Seeing the Whole Person: A Preventative Approach to Mental Health and Homelessness

One of a series of Pathway Policy Papers to inform the next decade of healthcare

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About the author

I am the consultant Psychiatrist in the START team, which is a community mental health team for people sleeping rough in Lambeth, Southwark, and Croydon. We also have sub-teams in Lambeth and Croydon for people who are insecurely housed and experiencing both mental health and substance misuse problems.

After training in medicine in Edinburgh and completing my Core Training in psychiatry, I happened to get a staff grade job in a homeless mental health team in North London (almost 20 years ago now). I loved it; next, because we had a lot of patients with substance misuse problems, I made sure to do an addictions job in my Higher Training. I loved that too, and my first consultant job was as an addiction psychiatrist in Soho, which I did for five years before coming back to homelessness in my current job in 2016.

I am currently chair of the mental health subgroup in Pathway's Faculty for Homeless and Inclusion Health. I am passionate about providing good quality joined-up care for people experiencing multiple disadvantage.

Acknowledgements

I'd like to thank the members of the Faculty's mental health subgroup for their wise and enthusiastic input into this paper. It is a privilege to be part of a network with such an extraordinary wealth of knowledge and experience.

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Any mistakes or important omissions are, of course, entirely my own work.

Foreword

We are at a turning point in the long and proud history of our National Health Service. Described as ‘broken’ by the Secretary of State, there is a clear choice in how the Government restores when developing its 10-year Plan. This choice is between the continued, widespread exclusion of people facing severe deprivation from care, or rebuilding the NHS inclusively, slanting effort and resources towards those people in inclusion health groups, whose needs are among the most complex and severe in our country.

Pathway is publishing these policy papers to inform this choice. Drawing on the expertise of some of our Pathway Fellows and Faculty members, as well as our colleagues with lived experience, we offer to shine a light on what is possible and to offer thoughts and actionable ideas for change. We invite Ministers to take these ideas and the problems they are designed to solve into account when shaping the 10-year Plan.

The challenges described in the papers echo those seen every day by our Pathway hospital teams. Patients who could have received help earlier only receiving it at crisis point, wasting human potential and precious resources. The desperate challenges people face accessing help for combined mental health and substance use problem. The failure of our housing system to provide safe places to recover from illness and to stay well.

It is not like this everywhere, however, and it does not have to be like this forever. The papers point to evidence of what works in health and care services to meet the needs of people in inclusion health groups, as well as beacons of good practice around the country. Together, they show how choices could be made within the NHS to reverse the inverse care law, tilting time and resource towards those who need it most. Prevention is a strong theme throughout, showing how people's problems can and should be addressed before they spiral out of control.

The benefits of action go far beyond health - meeting people’s health needs unlocks other gains, addressing underlying risks of homelessness in particular, enabling people to live well and for longer, as the Government wants to see us all do.

I am very grateful to our Pathway Fellows and other experts who have made time, often in the midst of busy clinical and frontline jobs, to share their thoughts and expertise in these papers. Britain led the world with the establishment of the NHS more than 70 years ago. As we write the next chapter of its history, let’s make care and compassion for those who need them most central to its mission.

Alex Bax, CEO, Pathway

Summary

- There is an opportunity for better mental health services to prevent homelessness, by identifying and treating illness before it results in crisis, and by working with other services to intervene when housing is at risk. Over 80% of people sleeping rough report a mental health vulnerability[1], and many had significant contact with NHS Mental Health Trusts while they were still housed.

- Despite developments such as the Rough Sleeping Initiative, services have suffered from a lack of sustained implementation of evidence-based solutions. A patchwork of pilot programmes, without consistent funding, have limited impact, leaving many gaps in care for people facing homelessness with mental health needs.

- The structure of mental health and addiction services often excludes people who are most in need. Challenges include high thresholds for care, fragmented services, and failure to meet the needs of those who also experience addiction. This leads to missed prevention opportunities and worsens health inequalities.

- The NHS 10-year Plan is an opportunity for a reset, putting plans in place to provide mental health services providing accessible and compassionate care for all, including those experiencing addiction. The building blocks are already there in the evidence and in pockets of good practice throughout the country.

- The Government must commit to action, including expanding the capacity of Community Mental Health Teams to allow them to better support people in crisis who are at risk of losing their homes, and creating meaningful and funded referral routes for people with severe and enduring mental illness and addiction. All of this must be underpinned by a clear plan to provide everyone with the homes they need, including building 90,000 social homes a year.

What is inclusion health?

Inclusion health is a growing field of research, activism, clinical practice, and care devoted to improving health and social outcomes for the most excluded groups in society. Although much early impetus focussed on improving health services for people experiencing homelessness, over the last 15 years the concept of inclusion health has expanded to cover a range of groups where extreme social and economic exclusion creates extreme health risks and health harms.

The degree of risk and harm observed in inclusion health groups falls far below even the depressing ‘normal’ range of health inequalities in British society. Disease prevalence rates can be up to 50 times higher than in the general population and mortality gaps between inclusion health groups and the average can be 30 or 40 years. Inclusion health groups can be defined by this observed extreme distance from the general population in terms of health status.

Currently identified inclusion health groups are: people experiencing homelessness, Gypsy, Roma and Traveller people, people engaged in sex work, vulnerable migrants. We now have a strong body of evidence of what works to improve health and care for these groups: NICE published guidance on homelessness in 2022 and NHS England produced a national inclusion health framework in 2023, however there is an ‘implementation gap’. The good practice evidence is available but all too often that evidence is ignored or only followed spasmodically.

Introduction

Good quality mental health care is a crucial part of ending homelessness. Over 80% of people sleeping rough report a mental health vulnerability[2], and just under 50% have received a diagnosis[3]. There are high levels of severe mental illness such as psychosis[4], as well as depression, anxiety, and complex trauma[5]. This is not simply because of the stress that sleeping on the streets can bring: many of those presenting to homeless mental health services had significant contact with NHS Mental Health Trusts[6] when they were still housed. But in too many cases no action is taken to change the trajectory of increasing housing instability, which often involves low quality temporary accommodation and sofa surfing before the final outrage of sleeping on the streets.

There is clearly an opportunity for mental health services to prevent homelessness, both by identifying and treating illness before it results in crisis, and by working with other services to intervene when housing is at risk. Sadly, these opportunities are often missed: people do not get help from mental health services early enough. Thresholds are high, and services are often structured in such a way that those most vulnerable are excluded. People with poor literacy, with difficulties accessing the internet, or with an unstable address may find themselves unable to access services even if they want to seek help - and many, particularly those who have experienced trauma from a young age, may be reluctant to approach a system that has failed them repeatedly in the past. Without intervention, paranoia and persecutory ideas can drive people out of their homes, and the self-neglect often central to schizophreniform illnesses can lead to insurmountable difficulty with maintaining housing.

Complex needs for those on the streets are common: mental ill-health often goes hand in hand with addiction. But despite recent guidelines calling for “no wrong door” when it comes to treating mental illness and substance misuse[7], the fragmentation of services means that in practice many continue to find themselves excluded from mental health treatment until they are abstinent from drugs and alcohol. This group should be the highest priority for help: people experiencing multiple exclusions as adults have often suffered lifelong difficulties, with early trauma and high numbers of Adverse Childhood Experiences. And the majority of deaths on the streets – at an average age of just 45 for a man, and 43 for a woman - are from drug poisoning, suicide, or alcohol related illnesses[8]. These are causes that should be preventable with targeted and coordinated work from mental health and substance misuse services, but too often that work does not happen.

This field therefore presents a major opportunity to make a reality of the Government’s ambition to embed a greater focus on prevention throughout the health care system. The myriad missed opportunities for prevention for people facing homelessness and other

excluded groups are all amenable to evidence-based change, to help to reduce health inequalities and create a healthier Britain where everyone lives well for longer.

Policy Background

Mental illness in England is treated with a stepped approach: around 90% of people with mental health problems are cared for entirely within primary care. General practitioners are in a unique position of providing longitudinal care, looking after patients “from cradle to grave”. However, their resources are often scarce: in 2017 only 10% of the total mental health expenditure was used in primary care[9].

If onward referral is required there are often limited options for those with complex needs, who have often not been a priority in mental health service planning. Since 2008, for example, there has been considerable investment in Improving Access to Psychological Therapies (now known as NHS Talking Therapies for anxiety and depression). But those with multiple exclusion homelessness are generally found to be too complex for this form of therapy, which leaves them without an easy route to psychological support.

Meanwhile, although investment in secondary mental health care has increased, this increase has not kept pace with demand[10]. A surge in referrals to mental health teams has led to long waiting times: Darzi highlighted that in April 2024 around 1 million people were waiting for community mental health care, and 345,000 had been waiting for over a year[11]. This places community services under enormous pressure and affects staff morale. It is understandable, if not excusable, that thresholds for acceptance to secondary care are high, and that there may be reluctance to take on cases with complex social needs. Similarly, if a patient facing a thorny housing situation drifts out of contact, a beleaguered team may be tempted to discharge them rather than taking on the challenge of leaning into the problem and preventing a crisis.

Alongside this, there have been significant changes to addiction services. The Health and Social Care Act of 2012 moved their commissioning to local authority control. With no ring-fenced funding for drug and alcohol treatment, services have been subject to repeated cuts, and frequent re-commissioning has led to a lack of continuity of care. Many drug and alcohol services are now run by third sector organisations, and are thus entirely separate from the local NHS Mental Health Trusts, which can create difficulty in providing joined up care.

Against this background, the number of people sleeping rough has increased dramatically - from an estimated 1,758 in 2010 to a peak of 4,751 in 2018. In response, that year the government launched its Rough Sleeping Initiative, with the aim of ending rough sleeping by

2027. Numbers did initially begin to fall – an effect that was boosted by the “Everyone In” campaign, which supported those rough sleeping during the Covid-19 lockdowns and saw a 37% decrease in numbers sleeping on the streets[12]. However, this has not been sustained, and the number of people in England estimated to be sleeping rough in the 2023 street count was 27% higher than 2022, at 3,898. In 2022 the cross-government Rough Sleeping Strategy pledged a further £500 million to end street homelessness.

Efforts have been made to address the potential link between this increase in rough sleeping and a lack of mental health and substance misuse care. Following the 2018 Rough Sleeping Initiative, the Department of Health and Social Care committed £30 million to specialist mental health support for people sleeping rough. In 2019, the NHS Mental Health Implementation Plan set out that all areas should have a mechanism in place to ensure their mental health services can support people sleeping rough. There are now 37 specialist mental health and homeless teams in areas of high need across England. In London, which has particularly high numbers of people sleeping rough, the Rough Sleeping and Mental Health Programme (RAHMP) was set up in 2020. This created teams of mental health practitioners working directly with outreach teams, across 16 London boroughs.

The sum of all of this activity, however, has been too little and too late, and has not amounted to the serious reform needed to deal with the mental illness that often accompanies severe social exclusion. Too many gaps exist through which people with mental illness can fall, ending up on the streets or in the unsafe and insecure parts of our housing system.

There is a lack of coherent planning to put interventions that are known to work into practice. Money is wasted in repetitive scoping exercises and in setting up pilot projects which may not receive long term commissioning despite their success. This causes considerable difficulties with recruitment and retention of specialist staff, as well as lack of continuity of care. Coupled with the rising pressures and reduced resources described above, the stand-alone initiatives and funding pots of recent years have only nibbled at the edges of the problem.

Solutions

The opportunity now is for a reset, putting plans in place to provide flexible, accessible mental health services that can provide compassionate and trauma-informed care for all, including those experiencing addiction. The building blocks are already there in the evidence and in pockets of excellent practice throughout the country.

Prevention

There needs to be good quality mental health care upstream to stop people sliding into homelessness. This means a renewed focus on providing mental health care which is accessible for all, and which catches those whom traditional services may struggle to keep engaged. A new culture needs to develop to end the so-called 'inverse care law', which states that the people who most need medical care are least likely to receive it[13]. To this end, teaching in homelessness and inclusion health should be part of undergraduate training for medical students and other healthcare professionals, ideally involving learning from people with lived experience.

In primary care, mental health needs will best be picked up - and support best given - in the context of a trusted relationship. The Government's pledge to make face-to-face GP appointments available, and to incentivise GPs to see the same patients over time, is therefore welcome, though focused action is needed to make general practice more accessible for people in inclusion health groups and for people at risk of homelessness (see the General Practice paper in this series).

Treatment and intervention

At the point of referral into secondary care, ICBs must ensure that mental health care in their areas is accessible to all: for example, the drive to further digitalisation of healthcare cannot mean that those without internet access are excluded from services.

Mental Health Trusts should ensure that people having no fixed abode, or not having a GP, are not exclusion criteria for community mental health teams at the point of referral. Similarly, becoming homeless must not be used as a reason for discharge.

For patients with serious mental illness who standard mental health teams fail to engage, there should be seamless access to assertive community treatment in all areas of the country. Assertive outreach teams have smaller caseloads, allowing more intensive and holistic care which is delivered at locations where the patient feels comfortable. ICBs have recently been reminded of their responsibility to provide intensive and assertive care to those who need it[14], and judicious use of such an approach can prevent people ending up on the streets.

People with mental illness who do become street homeless should have specialist care. There is now little need for further research into what needs be done: in 2022 NICE

published guidelines for Integrated Health and Social Care for People Experiencing Homelessness[15]. These stated that commissioners of health, social care and housing services should work together to plan and fund integrated multidisciplinary health and social care services for people experiencing homelessness. NICE also stressed the benefits of assertive outreach, and the evidence for the effectiveness of ongoing, sustained support which is "empathetic, trauma-informed, and person-led".

Focussed, outreach-based mental health teams for those who are street homeless can intervene quickly and assertively to assess and treat illness, and support people back into appropriate high-quality housing, in accordance with the principles in the NICE guideline. Evaluation of the RAMHP teams in London, which work to this model, showed that embedding mental health provision with street outreach can bring good results: 70% of those who received support did not return to rough sleeping within 12 months[16].

Despite this evidence, there is a lack of sustainable and coherent planning to ensure that services meet need. To counter this, the Homeless Health Partnership in London (part of Transformation Partners in Health and Care) has recently produced a service specification for delivering mental health care for people experiencing homelessness[17]. This gives guidance to commissioners on levels of offer needed according to the size of the rough sleeping population in a borough, or Trust area. The recommended offer for an area with minimal rough sleeping figures is a specialist homelessness "champion" role based in mainstream care; at the other end of the spectrum it advises on the specific make up of a multidisciplinary team able to support the mental health, substance misuse and physical health needs of a caseload of 50-60. This guidance can be followed nationwide. These teams should be co-produced with people with lived experience, and should receive long term funding.

Complex needs and co-occurring conditions

There have been multiple guidelines advocating for joined up commissioning and service delivery across drug and alcohol and mental health services. These include the report of the Kerslake Commission, which evaluated the success of "Everyone In"[18]. The most recent NICE guidelines for co-existing mental illness and substance misuse also stressed the need for accessible and flexible services[19]. However, as Dame Carol Black's independent review of drugs in 2021 described, these guidelines have been poorly implemented, and "access to services remains deeply inadequate"[20].

In reality, it seems difficult to change the culture of mental health teams to accept the need to treat people with addictions. To address this, teaching in substance misuse is imperative for all those who work in mental health. Psychiatrists in training may find it difficult to get jobs in substance misuse if their local Trust does not provide any addictions services: it is imperative that training programmes work to ensure they gain expertise. All mental health staff should be trained in order to assess their clients' substance use, and to deliver brief interventions when required.

Until culture change is achieved, one potential solution is specialist dual diagnosis teams to treat those with co-existing mental health and substance misuse needs – although the danger here is that these quickly become overwhelmed. Another option is to fund substance misuse services to have the ability to assess and treat mental ill-health conditions, such as anxiety, depression, and PTSD. However, this is not sufficient for people who have severe mental illness such as schizophrenia and bipolar affective disorder, who need the input of a full multidisciplinary community mental health team. There need to be quick and easy referral routes between services in crisis situations.

Hospital admission

While moving care to the community is a priority for the Government, in reality, admission to psychiatric hospital is often a necessary part of a person's journey off the streets. The utility of these admissions needs to be maximised. A lack of understanding of complexity often leads to premature discharge and repeated admission, which is both costly and hugely negative for a person's recovery. As Pathway have shown, at least 4,100 people were discharged from hospital to the streets in 2022-23[21]. Psychiatrists and other mental health and social care professionals need better training in inclusion health and assessing mental capacity, to ensure that wherever possible hospital admission only happens once.

A specialist Pathway team, offering enhanced care co-ordination, clinically-led advocacy and discharge planning that actively re-connects people with services in the community, is well-evidenced as helping to maximise the benefit of a psychiatric admission for patients experiencing homelessness, reducing use of crisis services and re-admission after the patient leaves hospital.

At the other extreme, people may stay in hospital when their mental health needs have been addressed: 57% of delayed discharges in mental health are due to a lack of social care provision[22]. Intermediate care beds can provide safe short-term accommodation following a

hospital admission: this is particularly appropriate when, as is often the case, people with multiple exclusion homelessness have significant physical co-morbidities.

Housing

In the longer term, for people to stay in accommodation – and out of hospital - there needs to be a range of appropriate housing options. Housing First is a way of providing intensive community support within stable housing, and there is evidence that it both improves tenancy sustainment and is cost effective[23]. For others, specialist onsite support may be needed. As noted by NICE, those with highly complex needs and those who are vulnerable to abuse and exploitation may well require 24-hour support. There is a need for flexibility in social care to allow timely access to Care Act Assessments, on the streets if necessary: these can be carried out by the mental health teams described above, if there is social care involvement. And there is a crucial need for good quality supported housing, including that which can support people with ongoing drug and alcohol misuse. The staff running such accommodation, often employed by the third sector, need to be able to access training in mental health and support from local NHS teams.

Conclusion

On a policy level, the solutions needed for people with multiple exclusion homelessness can appear complex, requiring joined up commissioning from multiple government departments including health, substance misuse, housing, and social care. Happily, many areas are starting to look at how they can achieve this: Surrey Heartlands ICB, for example, has recently produced a Joint Strategic Needs Assessment for people experiencing multiple disadvantage[24], co-produced with a lived experience group.

On a human level, it can perhaps be put more simply: people do best when they are treated as individuals, and their multiple needs addressed holistically. If this philosophy underlies all treatment options offered, and there is partnership working between the NHS, the third sector and people with lived experience, it should be possible to end the tragedy of people living on the streets because of their mental ill-health.

The NHS 10-year Plan is an opportunity to put fundamental reforms in place for people at the risk of the poorest outcomes – housing precarity and homelessness coupled with mental illness. Many of the actions needed are in line with the Government’s aspirations on mental

health – treating people with dignity and respect and ensuring earlier intervention, before problems spiral.

Recommendations

The Government and NHS England, working with the Royal College of Psychiatry, should ensure that mental health care is available for those who experience addiction.

- This will involve addressing the culture that drives the separate treatment of mental health and substance use issues. Actions could include making training on homelessness and inclusion health mandatory for health and social care professionals, and mental health training easily available for third sector housing workers.
- All addictions services should be funded and able to assess and treat less complex mental health conditions, and there should be easy referral routes into secondary mental health care for those found to have severe and enduring mental illness.
- ICBs should ensure that mental health teams are able to assess substance misuse disorders and deliver brief interventions to people experiencing them.

The Government should drive a focus on prevention, by ensuring that primary care services are equipped to provide longitudinal, relationship-based mental health care.

- This will rely on reforms to boost the provision of specialist general practice services for people facing social exclusion, and action to make mainstream services more accessible to people with complex needs, including homelessness (see the paper on general practice in this series).

The Government should promote early intervention by working with ICBs to ensure that Community Mental Health Teams provide easier access to assertive outreach teams, ensuring a better response to a crisis that could result in someone losing their home.

- This will require additional resource, which could come from the additional 8,500 mental health staff the Government committed to in its manifesto.

The Government and NHS England should ensure that all ICBs commission mental health care for people experiencing homelessness which is in line with NICE recommendations.

- The NHS 10-year Plan will need to reform funding and accountability mechanisms in order to put an end to the current pattern of short-term and pilot funding for specialist homelessness services.
- ICBs should explore the case for specialist 'Pathway' homelessness teams within their areas.

Over the longer term, the Government should ensure that ICBs across the country are robust in their approach to the social determinants of health.

- Lord Darzi's report highlighted that these have moved in the wrong direction in the past 15 years: for multiple exclusion homelessness to be prevented at its root, this trend needs to be reversed.

Ensure that a range of appropriate housing is available, including for those with co-existing mental health and substance misuse needs.

- The NHS 10-year Plan and Government homelessness strategy should have a set of shared outcomes on housing, health and homelessness, supported by a commitment in the long-term housing plan to build 90,000 social homes a year to meet need.

Lived Experience Perspective

Vanessa Lewin, Lived Experience Programme Volunteer, Pathway

People coming out of places like prisons, care homes or hostels face so many barriers. The reality for so many is a lack of ID, no permanent address, digital exclusion - and then there's the judgment, stigma, and language issues.

Services expect people to fit into their systems instead of the other way around. Services are few and far between, and then have such long waiting lists. People's mental health will worsen in the time spent waiting for any support. On the streets, we are not 9 – 5 people. Opening later, like 12 pm to 7 pm, would encourage more people to access the service.

Services need to be more joined-up, and led by people, not policies expecting everyone to be the same. Not all people facing homelessness are in addiction, and learning difficulties need to be added to the conversation.

Everyone needs better training. It's not just doctors and psychiatrists who need to understand homelessness, addiction, and mental health - it's anyone working in the sector. And let's bring people with lived experience into the training process and as peer workers - they know what it's really like.

Overwhelmed and burnt-out staff will have a negative impact on people accessing the services. Smaller caseloads would make a huge difference and communication about services needs to be more positive. Often people are told that the service is understaffed, overworked and budgets tight are tight - no one suffering with homelessness or mental health problems needs to be reminded of this.

Having to repeatedly retell traumatic events affects people's mental health further.

People should have more options and say in where and how they get treated. In being more holistic we can adapt to the person more, and there should definitely be more specialist services available. If you treat the person correctly, costs go down, instead of people always going through a revolving door.

I agree that people are discharged from mental health services too soon. If they're not fully recovered, they will bounce back to services, still struggling, and costing more to services. There are no set timeframes to getting well.

It should be a legal requirement to send discharge people to somewhere safe. Local community-based services are also a must. People feel more comfortable when they know and trust the professionals they're dealing with.

There has been too much talk about services, and not enough action to implement the changes needed. Lived experience should be at the heart of discussions and quality improvements such as implementation of the NICE guidelines.

References

[1] MHCLG (2020) Understanding the Multiple Vulnerabilities, Support Needs and Experiences of People who Sleep Rough in England: Initial findings from the Rough Sleeping Questionnaire

[2] MHCLG (2020) Understanding the Multiple Vulnerabilities, Support Needs and Experiences of People who Sleep Rough in England: Initial findings from the Rough Sleeping Questionnaire

[3] Homeless Link (2014) The Unhealthy State of Homelessness: Health Audit Results 2014. Homeless Link

[4] Timms and Drife (2021) BJPsych Advances: Mental health services for single homeless people

[5] Rees (2009) Crisis: Mental Ill health in the Adult Single Homeless Population: A review of the literature

[6] Timms P, Craig TKJ (2016) BJPsych: Deinstitutionalisation, imprisonment and homelessness (letter)

[7] PHE (2017): Better care for people with co-occurring mental health and alcohol/drug use conditions

[8] Office of National Statistics: Deaths of homeless people in England and Wales - 2021 registrations (2022)

[9] RCGP (2017): Mental Health in Primary Care

[10] Kings Fund (2024): Mental Health 360 - Funding and Costs

[11] Department of Health and Social Care (2024): Independent Investigation of the NHS in England

[12] Kerslake Commission (2023): Turning the Tide on Homelessness and Rough Sleeping

[13] Tudor Hart, The Lancet (1971): The Inverse Care Law

[14] NHSE (2024) Guidance to integrated care boards on intensive and assertive community mental health care

[15] NICE (2022): NG214 Integrated health and social care for people experiencing homelessness

[16] UCLP (2022) Rough sleeping and Mental Health Programme Evaluation

[17] TPHC (2024): Service Specification for Delivering Mental Health Care to People Experiencing Homelessness

[18] Kerslake Commission (2023): Turning the Tide on Homelessness and Rough Sleeping

[19] NICE (2016): NG58 Coexisting severe mental illness and substance misuse: community health and social care services

[20] DHSC (2021): Review of Drugs: Phase 2 Report

[21] Pathway (2024)

[22] NHSE (2022)

[23] NICE (2022) NG214 Integrated health and social care for people experiencing homelessness

[24] Surrey County Council (2024): JSNA Multiple Disadvantage