLOGICAL THERAPY]Which type(s) of psychological therapy was the service user referred to? *Please select ALL that apply*

☐ Individual therapy ☐ Group/family/couples therapy

30 [ONLY ANSWER IF THE SERVICE USER WAS REFERRED TO INDIVIDUAL THERAPY]Who was the referral for **individual** psychological therapy made to?

○ Private ○ Third sector

○ NHS secondary care ○ IAPT

○ Other

31 [ONLY ANSWER IF THE SERVICE USER WAS REFERRED TO INDIVIDUAL THERAPY]Has the service user started **individual** psychological therapy?

○ Yes ○ No

○ Unknown/not documented

If 'Yes', please state: Date of first session (DD/MM/YYYY)

32 [ONLY ANSWER IF THE SERVICE USER HAS NOT STARTED INDIVIDUAL THERAPY]Please select the reason why **individual** psychological therapy has not yet started

○ Service user is on waiting list ○ Unknown/not documented

○ Service user chose not to participate ○ Other

○ Service user is not currently able to participate

If 'Other', please state:

33	Which **individual** psychological therapy has the service user received?

Please select ALL that apply

- [ ] Acceptance and Commitment Therapy (ACT)
- [ ] Applied Relaxation
- [ ] Arts Psychotherapies (e.g. Art, music, movement)
- [ ] Behavioural Activation
- [ ] Cognitive Analytic Therapy (CAT)
- [ ] Cognitive Behavioural Therapy (CBT)
- [ ] Compassion Focussed Therapy
- [ ] Counselling
- [ ] Dialectical Behavioural Therapy (DBT)
- [ ] Dynamic Interpersonal Therapy (DIT)
- [ ] Eye Movement Desensitisation and Reprocessing (EMDR)
- [ ] Guided/Supported Self-help

- [ ] Humanistic/Person Centred Therapy
- [ ] Integrative Psychotherapy
- [ ] Interpersonal Psychotherapy (IPT)
- [ ] Mentalisation Based Therapy (MBT)
- [ ] Mindfulness
- [ ] Mindfulness Based Cognitive Therapy (MBCT)
- [ ] Narrative Exposure Therapy (NET)
- [ ] Problem Solving Therapy
- [ ] Short-term Psychodynamic/Psychoanalytic Psychotherapy
- [ ] Solution-Focussed Therapy
- [ ] Systemic Therapy
- [ ] Other

If 'Other', please state:

[   ]

---

34 Has the service user started **group/family/couples** therapy?

- ( ) Yes
- ( ) No
- ( ) Unknown/not documented

If 'Yes', please state: Date of first session (DD/MM/YYYY)   [   ]

---

35 Please select the reason why **group/family/couples** therapy has not yet started

- ( ) Service user on waiting list
- ( ) Service user chose not to participate
- ( ) Service user is not currently able to participate
- ( ) Unknown/not documented
- ( ) Other

If 'Other', please state:

[   ]

36 [ONLY ANSWER IF THE SERVICE USER HAS STARTED GROUP/FAMILY/COUPLES THERAPY]Which **group/family/couples** therapy has the service user received?
Please select ALL that apply

- ☐ Applied Relaxation
- ☐ Arts Psychotherapies (e.g. Art, music, movement)
- ☐ Behavioural Couples Therapy
- ☐ Cognitive Analytic Therapy (CAT)
- ☐ Cognitive Behavioural Therapy (CBT)
- ☐ Compassion Focussed Therapy
- ☐ Counselling
- ☐ Dialectical Behavioural Therapy (DBT)
- ☐ Dynamic Interpersonal Therapy (DIT)
- ☐ Humanistic/Person-Centred Therapy
- ☐ Integrative Psychotherapy

- ☐ Interpersonal Psychotherapy (IPT)
- ☐ Mentalisation Based Therapy (MBT)
- ☐ Mindfulness
- ☐ Mindfulness Based Cognitive Therapy (MBCT)
- ☐ Problem Solving Therapy
- ☐ Psycho-Education
- ☐ Short-term Psychodynamic/Psychoanalytic Psychotherapy
- ☐ Solution-Focussed Therapy
- ☐ Systemic Therapy
- ☐ Other

If 'Other', please state:

[   ]

156

PHYSICAL HEALTH

37 Current/most recent BMI

○ Documented evidence of refusal to be weighed/measured   ○ Unknown/not documented

BMI (Kg/m2 [*NN.N*]):   [_____]

38 [ONLY ANSWER IF THE SERVICE USER IS BEING PRESCRIBED ANTIPSYCHOTICS]Current/most recent blood pressure

○ Recorded   ○ Documented evidence of refusal of blood test

○ Unknown/not documented

If 'Recorded', please state:

Systolic blood pressure (mmHg [*NNN*])   [_____]

Diastolic blood pressure (mmHg [*NNN*])   [_____]

39 [ONLY ANSWER IF THE SERVICE USER IS BEING PRESCRIBED ANTIPSYCHOTICS]Current/most recent glucose level

○ Recorded   ○ Documented evidence of refusal of blood test

○ Unknown/not documented

If 'Recorded', please state:

Fasting Plasma Glucose (mmol/l [*N.N*])   [_____]

Glycated Haemoglobin (HbA1c; mmol/l [*N.N*])   [_____]

Random Plasma Glucose (mmol/l [*N.N*])   [_____]

40 [ONLY ANSWER IF THE SERVICE USER IS BEING PRESCRIBED ANTIPSYCHOTICS]Current/most recent cholesterol level

○ Recorded   ○ Documented evidence of refusal of blood test

○ Unknown/not documented

If 'Recorded', please state:

Total cholesterol (mmol/l [*N.N*])   [_____]

Non-HDL cholesterol (mmol/l [*N.N*])   [_____]

QRISK®2 (% [*N.N*])   [_____]

41 Smoking status at the point of admission

○ Current smoker   ○ Ex-smoker

○ Never smoked   ○ Service user declined to answer

○ Unknown/not documented

If 'Current smoker', please state: Number of cigarettes smoked per day   [_____]

42   Alcohol intake at the point of admission

○ Recorded   ○ Service user declined to answer
○ Service user does NOT drink   ○ Unknown/not documented

If 'Recorded', please state: Number of units consumed per week

43   Was the service user identified as misusing alcohol/drugs at the point of admission?

○ Yes   ○ No
○ Unknown/not documented

44   Which of the following interventions were offered prior to discharge:
Please select ALL that apply

☐ Advice about diet and exercise   ☐ Treatment for cardiovascular disease
☐ Help with smoking cessation   ☐ Treatment for diabetes
☐ Help reducing alcohol consumption ☐ None of the above
☐ Help with substance misuse   ☐ N/A - service user has NOT been discharged

DISCHARGE

45 Was the service user discharged from inpatient services during the audit period?

⚪ Yes ⚪ No

If 'Yes', please state:

Date of discharge (DD/MM/YYYY) [ ]

Time of discharge (HH:MM, 24hr) [ ]

If the time of discharge in NOT available, please enter 'Unknown'

46 [ONLY ANSWER IF THE SERVICE USER HAS BEEN DISCHARGED]Was the service user given at least 24 hours notice of discharge?

⚪ Yes ⚪ No

47 [ONLY ANSWER IF THE SERVICE USER HAS AN IDENTIFIED FAMILY MEMBER, FRIEND OR CARER AND HAS BEEN DISCHARGED]Was the identified family, friend or carer given at least 24 hours notice of discharge?

⚪ Yes ⚪ No

48 [ONLY ANSWER IF THE SERVICE USER HAS BEEN DISCHARGED]At discharge, was the service user given to take home (TTOs) medication?

⚪ Yes ⚪ No

⚪ Unknown/not documented

If 'Yes', please state: Number of days the TTOs were prescribed for [ ]

49 [ONLY ANSWER IF THE SERVICE USER HAS BEEN DISCHARGED AND WAS BEING PRESCRIBED PSYCHOTROPIC MEDICATION]Did a review of the service user's medication(s) take place between discharge and the end of the audit period?

⚪ Yes ⚪ Unknown/not documented

If 'Yes': Did the review include the following:
Please select ALL that apply

☐ Response to medication

☐ Side effects of medication

☐ Unknown/not documented

50 [ONLY ANSWER IF THE SERVICE USER HAS BEEN DISCHARGED]Was a discharge letter sent to the service user's GP?

⚪ Yes ⚪ Service user does NOT have a GP

⚪ Unknown/not documented

If 'Yes', please state: Date discharge letter sent to GP (DD/MM/YYYY) [ ]

51	[ONLY ANSWER IF THE SERVICE USER HAS BEEN DISCHARGED]Did the discharge letter include the following:

51 [ONLY ANSWER IF THE SERVICE USER HAS BEEN DISCHARGED]Did the discharge letter include the following:
Please select ALL that apply

- ☐ Contact details for the service/team responsible for the service user's care
- ☐ Medications including dosage and frequency
- ☐ Risk to and from self, others, neglect etc.
- ☐ Unknown/not documented

52 [ONLY ANSWER IF THE SERVICE USER HAS BEEN DISCHARGED]Was a care plan sent to a nominated person in an accepting service?

- ○ Yes
- ○ No
- ○ Unknown/not documented

If 'Yes', please state: Date care plan sent to nominated person (DD/MM/YYYY) [   ]

RE-ADMISSION TO SERVICE

53   [ONLY ANSWER IF THE SERVICE USER HAS BEEN DISCHARGED] Was the service user re-admitted to hospital between discharge and the end of the audit period?

○ Yes   ○ No

If 'Yes', please state: Number of re-admissions [_____]

FOLLOW-UP PROCESS

54   [ONLY ANSWER IF THE SERVICE USER HAS BEEN DISCHARGED]Did the service user receive follow-up after discharge?

◯ Yes   ◯ No

◯ Unknown/not documented

If this information in NOT available, please enter 'unknown'

Date of follow-up (DD/MM/YYYY)

Time of follow-up (HH:MM, 24hr)

55   [ONLY ANSWER IF THE SERVICE USER HAS RECEIVED FOLLOW-UP AFTER DISCHARGE]What was the mode of contact for the follow-up?

◯ Face-to-face   ◯ Telephone

CRISIS PLANNING

56   [ONLY ANSWER IF THE SERVICE USER HAS BEEN DISCHARGED]Did the service
        user have a crisis plan at the point of discharge?

        ◯ Yes   ◯ No

OUTCOME MEASURES

57 [ONLY ANSWER IF THE SERVICE USER IS AGED UNDER 18]Was a Children's Global Assessment Scale (CGAS) completed?

○ Yes   ○ No

If 'Yes', please state: CGAS score [   ]

58 [ONLY ANSWER IF THE SERVICE USER IS AGED 18 AND OVER]Was a Health of the Nation Outcomes Scale (HoNOS) completed?

○ Yes   ○ No

59 Were there any other outcome measures completed?

○ Yes   ○ No

[ONLY ANSWER IF ANOTHER OUTCOME MEASURE WAS COMPLETED AND THE SERVICE USER IS AGED 18 AND OVER]Which of the following outcome measures were completed:
Please select ALL that apply

☐ Beck Depression Inventory (BDI)

☐ BDD Dimensional Scale (BDD-D)

☐ Centre for Epidemiological Studies-Depression Scale (CES-D)

☐ Clinician-administered PTSD Scale for DSM-5 (CAPS-5)

☐ Clinical Outcomes in Routine Evaluation (CORE-10)

☐ Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM)

☐ DIALOG

☐ Generalised Anxiety Disorder Assessment (GAD-7)

☐ General Health Questionnaire (GHQ)

☐ Geriatric Depression Scale (GDS)

☐ Hamilton Anxiety Rating Scale

☐ Hamilton Depression Rating Scale

☐ Hospital Anxiety and Depression Scale (HADS)

☐ Impact of Events Scale-revised (IES-R)

☐ Inventory of Interpersonal Problems (IIP)

☐ Liebowitz Social Anxiety Scale (LSAS)

☐ Major Depression Inventory (MDI)

☐ Montgomery-Asberg Depression Rating Scale (MADRS)

☐ Obsessive-Compulsive Inventory (OCI)

☐ Panic and Agoraphobia Scale (PAS)

☐ Panic Disorder Severity Scale (PDSS)

☐ Patient Health Questionnaire-9 (PHQ-9)

☐ Questionnaire about Process of Recovery (QPR)

☐ Social Phobia Inventory (SPIN)

☐ The Appearance Anxiety Inventory (AAI)

☐ The Brown Assessment of Beliefs Scale (BABS)

☐ The Body Image Quality of Life Inventory (BIQLI)

☐ The Body Image Disturbance Questionnaire (BIDQ)

☐ The Cosmetic Procedure Screening Scale (COPS)

☐ The Dysmorphic Concern Questionnaire (DCQ)

☐ Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)

☐ Work and Social Adjustment Scale (WSAS)

☐ Yale-Brown Obsessive Compulsive Scale (Y-BOCS)

☐ Yale Brown Obsessive Compulsive Scale Modified for BDD (BDD-YBOCS)

☐ Zung's Self-rating Depression Scale

☐ Other

164

Which of the following outcome measures were completed:

Please select ALL that apply

- [ ] Beck Youth Inventory - Anxiety (BYI-2)
- [ ] Beck Youth Inventory - Depression (BYI-2)
- [ ] Children's Obsessive Compulsive Inventory – Revised (ChOCI-R) – Child
- [ ] Children's Obsessive Compulsive Inventory – Revised (ChOCI-R) – Parent
- [ ] Child PTSD Symptom Scale (CPSS)
- [ ] Children's Revised Impact of Events Scale (CRIES)
- [ ] Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS)
- [ ] Mood and Feelings Questionnaire (CAMHS)
- [ ] Penn State Worry Questionnaire - Children (PSWQ-C)
- [ ] Post-Traumatic Cognitions Inventory – Child Version (cPTCI)
- [ ] Revised Children's Anxiety and Depression Scale (RADS) - Child
- [ ] Revised Children's Anxiety and Depression Scale (RADS) - Parent
- [ ] Screen for Child Anxiety Related Disorders (SCARED) - Child
- [ ] Screen for Child Anxiety Related Disorders (SCARED) - Parent
- [ ] Strengths and Difficulties Questionnaire (SDQ) – Child
- [ ] Strengths and Difficulties Questionnaire (SDQ) – Parent
- [ ] Strengths and Difficulties Questionnaire (SDQ) – Teacher
- [ ] Other

165

Thank you for participating in the NCAAD Pilot Audit

Please use the button below to submit your data

You will NOT be able to make any changes after submitting, so please ensure you have double checked your data

Appendix D: Permission from the RCP

07 November 2019

Louise Kathrine Gregor
u1725784@uel.ac.uk

Dear Louise,

RE: STUDENT WORK PLACEMENT LETTER

I am writing to confirm that you have been offered the position of NCAAD – Student Placement in the National Clinical Audit of Anxiety and Depression (NCAAD) in the College Centre for Quality Improvement, based in [Address].

This is a Work Placement role for 6 months, one day per week from 08 November 2019 to 08 April 2019.

Your start date will be Friday 08 November 2019. Please arrive at 10am/or at the time agreed with your line manager and ask for [NAME].

Reasonable travel expenses will be covered.

I would like to take this opportunity to welcome you to the College.

Yours sincerely

[NAME]
Human Resources Administrator

Appendix E: Approved Ethics Application for Research Involving Secondary Analysis of Existing Data

UNIVERSITY OF EAST LONDON

School of Psychology

ETHICS APPLICATION FOR RESEARCH INVOLVING SECONDARY ANALYSIS OF EXISTING DATA

If your research solely involves access to and analysis of existing data please complete this application form electronically, fully and accurately.

Include electronic copies of document/s pertaining to the original ethics clearance of the initial dataset and other permissions as part of this **ONE DOCUMENT** SAVED AS **.doc**

Email your supervisor the completed application and all attachments as **ONE DOCUMENT**. INDICATE 'ETHICS SUBMISSION' IN THE SUBJECT FIELD OF THIS EMAIL.

If ethical and legal protocol is demonstrated your supervisor will type in his/her name in the 'supervisor's signature' section (5.2) and email your application to psychology.ethics@uel.ac.uk for processing. You should be copied into this email so that you know your application has been submitted. It is the responsibility of students to check this. Your supervisor will let you know the outcome of your application. Do NOT access and use the intended dataset until this ethics application has been approved.

Attach a copy of this application with completed approval section (below) to your thesis/dissertation/project.

PLEASE ANSWER THE FOLLOWING

1. Briefly outline the aims/objectives of the research and what it involves

This study will involve secondary analysis of data collected for the National Clinical Audit of Anxiety and Depression.

While the focus is primarily on the subsample of participants identified as being homeless, the study will also look to make comparisons with data on the care received by those identified as 'not homeless'. The following research questions will be addressed:

What is the demographic and clinical profile of homeless inpatients diagnosed with depression and/or anxiety?

How does the quality of care for homeless inpatients compare with the quality of inpatient mental health services, as well as that which is received by non-homeless counterparts?

What proportion of homeless inpatients are referred for psychological therapy? How does this compare to that of non-homeless inpatients?

Which demographic and clinical variables influence referrals for psychological therapy for homeless, and for non-homeless, inpatients?

2. Give details about the data you will be accessing

(e.g. what are the participant demographics of the original data you want to use? Is the original data anonymised? Is visual data involved and, if so, what is it?)

All data will be fully anonymised and only include participants aged 16 years and over who were included in the National Clinical Audit of Anxiety and Depression.

3. Who is the owner of the original data? (i.e. the copyright holder/s/initial researcher and their affiliation)

The Healthcare Quality Improvement Partnership (HQIP). Please see:

https://www.hqip.org.uk/a-z-of-nca/anxiety-and-depression/#.XYDl-W5Fxl8

4. Who is the guardian of the original data, if different from the above? (i.e. name of the archive through which you will access the data)

The Royal College of Psychiatrists Centre for Quality Improvement who are managing the National Clinical Audit of Anxiety and Depression.

5. If you are not accessing data through a data archive have you obtained permission from the owner of the data? If not, why not? (Attach evidence of permission or specify details)

Initial permission to access the data has been obtained from the team managing the National Clinical Audit of Anxiety and Depression at the Royal College of Psychiatrists. However, there is a formal approval process that needs to go through the Healthcare Quality Improvement Partnership and the data access request form requires evidence of ethical approval, which is why this application is being submitted first.

<u>**RESEARCHER OBLIGATIONS**</u>

1. It is your responsibility to ensure that in gaining access to and using existing data from another source that you have full and appropriate permission from the guardian of the data you intend to use and/or the owner of the data (copyright holder).

2. You must comply with any regulations of use that the guardian and owner of the data stipulate.

3. So as not to infringe copyright, the data source and the guardian and owner (copyright holder) of the data must be acknowledged in your research.

4. You must not pass on the data to other people or groups.

5. You will not need consent from research participants of exiting data where consent was gained as part of the initial data collection and where participants have agreed that their data can be used for further research. The guardian or owner of existing datasets should confirm this, and also that the data you intend to use has been properly anonymised.

I CONFIRM THAT	YES	NO

My proposed research involves no new participant recruitment and no new collection of data	X	
I have permission from the guardian or owner of the data set I intend to use and confirm that participants' consent to use their data is ongoing	X	
Relevant documentation such as permissions is attached. If not, why not? **Initial permission has been obtained from the team managing the National Clinical Audit of Anxiety and Depression at the Royal College of Psychiatrists. However, there is a formal approval process that needs to go through the Healthcare Quality Improvement Partnership and the data access request form requires evidence of ethical approval.**		X
I understand the nature of my ethical and legal obligations in this research (as above) and agree to comply	X	

SIGNATURES

THE TYPING OF FULL NAMES BELOW WILL ACTS AS SIGNATURES

Student's name/signature: Louise Gregor

Student Number: u1725784

Course: Professional Doctorate in Clinical Psychology

Title of research: The quality of mental health care received by homeless inpatients

Date: 29~~17~~.0~~1~~9.20~~19~~

I HAVE READ THE APPLICATION AND CONFIRM THAT THE PROPOSED RESEARCH INVOLVES NO NEW PARTICIPANT RECRUITMENT OR DATA COLLECTION

Supervisor's name/signature: Lorna Farquharson

Date: 29.01.20

ATTACH ELECTRONIC COPIES OF SUPPORTING DOCUMENTS HERE

IF SCANNING NECESSARY DOCUMENTS IS NOT *AT ALL* POSSIBLE, SUBMIT TWO HARDCOPIES OF YOUR APPLICATION (INCLUDING ALL ATTACHMENTS) DIRECTLY TO THE HELPDESK. HARDCOPY APPLICATIONS ARE TO BE SIGNED BY YOU AND YOUR SUPERVISOR AND DELIVERED TO THE HELPDESK BY YOU.

For School use only

APPROVED Chair of School REC	YES	NO
Recommendations (if any): Date: F.Hadjiefthyvoulou 1/10/19		

Appendix F: Approved Request for Amendment to an Ethics Application

UNIVERSITY OF EAST LONDON

School of Psychology

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

 FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact Dr Tim Lomas (Chair of the School Research Ethics Committee. t.lomas@uel.ac.uk).

HOW TO COMPLETE & SUBMIT THE REQUEST

Complete the request form electronically and accurately.

Type your name in the 'student's signature' section (page 2).

When submitting this request form, ensure that all necessary documents are attached (see below).

Using your UEL email address, email the completed request form along with associated documents to: Dr Tim Lomas at t.lomas@uel.ac.uk

Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.

Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

REQUIRED DOCUMENTS

A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.

Copies of updated documents that may relate to your proposed amendment(s). For example an updated recruitment notice, updated participant information letter, updated consent form etc.

A copy of the approval of your initial ethics application.

Name of applicant: Louise Gregor

Programme of study: Professional Doctorate in Clinical Psychology

Title of research: The quality of mental health care received by homeless inpatients

Name of supervisor: Dr Lorna Farquharson

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
My doctoral thesis is a secondary analysis of existing data from a national clinical audit. Initially, my project involved looking at data on just the homeless subsample. However, there is data available on the housed subsample that I would like to make comparisons to.	Being able to analyse data from the housed sample would allow comparisons to be made between the mental health care received by each group of individuals to establish any health inequalities.

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	X	

Student's signature (please type your name): Louise Gregor

Date: 29/01/2020

TO BE COMPLETED BY REVIEWER		
Amendment(s) approved	YES	
Comments		

Reviewer: Tim Lomas

Date: 29.1.2020

Appendix G: SPSS Data Output

Question 1: How do the demographic and clinical profiles of homeless service users diagnosed with anxiety and/or depression compare with those of housed service users?

Age Group Statistics

	Homeless or Housed	N	Mean	Std. Deviation	Std. Error Mean
Age	Homeless	223	38.93	12.041	.806
	Housed	3572	47.32	19.126	.320

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Age	Equal variances assumed	80.944	.000	-6.476	3793	.000	-8.396	1.297	-10.938	-5.854
	Equal variances not assumed			-9.679	296.984	.000	-8.396	.868	-10.103	-6.689

173

Homeless or Housed * Age Band Crosstabulation

		16-17 years	18-25 years	26-35 years	36-45 years	46-55 years	56-65 years	66+ years	Total
					Age Band				
Homeless	**Count**	**1**	**27**	**64**	**67**	**42**	**18**	**4**	223
	Expected Count	5.6	28.3	39.4	36.5	41.3	27.8	44.1	223.0
	% within Homeless or Housed	**0.4%**	**12.1%**	**28.7%**	**30.0%**	**18.9%**	**8.1%**	**1.8%**	100.0%
	% within Age Band	1.1%	5.6%	9.5%	10.8%	6.0%	3.8%	0.5%	5.9%
	% of Total	0.0%	0.7%	1.7%	1.8%	1.1%	0.5%	0.1%	5.9%
Housed	**Count**	**94**	**454**	**607**	**554**	**661**	**455**	**747**	3572
	Expected Count	89.4	452.7	631.6	584.5	661.7	445.2	706.9	3572.0
	% within Homeless or Housed	**2.6%**	**12.7%**	**17.0%**	**15.5%**	**18.5%**	**12.8%**	**20.9%**	100.0%
	% within Age Band	98.9%	94.4%	90.5%	89.2%	94.0%	96.2%	99.5%	94.1%
	% of Total	2.5%	12.0%	16.0%	14.6%	17.4%	12.0%	19.7%	94.1%
Total	Count	95	481	671	621	703	473	751	3795
	Expected Count	95.0	481.0	671.0	621.0	703.0	473.0	751.0	3795.0
	% within Homeless or Housed	2.5%	12.7%	17.7%	16.4%	18.5%	12.5%	19.8%	100.0%
	% within Age Band	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	% of Total	2.5%	12.7%	17.7%	16.4%	18.5%	12.5%	19.8%	100.0%

174

Age Band Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	**89.874**[a]	**6**	**.000**
Likelihood Ratio	109.333	6	.000
Linear-by-Linear Association	33.459	1	.000
N of Valid Cases	**3795**		

a.   0 cells (0.0%) have expected count less than 5. The minimum expected count is 5.58.

Homeless or Housed * Gender Crosstabulation

		Gender		
		Male	**Female**	**Total**
Homeless	**Count**	**178**	**45**	223
	Expected Count	114.4	108.6	223.0
	% within Homeless or Housed	**79.8%**	**20.2%**	100.0%
	% within Gender	9.2%	2.4%	5.9%
	% of Total	4.7%	1.2%	5.9%
Housed	**Count**	**1766**	**1800**	3566
	Expected Count	1829.6	1736.4	3566.0
	% within Homeless or Housed	**49.5%**	**50.5%**	100.0%
	% within Gender	90.8%	97.6%	94.1%
	% of Total	46.6%	47.5%	94.1%
Total	Count	1944	1845	3789
	Expected Count	1944.0	1845.0	3789.0
	% within Homeless or Housed	51.3%	48.7%	100.0%
	% within Gender	100.0%	100.0%	100.0%
	% of Total	51.3%	48.7%	100.0%

Gender Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	77.113[a]	1	.000		
Continuity Correction [b]	75.905	1	.000		
Likelihood Ratio	82.597	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	77.093	1	.000		
N of Valid Cases	3789				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 108.59.

b. Computed only for a 2x2 table

Homeless or Housed * Ethnicity Including Unknown Crosstabulation

		White	Mixed/Multiple	Asian	Black	Unknown	Total
		**Ethnicity Including Unknown**		
Homeless	**Count**	168	10	17	11	**17**	223
	Expected Count	187.7	7.9	9.1	4.8	13.5	223.0
	% within Homeless or Housed	75.3%	4.5%	7.6%	4.9%	7.6%	100.0%
	% within Ethnicity Including Unknown	5.3%	7.4%	11.0%	13.6%	7.4%	5.9%
	% of Total	4.4%	0.3%	0.4%	0.3%	0.4%	5.9%
Housed	**Count**	3026	125	138	70	**213**	3572
	Expected Count	3006.3	127.1	145.9	76.2	216.5	3572.0
	% within Homeless or Housed	84.7%	3.5%	3.9%	2.0%	6.0%	100.0%
	% within Ethnicity Including Unknown	94.7%	92.6%	89.0%	86.4%	92.6%	94.1%
	% of Total	79.7%	3.3%	3.6%	1.8%	5.6%	94.1%
Total	Count	3194	135	155	81	230	3795
	Expected Count	3194.0	135.0	155.0	81.0	230.0	3795.0
	% within Homeless or Housed	84.2%	3.6%	4.1%	2.1%	6.1%	100.0%
	% within Ethnicity Including Unknown	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	% of Total	84.2%	3.6%	4.1%	2.1%	6.1%	100.0%

178

Homeless or Housed * Ethnicity Excluding Unknown Crosstabulation

		Ethnicity Excluding Unknown				Total
		White	Mixed/Multiple	Asian	Black	
Homeless	**Count**	**168**	**10**	**17**	**11**	206
	Expected Count	184.6	7.8	9.0	4.7	206.0
	% within Homeless or Housed	**81.6%**	**4.9%**	**8.3%**	**5.3%**	100.0%
	% within Ethnicity Excluding Unknown	5.3%	7.4%	11.0%	13.6%	5.8%
	% of Total	4.7%	0.3%	0.5%	0.3%	5.8%
Housed	**Count**	**3026**	**125**	**138**	**70**	3359
	Expected Count	3009.4	127.2	146.0	76.3	3359.0
	% within Homeless or Housed	**90.1%**	**3.7%**	**4.1%**	**2.1%**	100.0%
	% within Ethnicity Excluding Unknown	94.7%	92.6%	89.0%	86.4%	94.2%
	% of Total	84.9%	3.5%	3.9%	2.0%	94.2%
Total	Count	3194	135	155	81	3565
	Expected Count	3194.0	135.0	155.0	81.0	3565.0
	% within Homeless or Housed	89.6%	3.8%	4.3%	2.3%	100.0%
	% within Ethnicity Excluding Unknown	100.0%	100.0%	100.0%	100.0%	100.0%
	% of Total	89.6%	3.8%	4.3%	2.3%	100.0%

179

Ethnicity Excluding Unknown Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	18.958[a]	3	.000
Likelihood Ratio	15.082	3	.002
Linear-by-Linear Association	18.850	1	.000
N of Valid Cases	3565		

a. 1 cells (12.5%) have expected count less than 5. The minimum expected count is 4.68.

Homeless or Housed * Employment Including Unknown Crosstabulation

		Employed <15 hour	Employed >15 hour	Home maker	Sick/ Disabled	Unemployed No benefits	Retired	Student	Seeking work	Volunteer	Unknown	Total
Homeless	**Count**	2	13	2	36	47	5	2	91	1	**24**	223
	Expected Count	4.8	39.3	5.3	39.1	11.2	45.3	9.3	38.8	1.2	28.8	223.0
	% within Homeless or Housed	0.9%	5.8%	0.9%	16.1%	21.1%	2.2%	0.9%	40.8%	0.4%	10.8%	100.0%
	% within Employment	2.5%	1.9%	2.2%	5.4%	24.6%	0.6%	1.3%	13.8%	4.8%	4.9%	5.9%
	% of Total	0.1%	0.3%	0.1%	0.9%	1.2%	0.1%	0.1%	2.4%	0.0%	0.6%	5.9%
Housed	**Count**	79	655	88	629	144	766	156	569	20	**466**	3572
	Expected Count	76.2	628.7	84.7	625.9	179.8	725.7	148.7	621.2	19.8	461.2	3572.0
	% within Homeless or Housed	2.2%	18.3%	2.5%	17.6%	4.0%	21.4%	4.4%	15.9%	0.6%	13.0%	100.0%
	% within Employment	97.5%	98.1%	97.8%	94.6%	75.4%	99.4%	98.7%	86.2%	95.2%	95.1%	94.1%
	% of Total	2.1%	17.3%	2.3%	16.6%	3.8%	20.2%	4.1%	15.0%	0.5%	12.3%	94.1%
Total	Count	81	668	90	665	191	771	158	660	21	490	3795
	Expected Count	81.0	668.0	90.0	665.0	191.0	771.0	158.0	660.0	21.0	490.0	3795.0
	% within Homeless or Housed	2.1%	17.6%	2.4%	17.5%	5.0%	20.3%	4.2%	17.4%	0.6%	12.9%	100.0%
	% within Employment	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	% of Total	2.1%	17.6%	2.4%	17.5%	5.0%	20.3%	4.2%	17.4%	0.6%	12.9%	100.0%

Homeless or Housed * Employment Excluding Unknown Crosstabulation

		Employed <15 hour	Employed >15 hour	Home maker	Sick/ Disabled	Unemployed No benefits	Retired	Student	Seeking work	Volunteer	Total
Homeless	**Count**	**2**	**13**	**2**	**36**	**47**	**5**	**2**	**91**	**1**	199
	Expected Count	4.9	40.2	5.4	40.0	11.5	46.4	9.5	39.7	1.3	199.0
	% within Homeless or Housed	**1.0%**	**6.5%**	**1.0%**	**18.1%**	**23.6%**	**2.5%**	**1.0%**	**45.7%**	**0.5%**	100.0%
	% within Employment Excluding Unknown	2.5%	1.9%	2.2%	5.4%	24.6%	0.6%	1.3%	13.8%	4.8%	6.0%
	% of Total	0.1%	0.4%	0.1%	1.1%	1.4%	0.2%	0.1%	2.8%	0.0%	6.0%
Housed	**Count**	**79**	**655**	**88**	**629**	**144**	**766**	**156**	**569**	**20**	3106
	Expected Count	76.1	627.8	84.6	625.0	179.5	724.6	148.5	620.3	19.7	3106.0
	% within Homeless or Housed	**2.5%**	**21.1%**	**2.8%**	**20.3%**	**4.6%**	**24.7%**	**5.0%**	**18.3%**	**0.7%**	100.0%
	% within Employment Excluding Unknown	97.5%	98.1%	97.8%	94.6%	75.4%	99.4%	98.7%	86.2%	95.2%	94.0%
	% of Total	2.4%	19.8%	2.7%	19.0%	4.4%	23.2%	4.7%	17.2%	0.6%	94.0%
Total	Count	81	668	90	665	191	771	158	660	21	3305
	Expected Count	81.0	668.0	90.0	665.0	191.0	771.0	158.0	660.0	21.0	3305.0
	% within Homeless or Housed	2.5%	20.2%	2.7%	20.1%	5.8%	23.3%	4.8%	20.0%	0.6%	100.0%
	% within Employment Excluding Unknown	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	% of Total	2.5%	20.2%	2.7%	20.1%	5.8%	23.3%	4.8%	20.0%	0.6%	100.0%

Employment Excluding Unknown

Employment Excluding Unknown Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	256.799[a]	8	.000
Likelihood Ratio	225.578	8	.000
Linear-by-Linear Association	44.278	1	.000
N of Valid Cases	3305		

a. 2 cells (11.1%) have expected count less than 5. The minimum expected count is 1.26.

Homeless or Housed * Primary Diagnosis Crosstabulation

			Primary Diagnosis			
		Depressive Episode	Recurrent depressive disorder/ Persistent mood disorder/ Other mood disorder	Phobic anxiety disorder/ Other anxiety disorder/ Obsessive-compulsive disorder	Reaction to severe stress and adjustment disorder	Total
Homeless	**Count**	**63**	**16**	**27**	**117**	223
	Expected Count	75.7	38.6	47.1	61.6	223.0
	% within Homeless or Housed	**28.3%**	**7.2%**	**12.1%**	**52.5%**	100.0%
	% within Primary Diagnosis	4.9%	2.4%	3.4%	11.2%	5.9%
	% of Total	1.7%	0.4%	0.7%	3.1%	5.9%
Housed	**Count**	**1226**	**641**	**774**	**931**	3572
	Expected Count	1213.3	618.4	753.9	986.4	3572.0
	% within Homeless or Housed	**34.3%**	**17.9%**	**21.7%**	**26.1%**	100.0%
	% within Primary Diagnosis	95.1%	97.6%	96.6%	88.8%	94.1%
	% of Total	32.3%	16.9%	20.4%	24.5%	94.1%
Total	Count	1289	657	801	1048	3795
	Expected Count	1289.0	657.0	801.0	1048.0	3795.0
	% within Homeless or Housed	34.0%	17.3%	21.1%	27.6%	100.0%
	% within Primary Diagnosis	100.0%	100.0%	100.0%	100.0%	100.0%
	% of Total	34.0%	17.3%	21.1%	27.6%	100.0%

Primary Diagnosis Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	78.416[a]	3	.000
Likelihood Ratio	73.426	3	.000
Linear-by-Linear Association	34.580	1	.000
N of Valid Cases	3795		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 38.61.

Homeless or Housed * Comorbid Diagnosis of Substance Use Crosstabulation

		Comorbid Diagnosis of Substance Use		
		Yes	No	Total
Homeless	**Count**	**79**	144	223
	Expected Count	31.9	191.1	223.0
	% within Homeless or Housed	**35.4%**	64.6%	100.0%
	% within Comorbid Diagnosis of Substance Use	14.5%	4.4%	5.9%
	% of Total	2.1%	3.8%	5.9%
Housed	**Count**	**464**	3108	3572
	Expected Count	511.1	3060.9	3572.0
	% within Homeless or Housed	**13.0%**	87.0%	100.0%
	% within Comorbid Diagnosis of Substance Use	85.5%	95.6%	94.1%
	% of Total	12.2%	81.9%	94.1%
Total	Count	543	3252	3795
	Expected Count	543.0	3252.0	3795.0
	% within Homeless or Housed	14.3%	85.7%	100.0%
	% within Comorbid Diagnosis of Substance Use	100.0%	100.0%	100.0%
	% of Total	14.3%	85.7%	100.0%

Comorbid Diagnosis of Substance Use Chi-Square Tests

	Value	df	Asymptotic Sig (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	86.173[a]	1	.000		
Continuity Correction[b]	84.353	1	.000		
Likelihood Ratio	66.956	1	.000		
Fisher's Exact Test				.000	**.000**
Linear-by-Linear Association	86.150	1	.000		
N of Valid Cases	3795				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 108.59.

b. Computed only for a 2x2 table

Homeless or Housed * Comorbid Diagnosis of Personality Disorder Crosstabulation

| | | Comorbid Diagnosis of Personality Disorder | | |
		Yes	No	Total
Homeless	**Count**	**31**	192	223
	Expected Count	24.4	198.6	223.0
	% within Homeless or Housed	**13.9%**	86.1%	100.0%
	% within Comorbid Diagnosis of Personality	7.5%	5.7%	5.9%
	% of Total	0.8%	5.1%	5.9%
Housed	**Count**	**385**	3187	3572
	Expected Count	391.6	3180.4	3572.0
	% within Homeless or Housed	**10.8%**	89.2%	100.0%
	% within Comorbid Diagnosis of Personality	92.5%	94.3%	94.1%
	% of Total	10.1%	84.0%	94.1%
Total	Count	416	3379	3795
	Expected Count	416.0	3379.0	3795.0
	% within Homeless or Housed	11.0%	89.0%	100.0%
	% within Comorbid Diagnosis of Personality	100.0%	100.0%	100.0%
	% of Total	11.0%	89.0%	100.0%

Comorbid Diagnosis of Personality Disorder Chi-Square Tests

	Value	df	Asymptotic Sig (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	2.098[a]	1	.148		
Continuity Correction[b]	1.790	1	.181		
Likelihood Ratio	1.962	1	.161		
Fisher's Exact Test				.151	**.093**
Linear-by-Linear Association	2.097	1	.148		
N of Valid Cases	**3795**				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 108.59.

b. Computed only for a 2x2 table

Homeless or Housed * Admission Type Crosstabulation

		Admission Type		Total
		Voluntary	Formal	
Homeless	**Count**	**201**	**22**	223
	Expected Count	186.0	37.0	223.0
	% within Homeless or Housed	**90.1%**	**9.9%**	100.0%
	% within Admission Type	6.4%	3.5%	5.9%
	% of Total	5.3%	0.6%	5.9%
Housed	**Count**	**2964**	**608**	3572
	Expected Count	2979.0	593.0	3572.0
	% within Homeless or Housed	**83.0%**	**17.0%**	100.0%
	% within Admission Type	93.6%	96.5%	94.1%
	% of Total	78.1%	16.0%	94.1%
Total	Count	3165	630	3795
	Expected Count	3165.0	630.0	3795.0
	% within Homeless or Housed	83.4%	16.6%	100.0%
	% within Admission Type	100.0%	100.0%	100.0%
	% of Total	83.4%	16.6%	100.0%

Admission Type Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	7.763[a]	1	.005		
Continuity Correction [b]	7.255	1	.007		
Likelihood Ratio	8.776	1	.003		
Fisher's Exact Test				.004	**.002**
Linear-by-Linear Association	7.761	1	.005		
N of Valid Cases	**3795**				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 37.02.

b. Computed only for a 2x2 table

Homeless or Housed * Formal Admission Basis Crosstabulation

		Formal Admission Basis					Total
		Section 2	Section 3	Section 4	Section 35	Section 36	
Homeless	**Count**	**21**	**0**	**0**	**1**	**0**	22
	Expected Count	20.0	1.2	.3	.0	.0	22.0
	% within Homeless or Housed	**95.5%**	**0.0%**	**0.0%**	**4.5%**	**0.0%**	100.0%
	% within Formal Admission Basis	3.7%	0.0%	0.0%	100.0%	0.0%	3.5%
	% of Total	3.3%	0.0%	0.0%	0.2%	0.0%	3.5%
Housed	**Count**	**565**	**33**	**9**	**0**	**1**	608
	Expected Count	554.0	31.8	8.7	1.0	1.0	608.0
	% within Homeless or Housed	**93.0%**	**5.4%**	**1.5%**	**0.0%**	**0.2%**	**100.0%**
	% within Formal Admission Basis	96.3%	100.0%	100.0%	0.0%	100.0%	96.5%
	% of Total	87.8%	5.2%	1.4%	0.0%	0.2%	96.5%
Total	Count	574	33	9	1	1	630
	Expected Count	574.0	33.0	9.0	1.0	1.0	630.0
	% within Homeless or Housed	91.1%	5.2%	1.4%	0.2%	0.2%	100.0%
	% within Formal Admission Basis	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	% of Total	91.1%	5.2%	1.4%	0.2%	0.2%	100.0%

192

Homeless or Housed * Admission Pathway Including Unknown Crosstabulation

| | | | Admission Pathway Including Unknown | | | | | | | | |
		Planned	Emergency via CRHT	Emergency via ED	Emergency via CMHT	Transfer inpatient mental health	Transfer acute hospital	Section 135/136 Custody	Other	Unknown	Total
Homeless	**Count**	9	46	84	5	12	25	38	3	**1**	223
	Expected Count	24.2	65.2	60.6	14.7	4.9	27.1	16.6	7.3	2.4	223.0
	% within Homeless or Housed	4.0%	20.6%	37.7%	2.2%	5.4%	11.2%	17.0%	1.3%	0.4%	100.0%
	% within Admission Pathway Including Unknown	2.2%	4.1%	8.1%	2.0%	14.3%	5.4%	13.4%	2.4%	2.5%	5.9%
	% of Total	0.2%	1.2%	2.2%	0.1%	0.3%	0.7%	1.0%	0.1%	0.0%	5.9%
Housed	**Count**	403	1063	947	246	72	436	245	121	**39**	3572
	Expected Count	387.8	1043.8	970.4	236.3	79.1	433.9	266.4	116.7	37.6	3572.0
	% within Homeless or Housed	11.3%	29.8%	26.5%	6.9%	2.0%	12.2%	6.9%	3.4%	1.1%	100.0%
	% within Admission Pathway Including Unknown	97.8%	95.9%	91.9%	98.0%	85.7%	94.6%	86.6%	97.6%	97.5%	94.1%
	% of Total	10.6%	28.0%	25.0%	6.5%	1.9%	11.5%	6.5%	3.2%	1.0%	94.1%
Total	Count	412	1109	1031	251	84	461	283	124	40	3795
	Expected Count	412.0	1109.0	1031.0	251.0	84.0	461.0	283.0	124.0	40.0	3795.0
	% within Homeless or Housed	10.9%	29.2%	27.2%	6.6%	2.2%	12.1%	7.5%	3.3%	1.1%	100.0%
	% within Admission Pathway Including Unknown	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	% of Total	10.9%	29.2%	27.2%	6.6%	2.2%	12.1%	7.5%	3.3%	1.1%	100.0%

Homeless or Housed * Admission Pathway Excluding Unknown Crosstabulation

| | | | | | | Transfer inpatient mental health | Transfer acute hospital | Section 135/ 136 custody | | |
		Planned	**Emergency via CRHT**	**Emergency via ED**	**Emergency via CMHT**				**Other**	**Total**
Homeless	**Count**	**9**	**46**	**84**	**5**	**12**	**25**	**38**	**3**	**223**
	Expected Count	24.2	65.2	60.6	14.7	4.9	27.1	16.6	7.3	223.0
	% within Homeless or Housed	**4.0%**	**20.7%**	**37.8%**	**2.2%**	**5.4%**	**11.3%**	**17.3%**	**1.3%**	**100.0%**
	% within Admission Pathway Excluding Unknown	2.2%	4.1%	8.1%	2.0%	14.3%	5.4%	13.4%	2.4%	5.9%
	% of Total	0.2%	1.2%	2.2%	0.1%	0.3%	0.7%	1.0%	0.1%	5.9%
Housed	**Count**	**403**	**1063**	**947**	**246**	**72**	**436**	**245**	**121**	**3572**
	Expected Count	387.8	1043.8	970.4	236.3	79.1	433.9	266.4	116.7	3572.0
	% within Homeless or Housed	**11.3%**	**29.8%**	**26.5%**	**6.9%**	**2.0%**	**12.2%**	**6.9%**	**3.4%**	**100.0%**
	% within Admission Pathway Excluding Unknown	97.8%	95.9%	91.9%	98.0%	85.7%	94.6%	86.6%	97.6%	94.1%
	% of Total	10.6%	28.0%	25.0%	6.5%	1.9%	11.5%	6.5%	3.2%	94.1%
Total	Count	412	1109	1031	251	84	461	283	124	3795
	Expected Count	412.0	1109.0	1031.0	251.0	84.0	461.0	283.0	124.0	3795.0
	% within Homeless or Housed	10.9%	29.2%	27.2%	6.6%	2.2%	12.1%	7.5%	3.3%	100.0%
	% within Admission Pathway Excluding Unknown	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0 %	100.0%
	% of Total	10.9%	29.2%	27.2%	6.6%	2.2%	12.1%	7.5%	3.3%	100.0%

Admission Pathway Excluding Unknown Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	75.087[a]	8	.000
Likelihood Ratio	70.866	8	.000
Linear-by-Linear Association	11.742	1	.001
N of Valid Cases	3755		

a. 2 cells (11.1%) have expected count less than 5. The minimum expected count is 3.25.

Question 2: How does the quality of mental health care received by homeless service users compare with that received by housed service users?

Homeless or Housed * Past Response Assessed Crosstabulation

| | | Past Response Assessed | | |
		Yes	No	Total
Homeless	**Count**	**123**	**58**	**181**
	Expected Count	147.4	33.6	181.0
	% within Homeless or Housed	**68.0%**	**32.0%**	**100.0%**
	% within Past Response Assessed	4.6%	9.5%	5.5%
	% of Total	3.7%	1.8%	5.5%
Housed	**Count**	**2553**	**553**	**3106**
	Expected Count	2528.6	577.4	3106.0
	% within Homeless or Housed	**82.2%**	**17.8%**	**100.0%**
	% within Past Response Assessed	95.4%	90.5%	94.5%
	% of Total	77.7%	16.8%	94.5%
Total	Count	2676	611	3287
	Expected Count	2676.0	611.0	3287.0
	% within Homeless or Housed	81.4%	18.6%	100.0%
	% within Past Response Assessed	100.0%	100.0%	100.0%
	% of Total	81.4%	18.6%	100.0%

Past Response Assessed Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	22.918[a]	1	.000		
Continuity Correction[b]	21.986	1	.000		
Likelihood Ratio	20.005	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	22.911	1	.000		
N of Valid Cases	3287				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 33.64. b. Computed only for a 2x2 table

Homeless or Housed * Employment Difficulties Assessed Crosstabulation

| | | Employment Difficulties Assessed | | |
		Yes	No	Total
Homeless	**Count**	**176**	**27**	**203**
	Expected Count	169.7	33.3	203.0
	% within Homeless or Housed	**86.7%**	**13.3%**	**100.0%**
	% within Employment Difficulties Assessed	6.9%	5.4%	6.7%
	% of Total	5.8%	0.9%	6.7%
Housed	**Count**	**2365**	**472**	**2837**
	Expected Count	2371.3	465.7	2837.0
	% within Homeless or Housed	**83.4%**	**16.6%**	**100.0%**
	% within Employment Difficulties Assessed	93.1%	94.6%	93.3%
	% of Total	77.8%	15.5%	93.3%
Total	Count	2541	499	3040
	Expected Count	2541.0	499.0	3040.0
	% within Homeless or Housed	83.6%	16.4%	100.0%
	% within Employment Difficulties Assessed	100.0%	100.0%	100.0%
	% of Total	83.6%	16.4%	100.0%

Employment Difficulties Assessed Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.537[a]	1	.215		
Continuity Correction[b]	1.304	1	.254		
Likelihood Ratio	1.618	1	.203		
Fisher's Exact Test				.240	.125
Linear-by-Linear Association	1.537	1	.215		
N of Valid Cases	3040				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 33.32. b. Computed only for a 2x2 table

Homeless or Housed * Financial Difficulties Assessed Crosstabulation

		Financial Difficulties Assessed		
		Yes	No	Total
Homeless	**Count**	**183**	**35**	**218**
	Expected Count	155.9	62.1	218.0
	% within Homeless or Housed	**83.9%**	**16.1%**	**100.0%**
	% within Financial Difficulties Assessed	7.8%	3.8%	6.7%
	% of Total	5.6%	1.1%	6.7%
Housed	**Count**	**2152**	**896**	**3048**
	Expected Count	2179.1	868.9	3048.0
	% within Homeless or Housed	**70.6%**	**29.4%**	**100.0%**
	% within Financial Difficulties Assessed	92.2%	96.2%	93.3%
	% of Total	65.9%	27.4%	93.3%
Total	Count	2335	931	3266
	Expected Count	2335.0	931.0	3266.0
	% within Homeless or Housed	71.5%	28.5%	100.0%
	% within Financial Difficulties Assessed	100.0%	100.0%	100.0%
	% of Total	71.5%	28.5%	100.0%

Financial Difficulties Assessed Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	17.768[a]	1	.000		
Continuity Correction[b]	17.120	1	.000		
Likelihood Ratio	19.752	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	17.763	1	.000		
N of Valid Cases	3266				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 62.14.

b. Computed only for a 2x2 table

Homeless or Housed * Social Difficulties Assessed Crosstabulation

| | | Social Difficulties Assessed | | |
		Yes	No	Total
Homeless	**Count**	**222**	**1**	**223**
	Expected Count	215.8	7.2	223.0
	% within Homeless or Housed	**99.6%**	**0.4%**	**100.0%**
	% within Social Difficulties Assessed	6.3%	0.8%	6.1%
	% of Total	6.1%	0.0%	6.1%
Housed	**Count**	**3326**	**118**	**3444**
	Expected Count	3332.2	111.8	3444.0
	% within Homeless or Housed	**96.6%**	**3.4%**	**100.0%**
	% within Social Difficulties Assessed	93.7%	99.2%	93.9%
	% of Total	90.7%	3.2%	93.9%
Total	Count	3548	119	3667
	Expected Count	3548.0	119.0	3667.0
	% within Homeless or Housed	96.8%	3.2%	100.0%
	% within Social Difficulties Assessed	100.0%	100.0%	100.0%
	% of Total	96.8%	3.2%	100.0%

Social Difficulties Assessed Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.915[a]	1	.015		
Continuity Correction[b]	5.004	1	.025		
Likelihood Ratio	9.047	1	.003		
Fisher's Exact Test				.010	.005
Linear-by-Linear Association	5.913	1	.015		
N of Valid Cases	3667				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 7.24. b. Computed only for a 2x2 table

Homeless or Housed * Dependents Assessed Crosstabulation

		Dependents Assessed		
		Yes	No	Total
Homeless	**Count**	**126**	**22**	**148**
	Expected Count	131.9	16.1	148.0
	% within Homeless or Housed	**85.1%**	**14.9%**	**100.0%**
	% within Dependents Assessed	5.7%	8.1%	5.9%
	% of Total	5.0%	0.9%	5.9%
Housed	**Count**	**2102**	**250**	**2352**
	Expected Count	2096.1	255.9	2352.0
	% within Homeless or Housed	**89.4%**	**10.6%**	**100.0%**
	% within Dependents Assessed	94.3%	91.9%	94.1%
	% of Total	84.1%	10.0%	94.1%
Total	Count	2228	272	2500
	Expected Count	2228.0	272.0	2500.0
	% within Homeless or Housed	89.1%	10.9%	100.0%
	% within Dependents Assessed	100.0%	100.0%	100.0%
	% of Total	89.1%	10.9%	100.0%

Dependents Assessed Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	2.576[a]	1	.108		
Continuity Correction[b]	2.158	1	.142		
Likelihood Ratio	2.357	1	.125		
Fisher's Exact Test				.132	.075
Linear-by-Linear Association	2.575	1	.109		
N of Valid Cases	2500				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 16.10. b. Computed only for a 2x2 table

Homeless or Housed * Trauma History Assessed Crosstabulation

| | | Trauma History Assessed | | |
		Yes	No	Total
Homeless	**Count**	**151**	**50**	**201**
	Expected Count	157.8	43.2	201.0
	% within Homeless or Housed	**75.1%**	**24.9%**	**100.0%**
	% within Trauma History Assessed	5.8%	7.0%	6.0%
	% of Total	4.5%	1.5%	6.0%
Housed	**Count**	**2464**	**665**	**3129**
	Expected Count	2457.2	671.8	3129.0
	% within Homeless or Housed	**78.7%**	**21.3%**	**100.0%**
	% within Trauma History Assessed	94.2%	93.0%	94.0%
	% of Total	74.0%	20.0%	94.0%
Total	Count	2615	715	3330
	Expected Count	2615.0	715.0	3330.0
	% within Homeless or Housed	78.5%	21.5%	100.0%
	% within Trauma History Assessed	100.0%	100.0%	100.0%
	% of Total	78.5%	21.5%	100.0%

Trauma History Assessed Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	**1.470[a]**	**1**	**.225**		
Continuity Correction[b]	1.263	1	.261		
Likelihood Ratio	1.422	1	.233		
Fisher's Exact Test				.249	.131
Linear-by-Linear Association	1.470	1	.225		
N of Valid Cases	**3330**				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 43.16. b. Computed only for a 2x2 table

Homeless or Housed * Identified Source of Social Support Crosstabulation

| | | Identified Source of Social Support | | |
		Yes	No	Total
Homeless	**Count**	**62**	**161**	**223**
	Expected Count	137.4	85.6	223.0
	% within Homeless or Housed	**27.8%**	**72.2%**	**100.0%**
	% within Identified Source of Social Support	2.7%	11.1%	5.9%
	% of Total	1.6%	4.2%	5.9%
Housed	**Count**	**2277**	**1295**	**3572**
	Expected Count	2201.6	1370.4	3572.0
	% within Homeless or Housed	**63.7%**	**36.3%**	**100.0%**
	% within Identified Source of Social Support	97.3%	88.9%	94.1%
	% of Total	60.0%	34.1%	94.1%
Total	Count	2339	1456	3795
	Expected Count	2339.0	1456.0	3795.0
	% within Homeless or Housed	61.6%	38.4%	100.0%
	% within Identified Source of Social Support	100.0%	100.0%	100.0%
	% of Total	61.6%	38.4%	100.0%

Identified Source of Social Support Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	114.675[a]	1	.000		
Continuity Correction[b]	113.160	1	.000		
Likelihood Ratio	111.650	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	114.645	1	.000		
N of Valid Cases	3794				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 85.56.

b. Computed only for a 2x2 table

Homeless or Housed * Carer Signposted to Support Crosstabulation

| | | Carer Signposted to Support | | |
		Yes	No	Total
Homeless	**Count**	**26**	**36**	**62**
	Expected Count	38.6	23.4	62.0
	% within Homeless or Housed	**41.9%**	**58.1%**	**100.0%**
	% within Carer Signposted to Support	1.8%	4.1%	2.7%
	% of Total	1.1%	1.5%	2.7%
Housed	**Count**	**1432**	**845**	**2277**
	Expected Count	1419.4	857.6	2277.0
	% within Homeless or Housed	**62.9%**	**37.1%**	**100.0%**
	% within Carer Signposted to Support	98.2%	95.9%	97.3%
	% of Total	61.2%	36.1%	97.3%
Total	Count	1458	881	2339
	Expected Count	1458.0	881.0	2339.0
	% within Homeless or Housed	62.3%	37.7%	100.0%
	% within Carer Signposted to Support	100.0%	100.0%	100.0%
	% of Total	62.3%	37.7%	100.0%

Carer Signposted to Support Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	11.287[a]	1	.001		
Continuity Correction[b]	10.413	1	.001		
Likelihood Ratio	10.850	1	.001		
Fisher's Exact Test				.001	.001
Linear-by-Linear Association	11.283	1	.001		
N of Valid Cases	2339				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 23.35.

b. Computed only for a 2x2 table

Homeless or Housed * Carer Assessment Offered Crosstabulation

		Carer Assessment Offered		Total
		Yes	**No**	**Total**
Homeless	**Count**	**6**	**56**	**62**
	Expected Count	15.3	46.7	62.0
	% within Homeless or Housed	**9.7%**	**90.3%**	**100.0%**
	% within Carer Assessment Offered	1.0%	3.2%	2.7%
	% of Total	0.3%	2.4%	2.7%
Housed	**Count**	**573**	**1704**	**2277**
	Expected Count	563.7	1713.3	2277.0
	% within Homeless or Housed	**25.2%**	**74.8%**	**100.0%**
	% within Carer Assessment Offered	99.0%	96.8%	97.3%
	% of Total	24.5%	72.9%	97.3%
Total	Count	579	1760	2339
	Expected Count	579.0	1760.0	2339.0
	% within Homeless or Housed	24.8%	75.2%	100.0%
	% within Carer Assessment Offered	100.0%	100.0%	100.0%
	% of Total	24.8%	75.2%	100.0%

Carer Assessment Offered Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	7.772[a]	1	.005		
Continuity Correction[b]	6.963	1	.008		
Likelihood Ratio	9.389	1	.002		
Fisher's Exact Test				.004	.002
Linear-by-Linear Association	7.769	1	.005		
N of Valid Cases	**2339**				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 15.35.

b. Computed only for a 2x2 table

Homeless or Housed * Care Plan in Place Crosstabulation

		Care Plan in Place		
		Yes	**No**	**Total**
Homeless	**Count**	**196**	**27**	**223**
	Expected Count	202.5	20.5	223.0
	% within Homeless or Housed	**87.9%**	**12.1%**	**100.0%**
	% within Care Plan in Place	5.7%	7.7%	5.9%
	% of Total	5.2%	0.7%	5.9%
Housed	**Count**	**3249**	**322**	**3571**
	Expected Count	3242.5	328.5	3571.0
	% within Homeless or Housed	**91.0%**	**9.0%**	**100.0%**
	% within Care Plan in Place	94.3%	92.3%	94.1%
	% of Total	85.6%	8.5%	94.1%
Total	Count	3445	349	3794
	Expected Count	3445.0	349.0	3794.0
	% within Homeless or Housed	90.8%	9.2%	100.0%
	% within Care Plan in Place	100.0%	100.0%	100.0%
	% of Total	90.8%	9.2%	100.0%

Care Plan in Place Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	2.400[a]	1	.121		
Continuity Correction[b]	2.044	1	.153		
Likelihood Ratio	2.216	1	.137		
Fisher's Exact Test				.121	.080
Linear-by-Linear Association	2.400	1	.121		
N of Valid Cases	3794				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 20.51.

b. Computed only for a 2x2 table

Homeless or Housed * Care Plan Produced in Conjunction with Service User Crosstabulation

		Care Plan Produced in Conjunction with Service User		Total
		Yes	No	
Homeless	**Count**	**155**	**41**	**196**
	Expected Count	160.8	35.2	196.0
	% within Homeless or Housed	**79.1%**	**20.9%**	**100.0%**
	% within Care Plan Produced in Conjunction with Service User	5.5%	6.6%	5.7%
	% of Total	4.5%	1.2%	5.7%
Housed	**Count**	**2671**	**578**	**3249**
	Expected Count	2665.2	583.8	3249.0
	% within Homeless or Housed	**82.2%**	**17.8%**	**100.0%**
	% within Care Plan Produced in Conjunction with Service User	94.5%	93.4%	94.3%
	% of Total	77.5%	16.8%	94.3%
Total	Count	2826	619	3445
	Expected Count	2826.0	619.0	3445.0
	% within Homeless or Housed	82.0%	18.0%	100.0%
	% within Care Plan Produced in Conjunction with Service User	100.0%	100.0%	100.0%
	% of Total	82.0%	18.0%	100.0%

Care Plan Produced in Conjunction with Service User Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.227[a]	1	.268		
Continuity Correction[b]	1.024	1	.312		
Likelihood Ratio	1.182	1	.277		
Fisher's Exact Test				.291	.156
Linear-by-Linear Association	1.227	1	.268		
N of Valid Cases	3445				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 35.22.

b. Computed only for a 2x2 table

Homeless or Housed * Care Plan Copy Given to Service User Crosstabulation

| | | Care Plan Copy Given to Service User | | |
		Yes	No	Total
Homeless	**Count**	**122**	**74**	**196**
	Expected Count	114.7	81.3	196.0
	% within Homeless or Housed	**62.2%**	**37.8%**	**100.0%**
	% within Care Plan Copy Given to Service User	6.1%	5.2%	5.7%
	% of Total	3.5%	2.1%	5.7%
Housed	**Count**	**1894**	**1355**	**3249**
	Expected Count	1901.3	1347.7	3249.0
	% within Homeless or Housed	**58.3%**	**41.7%**	**100.0%**
	% within Care Plan Copy Given to Service User	93.9%	94.8%	94.3%
	% of Total	55.0%	39.3%	94.3%
Total	Count	2016	1429	3445
	Expected Count	2016.0	1429.0	3445.0
	% within Homeless or Housed	58.5%	41.5%	100.0%
	% within Care Plan Copy Given to Service User	100.0%	100.0%	100.0%
	% of Total	58.5%	41.5%	100.0%

Care Plan Copy Given to Service User Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.188[a]	1	.276		
Continuity Correction[b]	1.031	1	.310		
Likelihood Ratio	1.199	1	.273		
Fisher's Exact Test				.296	.155
Linear-by-Linear Association	1.188	1	.276		
N of Valid Cases	3445				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 81.30.

b. Computed only for a 2x2 table

Homeless or Housed * Care Plan Review Conducted Prior to Discharge Crosstabulation

| | | Care Plan Review Conducted Prior to Discharge | | |
		Yes	No	Total
Homeless	**Count**	**121**	**75**	**196**
	Expected Count	128.1	67.9	196.0
	% within Homeless or Housed	**61.7%**	**38.3%**	**100.0%**
	% within Care Plan Review Conducted Prior to Discharge	5.4%	6.3%	5.7%
	% of Total	3.5%	2.2%	5.7%
Housed	**Count**	**2130**	**1119**	**3249**
	Expected Count	2122.9	1126.1	3249.0
	% within Homeless or Housed	**65.6%**	**34.4%**	**100.0%**
	% within Care Plan Review Conducted Prior to Discharge	94.6%	93.7%	94.3%
	% of Total	61.8%	32.5%	94.3%
Total	Count	2251	1194	3445
	Expected Count	2251.0	1194.0	3445.0
	% within Homeless or Housed	65.3%	34.7%	100.0%
	% within Care Plan Review Conducted Prior to Discharge	100.0%	100.0%	100.0%
	% of Total	65.3%	34.7%	100.0%

Care Plan Review Conducted Prior to Discharge Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.194[a]	1	.275		
Continuity Correction[b]	1.031	1	.310		
Likelihood Ratio	1.177	1	.278		
Fisher's Exact Test				.280	.155
Linear-by-Linear Association	1.193	1	.275		
N of Valid Cases	3445				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 67.93.

b. Computed only for a 2x2 table

Homeless or Housed * Psychotropic Medication Prescribed Crosstabulation

		Psychotropic Medication Prescribed		Total
		Yes	No	
Homeless	**Count**	**176**	**47**	**223**
	Expected Count	194.9	28.1	223.0
	% within Homeless or Housed	**78.9%**	**21.1%**	**100.0%**
	% within Psychotropic Medication Prescribed	5.3%	9.8%	5.9%
	% of Total	4.6%	1.2%	5.9%
Housed	**Count**	**3141**	**431**	**3572**
	Expected Count	3122.1	449.9	3572.0
	% within Homeless or Housed	**87.9%**	**12.1%**	**100.0%**
	% within Psychotropic Medication Prescribed	94.7%	90.2%	94.1%
	% of Total	82.8%	11.4%	94.1%
Total	Count	3317	478	3795
	Expected Count	3317.0	478.0	3795.0
	% within Homeless or Housed	87.4%	12.6%	100.0%
	% within Psychotropic Medication Prescribed	100.0%	100.0%	100.0%
	% of Total	87.4%	12.6%	100.0%

Psychotropic Medication Prescribed Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	**15.478**[a]	**1**	**.000**		
Continuity Correction[b]	14.671	1	.000		
Likelihood Ratio	13.386	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	15.474	1	.000		
N of Valid Cases	**3795**				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 28.09.

b. Computed only for a 2x2 table

Homeless or Housed * Verbal or Written Information about Medication Provided Crosstabulation

| | | Verbal or Written Information about Medication Provided | | |
		Yes	No	Total
Homeless	**Count**	**120**	**56**	**176**
	Expected Count	128.2	47.8	176.0
	% within Homeless or Housed	**68.2%**	**31.8%**	**100.0%**
	% within Verbal or Written Information about Medication Provided	5.0%	6.2%	5.3%
	% of Total	3.6%	1.7%	5.3%
Housed	**Count**	**2296**	**845**	**3141**
	Expected Count	2287.8	853.2	3141.0
	% within Homeless or Housed	**73.1%**	**26.9%**	**100.0%**
	% within Verbal or Written Information about Medication Provided	95.0%	93.8%	94.7%
	% of Total	69.2%	25.5%	94.7%
Total	Count	2416	901	3317
	Expected Count	2416.0	901.0	3317.0
	% within Homeless or Housed	72.8%	27.2%	100.0%
	% within Verbal or Written Information about Medication Provided	100.0%	100.0%	100.0%
	% of Total	72.8%	27.2%	100.0%

Verbal or Written Information about Medication Provided Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	2.036[a]	1	.154		
Continuity Correction[b]	1.795	1	.180		
Likelihood Ratio	1.973	1	.160		
Fisher's Exact Test				.164	.092
Linear-by-Linear Association	2.035	1	.154		
N of Valid Cases	3317				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 47.81.

b. Computed only for a 2x2 table

Homeless or Housed * Medication Review Prior to Discharge Crosstabulation

		Medication Review Prior to Discharge			Total
		Yes	No	N/A - not discharged	
Homeless	**Count**	**143**	**32**	**1**	**176**
	Expected Count	151.8	22.5	1.7	176.0
	% within Homeless or Housed	**81.3%**	**18.2%**	**0.6%**	**100.0%**
	% within Medication Review Prior to Discharge	5.0%	7.5%	3.1%	5.3%
	% of Total	4.3%	1.0%	0.0%	5.3%
Housed	**Count**	**2718**	**392**	**31**	**3141**
	Expected Count	2709.2	401.5	30.3	3141.0
	% within Homeless or Housed	**86.5%**	**12.5%**	**1.0%**	**100.0%**
	% within Medication Review Prior to Discharge	95.0%	92.5%	96.9%	94.7%
	% of Total	81.9%	11.8%	0.9%	94.7%
Total	Count	2861	424	32	3317
	Expected Count	2861.0	424.0	32.0	3317.0
	% within Homeless or Housed	86.3%	12.8%	1.0%	100.0%
	% within Medication Review Prior to Discharge	100.0%	100.0%	100.0%	100.0%
	% of Total	86.3%	12.8%	1.0%	100.0%

Medication Review Prior to Discharge Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	**5.081**[a]	**2**	**.079**
Likelihood Ratio	4.673	2	.097
Linear-by-Linear Association	2.723	1	.099
N of Valid Cases	**3317**		

a. 1 cells (16.7%) have expected count less than 5. The minimum expected count is 1.70.

Homeless or Housed * Medication Review Considered Response to Medication Crosstabulation

		Medication Review Considered Response to Medication		
		Yes	No	Total
Homeless	**Count**	**104**	**5**	**109**
	Expected Count	105.3	3.7	109.0
	% within Homeless or Housed	**95.4%**	**4.6%**	**100.0%**
	% within Medication Review Considered Response to Medication	4.5%	6.2%	4.6%
	% of Total	4.4%	0.2%	4.6%
Housed	**Count**	**2190**	**76**	**2266**
	Expected Count	2188.7	77.3	2266.0
	% within Homeless or Housed	**96.6%**	**3.4%**	**100.0%**
	% within Medication Review Considered Response to Medication	95.5%	93.8%	95.4%
	% of Total	92.2%	3.2%	95.4%
Total	Count	2294	81	2375
	Expected Count	2294.0	81.0	2375.0
	% within Homeless or Housed	96.6%	3.4%	100.0%
	% within Medication Review Considered Response to Medication	100.0%	100.0%	100.0%
	% of Total	96.6%	3.4%	100.0%

Medication Review Considered Response to Medication Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.480[a]	1	.488		
Continuity Correction[b]	.179	1	.672		
Likelihood Ratio	.437	1	.509		
Fisher's Exact Test				.418	.314
Linear-by-Linear Association	.480	1	.488		
N of Valid Cases	2375				

a. 1 cells (25.0%) have expected count less than 5. The minimum expected count is 3.72.

b. Computed only for a 2x2 table

Homeless or Housed * Medication Review Considered Side Effects to Medication Crosstabulation

		Medication Review Considered Side Effects to Medication		Total
		Yes	**No**	**Total**
Homeless	**Count**	**69**	**40**	**109**
	Expected Count	81.5	27.5	109.0
	% within Homeless or Housed	**63.3%**	**36.7%**	**100.0%**
	% within Medication Review Considered Side Effects to Medication	3.9%	6.7%	4.6%
	% of Total	2.9%	1.7%	4.6%
Housed	**Count**	**1706**	**560**	**2266**
	Expected Count	1693.5	572.5	2266.0
	% within Homeless or Housed	**75.3%**	**24.7%**	**100.0%**
	% within Medication Review Considered Side Effects to Medication	96.1%	93.3%	95.4%
	% of Total	71.8%	23.6%	95.4%
Total	Count	1775	600	2375
	Expected Count	1775.0	600.0	2375.0
	% within Homeless or Housed	74.7%	25.3%	100.0%
	% within Medication Review Considered Side Effects to Medication	100.0%	100.0%	100.0%
	% of Total	74.7%	25.3%	100.0%

Medication Review Considered Side Effects to Medication Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	7.911[a]	1	.005		
Continuity Correction[b]	7.289	1	.007		
Likelihood Ratio	7.319	1	.007		
Fisher's Exact Test				.007	.004
Linear-by-Linear Association	7.907	1	.005		
N of Valid Cases	2375				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 27.54.

b. Computed only for a 2x2 table

Homeless or Housed * Treatment Evaluated Using Any Outcome Measure Crosstabulation

		Treatment Evaluated Using Any Outcome Measure		Total
		Yes	No	
Homeless	**Count**	**134**	**89**	**223**
	Expected Count	136.0	87.0	223.0
	% within Homeless or Housed	**60.1%**	**39.9%**	**100.0%**
	% within Treatment Evaluated Using Any Outcome Measure	5.8%	6.0%	5.9%
	% of Total	3.5%	2.3%	5.9%
Housed	**Count**	**2180**	**1392**	**3572**
	Expected Count	2178.0	1394.0	3572.0
	% within Homeless or Housed	**61.0%**	**39.0%**	**100.0%**
	% within Treatment Evaluated Using Any Outcome Measure	94.2%	94.0%	94.1%
	% of Total	57.4%	36.7%	94.1%
Total	Count	2314	1481	3795
	Expected Count	2314.0	1481.0	3795.0
	% within Homeless or Housed	61.0%	39.0%	100.0%
	% within Treatment Evaluated Using Any Outcome Measure	100.0%	100.0%	100.0%
	% of Total	61.0%	39.0%	100.0%

Treatment Evaluated Using Any Outcome Measure Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.078[a]	1	.780		
Continuity Correction[b]	.044	1	.835		
Likelihood Ratio	.078	1	.780		
Fisher's Exact Test				.778	.416
Linear-by-Linear Association	.078	1	.780		
N of Valid Cases	3795				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 87.03.

b. Computed only for a 2x2 table

Homeless or Housed * Discharged During Audit Period Crosstabulation

| | | Discharged During Audit Period | | |
		Yes	No	Total
Homeless	**Count**	**202**	**21**	**223**
	Expected Count	193.7	29.3	223.0
	% within Homeless or Housed	**90.6%**	**9.4%**	**100.0%**
	% within Discharged During Audit Period	6.1%	4.2%	5.9%
	% of Total	5.3%	0.6%	5.9%
Housed	**Count**	**3094**	**478**	**3572**
	Expected Count	3102.3	469.7	3572.0
	% within Homeless or Housed	**86.6%**	**13.4%**	**100.0%**
	% within Discharged During Audit Period	93.9%	95.8%	94.1%
	% of Total	81.5%	12.6%	94.1%
Total	Count	3296	499	3795
	Expected Count	3296.0	499.0	3795.0
	% within Homeless or Housed	86.9%	13.1%	100.0%
	% within Discharged During Audit Period	100.0%	100.0%	100.0%
	% of Total	86.9%	13.1%	100.0%

Discharged During Audit Period Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	2.889[a]	1	.089		
Continuity Correction[b]	2.553	1	.110		
Likelihood Ratio	3.145	1	.076		
Fisher's Exact Test				.102	.051
Linear-by-Linear Association	2.889	1	.089		
N of Valid Cases	3795				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 29.32.

b. Computed only for a 2x2 table

Homeless or Housed * Readmitted During Audit Period Crosstabulation

| | | Readmitted During Audit Period | | |
		Yes	No	Total
Homeless	**Count**	**23**	**179**	**202**
	Expected Count	25.2	176.8	202.0
	% within Homeless or Housed	**11.4%**	**88.6%**	**100.0%**
	% within Readmitted During Audit Period	5.6%	6.2%	6.1%
	% of Total	0.7%	5.4%	6.1%
Housed	**Count**	**388**	**2706**	**3094**
	Expected Count	385.8	2708.2	3094.0
	% within Homeless or Housed	**12.5%**	**87.5%**	**100.0%**
	% within Readmitted During Audit Period	94.4%	93.8%	93.9%
	% of Total	11.8%	82.1%	93.9%
Total	Count	411	2885	3296
	Expected Count	411.0	2885.0	3296.0
	% within Homeless or Housed	12.5%	87.5%	100.0%
	% within Readmitted During Audit Period	100.0%	100.0%	100.0%
	% of Total	12.5%	87.5%	100.0%

Readmitted During Audit Period Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.231[a]	1	.630		
Continuity Correction[b]	.138	1	.710		
Likelihood Ratio	.237	1	.626		
Fisher's Exact Test				.741	.363
Linear-by-Linear Association	.231	1	.630		
N of Valid Cases	**3296**				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 25.19.

b. Computed only for a 2x2 table

Homeless or Housed * Care Plan Sent to Accepting Service Crosstabulation

		Care Plan Sent to Accepting Service			
		Yes	No	Unknown	Total
Homeless	**Count**	**71**	**48**	**83**	**202**
	Expected Count	93.4	30.8	77.8	202.0
	% within Homeless or Housed	**35.1%**	**23.8%**	**41.1%**	**100.0%**
	% within Care Plan Sent to Accepting Service	4.7%	9.5%	6.5%	6.1%
	% of Total	2.2%	1.5%	2.5%	6.1%
Housed	**Count**	**1455**	**456**	**1188**	**3099**
	Expected Count	1432.6	473.2	1193.2	3099.0
	% within Homeless or Housed	**47.0%**	**14.7%**	**38.3%**	**100.0%**
	% within Care Plan Sent to Accepting Service	95.3%	90.5%	93.5%	93.9%
	% of Total	44.1%	13.8%	36.0%	93.9%
Total	Count	1526	504	1271	3301
	Expected Count	1526.0	504.0	1271.0	3301.0
	% within Homeless or Housed	46.2%	15.3%	38.5%	100.0%
	% within Care Plan Sent to Accepting Service	100.0%	100.0%	100.0%	100.0%
	% of Total	46.2%	15.3%	38.5%	100.0%

Care Plan Sent to Accepting Service Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	**16.256[a]**	**2**	**.000**
Likelihood Ratio	15.344	2	.000
Linear-by-Linear Association	4.774	1	.029
N of Valid Cases	**3301**		

a.   0 cells (0.0%) have expected count less than 5. The minimum expected count is 30.84.

Homeless or Housed * GP Letter Sent upon Discharge Crosstabulation

| | | GP Letter Sent upon Discharge | | | |
		Yes	Unknown	No GP	Total
Homeless	**Count**	**164**	**14**	**24**	**202**
	Expected Count	173.4	2.2	26.4	202.0
	% within Homeless or Housed	**81.2%**	**6.9%**	**11.9%**	**100.0%**
	% within GP Letter Sent upon Discharge	5.8%	38.9%	5.6%	6.1%
	% of Total	5.0%	0.4%	0.7%	6.1%
Housed	**Count**	**2665**	**22**	**407**	**3094**
	Expected Count	2655.6	33.8	404.6	3094.0
	% within Homeless or Housed	**86.1%**	**0.7%**	**13.2%**	**100.0%**
	% within GP Letter Sent upon Discharge	94.2%	61.1%	94.4%	93.9%
	% of Total	80.9%	0.7%	12.3%	93.9%
Total	Count	2829	36	431	3296
	Expected Count	2829.0	36.0	431.0	3296.0
	% within Homeless or Housed	85.8%	1.1%	13.1%	100.0%
	% within GP Letter Sent upon Discharge	100.0%	100.0%	100.0%	100.0%
	% of Total	85.8%	1.1%	13.1%	100.0%

GP Letter Sent upon Discharge Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	67.934[a]	2	.000
Likelihood Ratio	33.642	2	.000
Linear-by-Linear Association	.556	1	.456
N of Valid Cases	**3296**		

a. 1 cells (16.7%) have expected count less than 5. The minimum expected count is 2.21.

Homeless or Housed * GP Letter Sent within 24 Hours of Discharge Crosstabulation

| | | GP Letter Sent within 24 Hours of Discharge | | |
		Within 24 Hours	Greater than 24 hours	Total
Homeless	**Count**	**74**	**89**	**163**
	Expected Count	73.7	89.3	163.0
	% within Homeless or Housed	**45.4%**	**54.6%**	**100.0%**
	% within GP Letter Sent within 24 Hours of Discharge	5.8%	5.8%	5.8%
	% of Total	2.6%	3.2%	5.8%
Housed	**Count**	**1194**	**1446**	**2640**
	Expected Count	1194.3	1445.7	2640.0
	% within Homeless or Housed	**45.2%**	**54.8%**	**100.0%**
	% within GP Letter Sent within 24 Hours of Discharge	94.2%	94.2%	94.2%
	% of Total	42.6%	51.6%	94.2%
Total	Count	1268	1535	2803
	Expected Count	1268.0	1535.0	2803.0
	% within Homeless or Housed	45.2%	54.8%	100.0%
	% within GP Letter Sent within 24 Hours of Discharge	100.0%	100.0%	100.0%
	% of Total	45.2%	54.8%	100.0%

GP Letter Sent within 24 Hours of Discharge Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.002[a]	1	.966		
Continuity Correction[b]	.000	1	1.000		
Likelihood Ratio	.002	1	.966		
Fisher's Exact Test				1.000	.514
Linear-by-Linear Association	.002	1	.966		
N of Valid Cases	2803				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 73.74.

b. Computed only for a 2x2 table

Homeless or Housed * Service Contact Details Included in GP Letter Crosstabulation

| | | Service Contact Details Included in GP Letter | | |
		Yes	No	Total
Homeless	**Count**	**126**	**32**	**158**
	Expected Count	129.2	28.8	158.0
	% within Homeless or Housed	**79.7%**	**20.3%**	**100.0%**
	% within Service Contact Details Included in GP Letter	5.6%	6.3%	5.7%
	% of Total	4.5%	1.2%	5.7%
Housed	**Count**	**2140**	**474**	**2614**
	Expected Count	2136.8	477.2	2614.0
	% within Homeless or Housed	**81.9%**	**18.1%**	**100.0%**
	% within Service Contact Details Included in GP Letter	94.4%	93.7%	94.3%
	% of Total	77.2%	17.1%	94.3%
Total	Count	2266	506	2772
	Expected Count	2266.0	506.0	2772.0
	% within Homeless or Housed	81.7%	18.3%	100.0%
	% within Service Contact Details Included in GP Letter	100.0%	100.0%	100.0%
	% of Total	81.7%	18.3%	100.0%

Service Contact Details Included in GP Letter Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.449[a]	1	.503		
Continuity Correction[b]	.318	1	.573		
Likelihood Ratio	.437	1	.508		
Fisher's Exact Test				.524	.282
Linear-by-Linear Association	.449	1	.503		
N of Valid Cases	**2772**				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 28.84.

b. Computed only for a 2x2 table

Homeless or Housed * Medication Details Included in the GP Letter Crosstabulation

		Medication Details Included in the GP Letter		
		Yes	**No**	**Total**
Homeless	**Count**	**137**	**21**	**158**
	Expected Count	147.8	10.2	158.0
	% within Homeless or Housed	**86.7%**	**13.3%**	**100.0%**
	% within Medication Details Included in the GP Letter	5.3%	11.7%	5.7%
	% of Total	4.9%	0.8%	5.7%
Housed	**Count**	**2456**	**158**	**2614**
	Expected Count	2445.2	168.8	2614.0
	% within Homeless or Housed	**94.0%**	**6.0%**	**100.0%**
	% within Medication Details Included in the GP Letter	94.7%	88.3%	94.3%
	% of Total	88.6%	5.7%	94.3%
Total	Count	2593	179	2772
	Expected Count	2593.0	179.0	2772.0
	% within Homeless or Housed	93.5%	6.5%	100.0%
	% within Medication Details Included in the GP Letter	100.0%	100.0%	100.0%
	% of Total	93.5%	6.5%	100.0%

Medication Details Included in the GP Letter Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	12.954[a]	1	.000		
Continuity Correction[b]	11.782	1	.001		
Likelihood Ratio	10.286	1	.001		
Fisher's Exact Test				.001	.001
Linear-by-Linear Association	12.949	1	.000		
N of Valid Cases	2772				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 10.20.

Homeless or Housed * Risk Details Included in the GP Letter Crosstabulation

		Risk Details Included in the GP Letter		
		Yes	No	Total
Homeless	**Count**	**127**	**31**	**158**
	Expected Count	127.0	31.0	158.0
	% within Homeless or Housed	**80.4%**	**19.6%**	**100.0%**
	% within Risk Details Included in the GP Letter	5.7%	5.7%	5.7%
	% of Total	4.6%	1.1%	5.7%
Housed	**Count**	**2101**	**513**	**2614**
	Expected Count	2101.0	513.0	2614.0
	% within Homeless or Housed	**80.4%**	**19.6%**	**100.0%**
	% within Risk Details Included in the GP Letter	94.3%	94.3%	94.3%
	% of Total	75.8%	18.5%	94.3%
Total	Count	2228	544	2772
	Expected Count	2228.0	544.0	2772.0
	% within Homeless or Housed	80.4%	19.6%	100.0%
	% within Risk Details Included in the GP Letter	100.0%	100.0%	100.0%
	% of Total	80.4%	19.6%	100.0%

Risk Details Included in the GP Letter Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.000[a]	1	.999		
Continuity Correction[b]	.000	1	1.000		
Likelihood Ratio	.000	1	.999		
Fisher's Exact Test				1.000	.548
Linear-by-Linear Association	.000	1	.999		
N of Valid Cases	2772				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 31.01.

b. Computed only for a 2x2 table

Homeless or Housed * Service User Provided 24 Hour Notice of Discharge Crosstabulation

		Service User Provided 24 Hour Notice of Discharge		
		Yes	No	Total
Homeless	**Count**	**139**	**63**	**202**
	Expected Count	155.8	46.2	202.0
	% within Homeless or Housed	**68.8%**	**31.2%**	**100.0%**
	% within Service User Provided 24 Hour Notice of Discharge	5.5%	8.4%	6.1%
	% of Total	4.2%	1.9%	6.1%
Housed	**Count**	**2403**	**691**	**3094**
	Expected Count	2386.2	707.8	3094.0
	% within Homeless or Housed	**77.7%**	**22.3%**	**100.0%**
	% within Service User Provided 24 Hour Notice of Discharge	94.5%	91.6%	93.9%
	% of Total	72.9%	21.0%	93.9%
Total	Count	2542	754	3296
	Expected Count	2542.0	754.0	3296.0
	% within Homeless or Housed	77.1%	22.9%	100.0%
	% within Service User Provided 24 Hour Notice of Discharge	100.0%	100.0%	100.0%
	% of Total	77.1%	22.9%	100.0%

Service User Provided 24 Hour Notice of Discharge Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	8.426[a]	1	.004		
Continuity Correction[b]	7.932	1	.005		
Likelihood Ratio	7.870	1	.005		
Fisher's Exact Test				.005	.003
Linear-by-Linear Association	8.424	1	.004		
N of Valid Cases	3296				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 46.21.

b. Computed only for a 2x2 table

Homeless or Housed * Carer Provided 24 Hour Notice of Discharge Crosstabulation

| | | Carer Provided 24 Hour Notice of Discharge | | |
		Yes	No	Total
Homeless	**Count**	**20**	**33**	**53**
	Expected Count	36.9	16.1	53.0
	% within Homeless or Housed	**37.7%**	**62.3%**	**100.0%**
	% within Carer Provided 24 Hour Notice of Discharge	1.4%	5.4%	2.6%
	% of Total	1.0%	1.6%	2.6%
Housed	**Count**	**1379**	**575**	**1954**
	Expected Count	1362.1	591.9	1954.0
	% within Homeless or Housed	**70.6%**	**29.4%**	**100.0%**
	% within Carer Provided 24 Hour Notice of Discharge	98.6%	94.6%	97.4%
	% of Total	68.7%	28.6%	97.4%
Total	Count	1399	608	2007
	Expected Count	1399.0	608.0	2007.0
	% within Homeless or Housed	69.7%	30.3%	100.0%
	% within Carer Provided 24 Hour Notice of Discharge	100.0%	100.0%	100.0%
	% of Total	69.7%	30.3%	100.0%

Carer Provided 24 Hour Notice of Discharge Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	**26.349**[a]	**1**	**.000**		
Continuity Correction[b]	24.817	1	.000		
Likelihood Ratio	23.701	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	26.336	1	.000		
N of Valid Cases	**2007**				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 16.06.

b. Computed only for a 2x2 table

Homeless or Housed * Discharged with TTO Medication Crosstabulation

| | | Discharged with TTO Medication | | | |
		Yes	No	Unknown	Total
Homeless	**Count**	**128**	**52**	**22**	**202**
	Expected Count	155.9	28.4	17.7	202.0
	% within Homeless or Housed	**63.4%**	**25.7%**	**10.9%**	**100.0%**
	% within Discharged with TTO Medication	5.0%	11.2%	7.6%	6.1%
	% of Total	3.9%	1.6%	0.7%	6.1%
Housed	**Count**	**2419**	**412**	**268**	**3099**
	Expected Count	2391.1	435.6	272.3	3099.0
	% within Homeless or Housed	**78.1%**	**13.3%**	**8.6%**	**100.0%**
	% within Discharged with TTO Medication	95.0%	88.8%	92.4%	93.9%
	% of Total	73.3%	12.5%	8.1%	93.9%
Total	Count	2547	464	290	3301
	Expected Count	2547.0	464.0	290.0	3301.0
	% within Homeless or Housed	77.2%	14.1%	8.8%	100.0%
	% within Discharged with TTO Medication	100.0%	100.0%	100.0%	100.0%
	% of Total	77.2%	14.1%	8.8%	100.0%

Discharged with TTO Medication Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	27.296[a]	2	.000
Likelihood Ratio	23.662	2	.000
Linear-by-Linear Association	13.871	1	.000
N of Valid Cases	3301		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 17.75.

Homeless or Housed * Medication Reviewed Upon Discharge Crosstabulation

		Medication Reviewed Upon Discharge		Total
		Yes	Unknown	
Homeless	**Count**	**70**	**78**	**148**
	Expected Count	95.3	52.7	148.0
	% within Homeless or Housed	**47.3%**	**52.7%**	**100.0%**
	% within Medication Reviewed Upon Discharge	4.1%	8.4%	5.7%
	% of Total	2.7%	3.0%	5.7%
Housed	**Count**	**1617**	**854**	**2471**
	Expected Count	1591.7	879.3	2471.0
	% within Homeless or Housed	**65.4%**	**34.6%**	**100.0%**
	% within Medication Reviewed Upon Discharge	95.9%	91.6%	94.3%
	% of Total	61.7%	32.6%	94.3%
Total	Count	1687	932	2619
	Expected Count	1687.0	932.0	2619.0
	% within Homeless or Housed	64.4%	35.6%	100.0%
	% within Medication Reviewed Upon Discharge	100.0%	100.0%	100.0%
	% of Total	64.4%	35.6%	100.0%

Medication Reviewed Upon Discharge Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	20.049[a]	1	.000		
Continuity Correction[b]	19.266	1	.000		
Likelihood Ratio	19.158	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	20.042	1	.000		
N of Valid Cases	**2619**				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 52.67.

b. Computed only for a 2x2 table

Homeless or Housed * Review Considered Response to Medication Crosstabulation

| | | Review Considered Response to Medication | | |
		Yes	No	Total
Homeless	**Count**	**67**	**3**	**70**
	Expected Count	67.8	2.2	70.0
	% within Homeless or Housed	**95.7%**	**4.3%**	**100.0%**
	% within Review Considered Response to Medication	4.1%	5.6%	4.1%
	% of Total	4.0%	0.2%	4.1%
Housed	**Count**	**1566**	**51**	**1617**
	Expected Count	1565.2	51.8	1617.0
	% within Homeless or Housed	**96.8%**	**3.2%**	**100.0%**
	% within Review Considered Response to Medication	95.9%	94.4%	95.9%
	% of Total	92.8%	3.0%	95.9%
Total	Count	1633	54	1687
	Expected Count	1633.0	54.0	1687.0
	% within Homeless or Housed	96.8%	3.2%	100.0%
	% within Review Considered Response to Medication	100.0%	100.0%	100.0%
	% of Total	96.8%	3.2%	100.0%

Review Considered Response to Medication Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.277[a]	1	.598		
Continuity Correction[b]	.032	1	.857		
Likelihood Ratio	.252	1	.615		
Fisher's Exact Test				.488	.390
Linear-by-Linear Association	.277	1	.599		
N of Valid Cases	1687				

a. 1 cells (25.0%) have expected count less than 5. The minimum expected count is 2.24.

b. Computed only for a 2x2 table

Homeless or Housed * Review Considered Side-Effects of Medication Crosstabulation

		Review Considered Side-Effects of Medication		
		Yes	No	Total
Homeless	**Count**	**47**	**23**	**70**
	Expected Count	51.5	18.5	70.0
	% within Homeless or Housed	**67.1%**	**32.9%**	**100.0%**
	% within Review Considered Side-Effects of Medication	3.8%	5.2%	4.1%
	% of Total	2.8%	1.4%	4.1%
Housed	**Count**	**1194**	**423**	**1617**
	Expected Count	1189.5	427.5	1617.0
	% within Homeless or Housed	**73.8%**	**26.2%**	**100.0%**
	% within Review Considered Side-Effects of Medication	96.2%	94.8%	95.9%
	% of Total	70.8%	25.1%	95.9%
Total	Count	1241	446	1687
	Expected Count	1241.0	446.0	1687.0
	% within Homeless or Housed	73.6%	26.4%	100.0%
	% within Review Considered Side-Effects of Medication	100.0%	100.0%	100.0%
	% of Total	73.6%	26.4%	100.0%

Review Considered Side-Effects of Medication Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.548[a]	1	.213		
Continuity Correction[b]	1.222	1	.269		
Likelihood Ratio	1.481	1	.224		
Fisher's Exact Test				.215	.135
Linear-by-Linear Association	1.547	1	.214		
N of Valid Cases	1687				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 18.51.

b. Computed only for a 2x2 table

Homeless or Housed * Crisis Plan in Place Crosstabulation

| | | Crisis Plan in Place | | |
		Yes	No	Total
Homeless	**Count**	**127**	**75**	**202**
	Expected Count	150.0	52.0	202.0
	% within Homeless or Housed	**62.9%**	**37.1%**	**100.0%**
	% within Crisis Plan in Place	5.2%	8.8%	6.1%
	% of Total	3.9%	2.3%	6.1%
Housed	**Count**	**2319**	**774**	**3093**
	Expected Count	2296.0	797.0	3093.0
	% within Homeless or Housed	**75.0%**	**25.0%**	**100.0%**
	% within Crisis Plan in Place	94.8%	91.2%	93.9%
	% of Total	70.4%	23.5%	93.9%
Total	Count	2446	849	3295
	Expected Count	2446.0	849.0	3295.0
	% within Homeless or Housed	74.2%	25.8%	100.0%
	% within Crisis Plan in Place	100.0%	100.0%	100.0%
	% of Total	74.2%	25.8%	100.0%

Crisis Plan in Place Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	**14.525**[a]	**1**	**.000**		
Continuity Correction[b]	13.899	1	.000		
Likelihood Ratio	13.498	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	14.521	1	.000		
N of Valid Cases	**3295**				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 52.05.

b. Computed only for a 2x2 table

Homeless or Housed * Follow Up Crosstabulation

		Follow Up			
		Yes	No	Unknown	Total
Homeless	**Count**	**164**	**26**	**12**	**202**
	Expected Count	181.5	10.1	10.4	202.0
	% within Homeless or Housed	**81.2%**	**12.9%**	**5.9%**	**100.0%**
	% within Follow Up	5.5%	15.9%	7.1%	6.1%
	% of Total	5.0%	0.8%	0.4%	6.1%
Housed	**Count**	**2798**	**138**	**158**	**3094**
	Expected Count	2780.5	153.9	159.6	3094.0
	% within Homeless or Housed	**90.4%**	**4.5%**	**5.1%**	**100.0%**
	% within Follow Up	94.5%	84.1%	92.9%	93.9%
	% of Total	84.9%	4.2%	4.8%	93.9%
Total	Count	2962	164	170	3296
	Expected Count	2962.0	164.0	170.0	3296.0
	% within Homeless or Housed	89.9%	5.0%	5.2%	100.0%
	% within Follow Up	100.0%	100.0%	100.0%	100.0%
	% of Total	89.9%	5.0%	5.2%	100.0%

Follow Up Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	29.020[a]	2	.000
Likelihood Ratio	21.342	2	.000
Linear-by-Linear Association	8.276	1	.004
N of Valid Cases	3296		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 10.05.

Homeless or Housed * Follow Up Method Crosstabulation

| | | Follow Up Method | | Total |
		Face-to-Face	Telephone	
Homeless	**Count**	**108**	**53**	**161**
	Expected Count	131.4	29.6	161.0
	% within Homeless or Housed	**67.1%**	**32.9%**	**100.0%**
	% within Follow Up Method	4.5%	9.9%	5.5%
	% of Total	3.7%	1.8%	5.5%
Housed	**Count**	**2274**	**484**	**2758**
	Expected Count	2250.6	507.4	2758.0
	% within Homeless or Housed	**82.5%**	**17.5%**	**100.0%**
	% within Follow Up Method	95.5%	90.1%	94.5%
	% of Total	77.9%	16.6%	94.5%
Total	Count	2382	537	2919
	Expected Count	2382.0	537.0	2919.0
	% within Homeless or Housed	81.6%	18.4%	100.0%
	% within Follow Up Method	100.0%	100.0%	100.0%
	% of Total	81.6%	18.4%	100.0%

Follow up Method Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	**23.939**[a]	**1**	**.000**		
Continuity Correction[b]	22.926	1	.000		
Likelihood Ratio	20.686	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	23.931	1	.000		
N of Valid Cases	**2919**				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 29.62.

b. Computed only for a 2x2 table

Homeless or Housed * Follow Up within 48 Hours of Discharge Crosstabulation

		Follow Up within 48 Hours of Discharge		
		Within 48 hours	Greater than 48 hours	Total
Homeless	**Count**	**70**	**86**	156
	Expected Count	89.1	66.9	156.0
	% within Homeless or Housed	**44.9%**	**55.1%**	**100.0%**
	% within Follow Up within 48 Hours of Discharge	4.3%	7.0%	5.5%
	% of Total	2.5%	3.0%	5.5%
Housed	**Count**	**1558**	**1135**	**2693**
	Expected Count	1538.9	1154.1	2693.0
	% within Homeless or Housed	**55.7%**	**44.3%**	**100.0%**
	% within Follow Up within 48 Hours of Discharge	95.7%	93.0%	94.5%
	% of Total	54.7%	39.8%	94.5%
Total	Count	1628	1221	2849
	Expected Count	1628.0	1221.0	2849.0
	% within Homeless or Housed	57.1%	42.9%	100.0%
	% within Follow Up within 48 Hours of Discharge	100.0%	100.0%	100.0%
	% of Total	57.1%	42.9%	100.0%

Follow Up within 48 Hours of Discharge Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	10.148[a]	1	.001		
Continuity Correction[b]	9.624	1	.002		
Likelihood Ratio	10.020	1	.002		
Fisher's Exact Test				.002	.001
Linear-by-Linear Association	10.144	1	.001		
N of Valid Cases	2849				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 66.86.

b. Computed only for a 2x2 table

Question 3: What Proportion of Homeless Service Users are Referred for Psychological Therapy?

Homeless or Housed * Referred for Psychological Therapy Crosstabulation

		Referred for Psychological Therapy		
		Yes	**No**	**Total**
Homeless	**Count**	**62**	**161**	**223**
	Expected Count	86.9	136.1	223.0
	% within Homeless or Housed	**27.8%**	**72.2%**	**100.0%**
	% within Referred for Psychological Therapy	4.2%	7.0%	5.9%
	% of Total	1.6%	4.2%	5.9%
Housed	**Count**	**1416**	**2155**	**3571**
	Expected Count	1391.1	2179.9	3571.0
	% within Homeless or Housed	**39.7%**	**60.3%**	**100.0%**
	% within Referred for Psychological Therapy	95.8%	93.0%	94.1%
	% of Total	37.3%	56.8%	94.1%
Total	Count	1478	2316	3794
	Expected Count	1478.0	2316.0	3794.0
	% within Homeless or Housed	39.0%	61.0%	100.0%
	% within Referred for Psychological Therapy	100.0%	100.0%	100.0%
	% of Total	39.0%	61.0%	100.0%

Referred for Psychological Therapy Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	**12.394**[a]	**1**	**.000**		
Continuity Correction[b]	11.901	1	.001		
Likelihood Ratio	12.936	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	12.391	1	.000		
N of Valid Cases	**3794**				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 86.87.

b. Computed only for a 2x2 table

Homeless or Housed * Referred for Individual Psychological Therapy Crosstabulation

		Referred for Individual Psychological Therapy		
		Yes	No	Total
Homeless	**Count**	**43**	**14**	**57**
	Expected Count	45.8	11.2	57.0
	% within Homeless or Housed	**75.4%**	**24.6%**	**100.0%**
	% within Referred for Individual Psychological Therapy	3.9%	5.2%	4.2%
	% of Total	3.1%	1.0%	4.2%
Housed	**Count**	**1060**	**255**	**1315**
	Expected Count	1057.2	257.8	1315.0
	% within Homeless or Housed	**80.6%**	**19.4%**	**100.0%**
	% within Referred for Individual Psychological Therapy	96.1%	94.8%	95.8%
	% of Total	77.3%	18.6%	95.8%
Total	Count	1103	269	1372
	Expected Count	1103.0	269.0	1372.0
	% within Homeless or Housed	80.4%	19.6%	100.0%
	% within Referred for Individual Psychological Therapy	100.0%	100.0%	100.0%
	% of Total	80.4%	19.6%	100.0%

Referred for Individual Therapy Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.926[a]	1	.336		
Continuity Correction[b]	.627	1	.428		
Likelihood Ratio	.877	1	.349		
Fisher's Exact Test				.312	.211
Linear-by-Linear Association	.926	1	.336		
N of Valid Cases	1372				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 11.18.

b. Computed only for a 2x2 table

Homeless or Housed * Referred for Group Psychological Therapy Crosstabulation

		Referred for Group Psychological Therapy		
		Yes	**No**	**Total**
Homeless	**Count**	**17**	**40**	**57**
	Expected Count	17.3	39.7	57.0
	% within Homeless or Housed	**29.8%**	**70.2%**	**100.0%**
	% within Referred for Group Psychological Therapy	4.1%	4.2%	4.2%
	% of Total	1.2%	2.9%	4.2%
Housed	**Count**	**400**	**916**	**1316**
	Expected Count	399.7	916.3	1316.0
	% within Homeless or Housed	**30.4%**	**69.6%**	**100.0%**
	% within Referred for Group Psychological Therapy	95.9%	95.8%	95.8%
	% of Total	29.1%	66.7%	95.8%
Total	Count	417	956	1373
	Expected Count	417.0	956.0	1373.0
	% within Homeless or Housed	30.4%	69.6%	100.0%
	% within Referred for Group Psychological Therapy	100.0%	100.0%	100.0%
	% of Total	30.4%	69.6%	100.0%

Referred for Group Therapy Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.008[a]	1	.927		
Continuity Correction[b]	.000	1	1.000		
Likelihood Ratio	.008	1	.927		
Fisher's Exact Test				1.000	.529
Linear-by-Linear Association	.008	1	.927		
N of Valid Cases	1373				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 17.31.

b. Computed only for a 2x2 table

Homeless or Housed * Accepting Services of Referrals for Individual Therapy Crosstabulation

		Accepting Services of Referrals for Individual Therapy					Total
		Private	Third sector	NHS secondary care	IAPT	Other	
Homeless	**Count**	**0**	**2**	**25**	**13**	**3**	**43**
	Expected Count	.4	1.0	33.0	5.5	3.2	43.0
	% within Homeless or Housed	**0.0%**	**4.7%**	**58.1%**	**30.2%**	**7.0%**	**100.0%**
	% within Accepting Services of Referrals for Individual Therapy	0.0%	7.7%	3.0%	9.3%	3.7%	3.9%
	% of Total	0.0%	0.2%	2.3%	1.2%	0.3%	3.9%
Housed	**Count**	**10**	**24**	**821**	**127**	**78**	**1060**
	Expected Count	9.6	25.0	813.0	134.5	77.8	1060.0
	% within Homeless or Housed	**0.9%**	**2.3%**	**77.5%**	**12.0%**	**7.4%**	**100.0%**
	% within Accepting Services of Referrals for Individual Therapy	100.0%	92.3%	97.0%	90.7%	96.3%	96.1%
	% of Total	0.9%	2.2%	74.4%	11.5%	7.1%	96.1%
Total	Count	10	26	846	140	81	1103
	Expected Count	10.0	26.0	846.0	140.0	81.0	1103.0
	% within Homeless or Housed	0.9%	2.4%	76.7%	12.7%	7.3%	100.0%
	% within Accepting Services of Referrals for Individual Therapy	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	% of Total	0.9%	2.4%	76.7%	12.7%	7.3%	100.0%

Accepting Services of Referrals for Individual Therapy Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	14.268[a]	4	.006
Likelihood Ratio	11.688	4	.020
Linear-by-Linear Association	2.793	1	.095
N of Valid Cases	1103		

a. 3 cells (30.0%) have expected count less than 5. The minimum expected count is .39.

Homeless or Housed * Started Individual Therapy Crosstabulation

		Started Individual Therapy			Total
		Yes	No	Unknown	
Homeless	**Count**	**16**	**21**	**7**	**44**
	Expected Count	23.6	14.7	5.7	44.0
	% within Homeless or Housed	**36.4%**	**47.7%**	**15.9%**	**100.0%**
	% within Started Individual Therapy	2.7%	5.7%	4.9%	4.0%
	% of Total	1.4%	1.9%	0.6%	4.0%
Housed	**Count**	**577**	**348**	**136**	**1061**
	Expected Count	569.4	354.3	137.3	1061.0
	% within Homeless or Housed	**54.4%**	**32.8%**	**12.8%**	**100.0%**
	% within Started Individual Therapy	97.3%	94.3%	95.1%	96.0%
	% of Total	52.2%	31.5%	12.3%	96.0%
Total	Count	593	369	143	1105
	Expected Count	593.0	369.0	143.0	1105.0
	% within Homeless or Housed	53.7%	33.4%	12.9%	100.0%
	% within Started Individual Therapy	100.0%	100.0%	100.0%	100.0%
	% of Total	53.7%	33.4%	12.9%	100.0%

Started Individual Therapy Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	**5.687ª**	**2**	**.058**
Likelihood Ratio	5.663	2	.059
Linear-by-Linear Association	3.760	1	.052
N of Valid Cases	**1105**		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 5.69.

Homeless or Housed * Started Group Therapy Crosstabulation

		Started Group Therapy			
		Yes	No	Unknown	Total
Homeless	**Count**	**10**	**5**	**2**	**17**
	Expected Count	12.3	2.9	1.9	17.0
	% within Homeless or Housed	**58.8%**	**29.4%**	**11.8%**	**100.0%**
	% within Started Group Therapy	3.3%	7.1%	4.3%	4.1%
	% of Total	2.4%	1.2%	0.5%	4.1%
Housed	**Count**	**291**	**65**	**44**	**400**
	Expected Count	288.7	67.1	44.1	400.0
	% within Homeless or Housed	**72.8%**	**16.3%**	**11.0%**	**100.0%**
	% within Started Group Therapy	96.7%	92.9%	95.7%	95.9%
	% of Total	69.8%	15.6%	10.6%	95.9%
Total	Count	301	70	46	417
	Expected Count	301.0	70.0	46.0	417.0
	% within Homeless or Housed	72.2%	16.8%	11.0%	100.0%
	% within Started Group Therapy	100.0%	100.0%	100.0%	100.0%
	% of Total	72.2%	16.8%	11.0%	100.0%

Started Group Therapy Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	2.130[a]	2	.345
Likelihood Ratio	1.860	2	.395
Linear-by-Linear Association	.766	1	.381
N of Valid Cases	417		

a. 2 cells (33.3%) have expected count less than 5. The minimum expected count is 1.88.

Question 4: Which Demographic and Clinical Variables Predict Referral of Homeless Service Users for Psychological Therapy?

Psychological Therapy Referral * Age Categories Crosstabulation

		Age Categories			
		16-25 years	26-55 years	56+ years	Total
Referred for Psychological Therapy	**Count**	**8**	**48**	**6**	**62**
	Expected Count	7.8	48.1	6.1	62.0
	% within Psychological Therapy Referral	**12.9%**	**77.4%**	**9.7%**	**100.0%**
	% within Age Categories	28.6%	27.7%	27.3%	27.8%
	% of Total	3.6%	21.5%	2.7%	27.8%
Not Referred for Psychological Therapy	**Count**	**20**	**125**	**16**	**161**
	Expected Count	20.2	124.9	15.9	161.0
	% within Psychological Therapy Referral	**12.4%**	**77.6%**	**9.9%**	**100.0%**
	% within Age Categories	71.4%	72.3%	72.7%	72.2%
	% of Total	9.0%	56.1%	7.2%	72.2%
Total	Count	28	173	22	223
	Expected Count	28.0	173.0	22.0	223.0
	% within Psychological Therapy Referral	12.6%	77.6%	9.9%	100.0%
	% within Age Categories	100.0%	100.0%	100.0%	100.0%
	% of Total	12.6%	77.6%	9.9%	100.0%

Age Categories Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	.012[a]	2	.994
Likelihood Ratio	.012	2	.994
Linear-by-Linear Association	.011	1	.917
N of Valid Cases	223		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 6.12.

Psychological Therapy Referral * Gender Crosstabulation

		Gender		Total
		Male	Female	
Referred for Psychological Therapy	**Count**	**49**	**13**	**62**
	Expected Count	49.5	12.5	62.0
	% within Psychological Therapy Referral	**79.0%**	**21.0%**	**100.0%**
	% within Gender	27.5%	28.9%	27.8%
	% of Total	22.0%	5.8%	27.8%
Not Referred for Psychological Therapy	**Count**	**129**	**32**	**161**
	Expected Count	128.5	32.5	161.0
	% within Psychological Therapy Referral	**80.1%**	**19.9%**	**100.0%**
	% within Gender	72.5%	71.1%	72.2%
	% of Total	57.8%	14.3%	72.2%
Total	Count	178	45	223
	Expected Count	178.0	45.0	223.0
	% within Psychological Therapy Referral	79.8%	20.2%	100.0%
	% within Gender	100.0%	100.0%	100.0%
	% of Total	79.8%	20.2%	100.0%

Gender Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.033[a]	1	.856		
Continuity Correction[b]	.000	1	1.000		
Likelihood Ratio	.033	1	.856		
Fisher's Exact Test				.854	.495
Linear-by-Linear Association	.033	1	.856		
N of Valid Cases	223				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 12.51.

b. Computed only for a 2x2 table

Psychological Therapy Referral * Ethnicity Crosstabulation

		White	Mixed/Multiple	Asian	Black	Unknown	Total
				Ethnicity			
Referred for Psychological Therapy	Count	49	1	3	4	5	62
	Expected Count	46.7	2.8	4.7	3.1	4.7	62.0
	% within Psychological Therapy Referral	**79.0%**	**1.6%**	**4.8%**	**6.5%**	**8.1%**	**100.0%**
	% within Ethnicity	29.2%	10.0%	17.6%	36.4%	29.4%	27.8%
	% of Total	22.0%	0.4%	1.3%	1.8%	2.2%	27.8%
Not Referred for Psychological Therapy	Count	119	9	14	7	12	161
	Expected Count	121.3	7.2	12.3	7.9	12.3	161.0
	% within Psychological Therapy Referral	**73.9%**	**5.6%**	**8.7%**	**4.3%**	**7.5%**	**100.0%**
	% within Ethnicity	70.8%	90.0%	82.4%	63.6%	70.6%	72.2%
	% of Total	53.4%	4.0%	6.3%	3.1%	5.4%	72.2%
Total	Count	168	10	17	11	17	223
	Expected Count	168.0	10.0	17.0	11.0	17.0	223.0
	% within Psychological Therapy Referral	75.3%	4.5%	7.6%	4.9%	7.6%	100.0%
	% within Ethnicity	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	% of Total	75.3%	4.5%	7.6%	4.9%	7.6%	100.0%

Ethnicity Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	3.032 [a]	4	.553
Likelihood Ratio	3.436	4	.488
Linear-by-Linear Association	.024	1	.877
N of Valid Cases	223		

a. 4 cells (40.0%) have expected count less than 5. The minimum expected count is 2.78.

Psychological Therapy Referral * Primary Diagnosis Crosstabulation

		Primary Diagnosis				
		Depressive Episode	Recurrent depressive disorder/ Persistent mood disorder/ Other mood disorder	Phobic anxiety disorder/ Other anxiety disorder/ Obsessive-compulsive disorder	Reaction to severe stress and adjustment disorder	Total
Referred for Psychological Therapy	**Count**	**14**	**8**	**8**	**32**	**62**
	Expected Count	17.5	4.4	7.5	32.5	62.0
	% within Psychological Therapy Referral	**22.6%**	**12.9%**	**12.9%**	**51.6%**	**100.0%**
	% within Primary Diagnosis	22.2%	50.0%	29.6%	27.4%	27.8%
	% of Total	6.3%	3.6%	3.6%	14.3%	27.8%
Not Referred for Psychological Therapy	**Count**	**49**	**8**	**19**	**85**	**161**
	Expected Count	45.5	11.6	19.5	84.5	161.0
	% within Psychological Therapy Referral	**30.4%**	**5.0%**	**11.8%**	**52.8%**	**100.0%**
	% within Primary Diagnosis	77.8%	50.0%	70.4%	72.6%	72.2%
	% of Total	22.0%	3.6%	8.5%	38.1%	72.2%
Total	Count	63	16	27	117	223
	Expected Count	63.0	16.0	27.0	117.0	223.0
	% within Psychological Therapy Referral	28.3%	7.2%	12.1%	52.5%	100.0%
	% within Primary Diagnosis	100.0%	100.0%	100.0%	100.0%	100.0%
	% of Total	28.3%	7.2%	12.1%	52.5%	100.0%

Primary Diagnosis Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	4.962[a]	3	.175
Likelihood Ratio	4.592	3	.204
Linear-by-Linear Association	.113	1	.737
N of Valid Cases	**223**		

a. 1 cells (12.5%) have expected count less than 5. The minimum expected count is 4.45.

Psychological Therapy Referral * Comorbid Diagnosis of Substance Use Crosstabulation

		Comorbid Diagnosis of Substance Use		
		Yes	No	Total
Referred for Psychological Therapy	**Count**	**19**	**43**	**62**
	Expected Count	22.0	40.0	62.0
	% within Psychological Therapy Referral	**30.6%**	**69.4%**	**100.0%**
	% within Comorbid Diagnosis of Substance Use	24.1%	29.9%	27.8%
	% of Total	8.5%	19.3%	27.8%
Not Referred for Psychological Therapy	**Count**	**60**	**101**	**161**
	Expected Count	57.0	104.0	161.0
	% within Psychological Therapy Referral	**37.3%**	**62.7%**	**100.0%**
	% within Comorbid Diagnosis of Substance Use	75.9%	70.1%	72.2%
	% of Total	26.9%	45.3%	72.2%
Total	Count	79	144	223
	Expected Count	79.0	144.0	223.0
	% within **Psychological Therapy Referral**	35.4%	64.6%	100.0%
	% within Comorbid Diagnosis of Substance Use	100.0%	100.0%	100.0%
	% of Total	35.4%	64.6%	100.0%

Comorbid Diagnosis of Substance Use Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.858[a]	1	.354		
Continuity Correction[b]	.593	1	.441		
Likelihood Ratio	.870	1	.351		
Fisher's Exact Test				.435	.222
Linear-by-Linear Association	.854	1	.355		
N of Valid Cases	**223**				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 21.96.

b. Computed only for a 2x2 table

Psychological Therapy Referral * Comorbid Diagnosis of Personality Disorder

		Comorbid Diagnosis of Personality Disorder		
		Yes	No	Total
Referred for Psychological Therapy	**Count**	**11**	**51**	**62**
	Expected Count	8.6	53.4	62.0
	% within Psychological Therapy Referral	**17.7%**	**82.3%**	**100.0%**
	% within Comorbid Diagnosis of Personality Disorder	35.5%	26.6%	27.8%
	% of Total	4.9%	22.9%	27.8%
Not Referred for Psychological Therapy	**Count**	**20**	**141**	**161**
	Expected Count	22.4	138.6	161.0
	% within Psychological Therapy Referral	**12.4%**	**87.6%**	**100.0%**
	% within Comorbid Diagnosis of Personality Disorder	64.5%	73.4%	72.2%
	% of Total	9.0%	63.2%	72.2%
Total	Count	31	192	223
	Expected Count	31.0	192.0	223.0
	% within Psychological Therapy Referral	13.9%	86.1%	100.0%
	% within Comorbid Diagnosis of Personality Disorder	100.0%	100.0%	100.0%
	% of Total	13.9%	86.1%	100.0%

Comorbid Diagnosis of Personality Disorder Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.058[a]	1	.304		
Continuity Correction[b]	.661	1	.416		
Likelihood Ratio	1.016	1	.314		
Fisher's Exact Test				.387	.206
Linear-by-Linear Association	1.054	1	.305		
N of Valid Cases	223				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 8.62.

b. Computed only for a 2x2 table

Logistic Regression

Case Processing Summary

Unweighted Cases[a]		N	Percent
Selected Cases	Included in Analysis	223	100.0
	Missing Cases	0	.0
	Total	223	100.0
Unselected Cases		0	.0
Total		223	100.0

a. If weight is in effect, see classification table for the total number of cases.

Dependent Variable Encoding

Original Value	Internal Value
Yes	0
No	1

Categorical Variables Codings

		Frequency	Parameter coding		
			(1)	(2)	(3)
Primary Diagnosis	Depressive Episode	63	1.000	.000	.000
	Recurrent Depression	16	.000	1.000	.000
	Anxiety Disorder	27	.000	.000	1.000
	Stress or Adjustment Disorder	117	.000	.000	.000
Age	16-25	28	1.000	.000	
	26-55	173	.000	1.000	
	56+	22	.000	.000	
Gender	Male	178	1.000		
	Female	45	.000		

Block 0: Beginning Block

Classification Table[a,b]

				Predicted		
				Referred for Therapy		
	Observed			Yes	No	Percentage Correct
Step 0	Referred for Therapy	Yes		0	62	.0
		No		0	161	100.0
	Overall Percentage					72.2

a. Constant is included in the model.

b. The cut value is .500

Variables in the Equation

		B	S.E.	Wald	df	Sig.	Exp(B)
Step 0	Constant	.954	.149	40.762	1	.000	2.597

Variables not in the Equation

			Score	df	Sig.
Step 0	Variables	Gender	.033	1	.856
		Age (16-25)	.012	2	.994
		Age (26-55)	.009	1	.923
		Age (56+)	.001	1	.972
		Diagnosis (Depressive Episode)	4.962	3	.175
		Diagnosis (Recurrent Depression)	1.362	1	.243
		Diagnosis (Anxiety Disorder)	4.231	1	.040
		Diagnosis (Stress or Adjustment Disorder)	.051	1	.821
	Overall Statistics		5.107	6	.530

Block 1: Method = Enter

Omnibus Tests of Model Coefficients

		Chi-square	df	Sig.
Step 1	Step	4.741	6	.577
	Block	4.741	6	.577
	Model	4.741	6	.577

Model Summary

Step	-2 Log likelihood	Cox & Snell R Square	Nagelkerke R Square
1	258.880[a]	.021	.030

a. Estimation terminated at iteration number 4 because parameter estimates changed by less than .001.

Hosmer and Lemeshow Test

Step	Chi-square	df	Sig.
1	6.179	6	.403

Contingency Table for Hosmer and Lemeshow Test

		Referred for Therapy = Yes		Referred for Therapy = No		Total
		Observed	Expected	Observed	Expected	
Step 1	1	11	9.901	11	12.099	22
	2	5	8.258	23	19.742	28
	3	8	7.699	19	19.301	27
	4	2	2.768	8	7.232	10
	5	22	19.374	51	53.626	73
	6	6	4.734	14	15.266	20
	7	3	1.566	4	5.434	7
	8	5	7.700	31	28.300	36

Classification Table[a]

			Predicted		
			Referred for Therapy		
	Observed		Yes	No	Percentage Correct
Step 1	Referred for Therapy	Yes	1	61	1.6
		No	3	158	98.1
	Overall Percentage				71.3

a. The cut value is .500

Variables in the Equation

		B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I.for EXP(B) Lower	95% C.I.for EXP(B) Upper
Step 1[a]	Gender (Female)	.128	.375	.117	1	.733	1.137	.545	2.370
	Age (16-25)			.041	2	.980			
	Age (26-55)	.032	.643	.003	1	.960	1.033	.293	3.643
	Age (56+)	.090	.513	.031	1	.861	1.094	.400	2.990
	Depressive Episode			4.761	3	.190			
	Recurrent Depression	.284	.368	.594	1	.441	1.328	.645	2.731
	Anxiety Disorder	-.995	.545	3.329	1	.068	.370	.127	1.077
	Stress or Adjustment Disorder	-.107	.472	.051	1	.821	.899	.357	2.265
	Constant	.800	.586	1.863	1	.172	2.226		

a. Variable(s) entered on step 1: q2_gender, AGE_3_Categories, Diagnosis_4.

Step number: 1

Observed Groups and Predicted Probabilities

```
      80 +                                                    +
         I                                    n               I
         I                                    n               I
 F       I                                    n               I
 R    60 +                                      n               +
 E       I                                    n               I
 Q       I                                    n               I
 U       I                                    n               I
 E    40 +                                      n               +
 N       I                                    n   n           I
 C       I                                    n   n           I
 Y       I                                  nn n   n           I
      20 +                                  nn y   n             +
         I                                  nn y   n           I
         I                  n               nyny nnn           I
         I                  y               ynyyny yyy         I
Predicted ---------+---------+---------+---------+---------+---------+---------+---------+---------+----------
    Prob:  0    .1    .2    .3    .4    .5    .6    .7    .8    .9    1
   Group:  yyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyynnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnnn
```

Predicted Probability is of Membership for no
The Cut Value is .50
Symbols: y - yes
         n - no
Each Symbol Represents 5 Cases.

Appendix H: National Demographic Data on Homeless Population

	National homelessness data %
Age of main household member before priority need assessment, England, October to December 2018 (Source: ONS, 2019; Initial assessments live tables on homelessness, Ministry of Housing, Communities and Local Government)	
16-24 years	21%
25-44 years	54%
45-64 years	22%
65 years and over	3%
Sex of main homeless applicant with or without priority need assessment, England, October to December 2018 (Source: ONS, 2019; Initial assessments live tables on homelessness, Ministry of Housing, Communities and Local Government)	
Male	62%
Female	38%
Ethnicity of homeless households, England, 2017-2018 (Source: Ethnicity Facts and Figures, 2019; Initial assessments live tables on homelessness, Ministry of Housing, Communities and Local Government)	
White British/Irish/Other	62%
Mixed/Multiple/Other	4%
Asian/Asian British	9%
Black African/Caribbean/Black British	14%
Other	4%
Unknown/not recorded	6%

	NCAAD homeless data %	National homelessness data %
		Source: ONS, 2019
16-24 years	9%	21%
25-44 years	59.2%	54%
45-64 years	30%	22%
65 years and over	1.8%	3%
		Source: ONS, 2019
Male	79.8%	72%
Female	20.2%	28%
		Source: Ethnicity Facts and Figures, 2019
White British/Irish/Other	75.3%	62%
Mixed/Multiple/Other	1.3%	4%
Asian/Asian British	7.6%	9%
Black African/Caribbean/Black British	4.9%	14%
Other	3.1%	4%
Unknown/not recorded	7.6%	6%