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Homelessness and mental health: A challenge

Introduction

Patients affected by severe mental disorders (SMDs) often experience a variety of approaches to housing based on their family and economic conditions or personal rehabilitation programmes (Geoffrey, Aubry, & Hutchison, 2010), as well as social conditions and governmental policies. Following the deinstitutionalization processes in the 1950s, when patients were discharged after the closure of psychiatric hospitals and old fashioned asylums, people with SMDs were discharged to the care of their families or to custodial houses, supportive or assisted accommodation which may have had specific rehabilitation programmes (Geoffrey et al., 2010). Consequently, many individuals with serious mental illness who had inadequate economic or familial resources ended up becoming homeless, thereby relying on shelter systems for homeless individuals or living on the streets.

Homelessness

Homelessness itself is a highly risky condition contributing to mental illness, and its association with poverty and poor resources available for living in adequate housing adds to the problem (Geoffrey et al., 2010). It is inevitable that those who are living on the streets or in housing shelters and are also additionally vulnerable due to their mental illness will become victims of violence, crimes and severe physical diseases (such as infectious diseases) with increased likelihood of mortality. Studies have shown a mortality rate which is five to six times in excess, mostly due to infectious diseases and traumatic injuries, high rates of untreated hypertension and diabetes (Geddes & Fazel, 2011). In addition, homeless patients may have no access to an adequate mental health care programme with a remarkable negative influence on their clinical and cognitive outcomes (Gaebel & Zielasek, 2015). In fact, homelessness has been shown to be strongly associated with cognitive impairment partially due to the psychiatric condition (Stergiopoulos et al., 2015). It is inevitable that international organizations have started to address issues related to social policies and structural factors which may lead to homelessness (Hwang & Burns, 2014).

Housing and rehabilitation

Families are the most common caregivers for a majority of patients worldwide, especially those with SMDs. Even if the families are committed and determined to care for their family members who have SMDs, often they do not have the skills to provide patients with professional support or rehabilitation treatments. Also, Expressed Emotion and family problems may further negatively influence psychopathology as well as quality of life. Furthermore, there is little evidence on the clinical outcome of patients affected by SMDs living with families; data available do not show significant changes in symptoms, functioning and quality of life for patients affected by psychotic disorders (Hansson et al., 2002).

Housing programmes which focus on rehabilitation often aim to combine mental health care with residential activities in order to provide patients with treatments, daily assistance and increase the amount of autonomy until they become independent for living in the community. There may be different levels of support and assistance including halfway houses, group homes and supervised apartments in a *continuum* of residential programmes (Carling, 1993; Geoffrey et al., 2010). However, the *continuum* model has been criticized because of combining housing and providing treatments with therapeutic trials. Such a combined approach has been recommended by Carling (1993), who suggests that a step-by-step integration in the community and tailored therapeutic support to patients may be the best option. In addition, supportive housing can promote group decision-making, group problem solving and conflict resolution which can enable the individuals to enhance their own individual skills so that they can better cope with the problems related to the independent living situation (Sylvestre, Nelson, Sabloff, & Peddle, 2007). Many studies on supportive housing have shown a reduction of rates of homelessness, hospitalizations, psychopathology and substance abuse, with an improvement of financial stability and quality of life (Leff et al., 2009). In contrast, supported housing can provide individualized treatments in regular housing situations, but these are not considered as a treatment setting. Patients may select the physical and geographical location, their preferred neighbourhoods and social networks. Even if the evidence on the effectiveness of these interventions is limited, the supported housing can improve personal skills and psychopathology as well as supportive conditions do (Leff et al., 2009).

The way forward

We believe that early interventions and treatments are extremely important, but they work only if individuals have addresses with an element of security in their housing

(Bhugra & Ventriglio, 2015). Modern psychiatric practice needs to take into account social determinants which may lead to poverty and homelessness among the psychiatric population, and psychiatrists must advocate for change in social policy through the prism of social justice (Ventriglio & Bhugra, 2015). The vicious cycle of homelessness and mental illness must be broken at policy as well as at clinical levels. There is thus an urgent need to ensure that homeless individuals who also have mental illness who may also be keen not to use usual approaches should have easy access to psychiatric services. Service planning and delivery may further be facilitated and become evidence-based by encouraging the development and promotion of research networks which can measure the effectiveness of housing rehabilitation in psychiatry in different settings in different countries or even different parts of the same country. As Stergiopoulos et al. (2015) have recommended, the efficacy of housing interventions in the improvement of cognitive functioning must be tested more robustly and modified accordingly. Housing and social security need to be part of innovative comprehensive campaigns and programmes in psychiatric practice. It is critical that rehabilitation needs of homeless individuals should be part of the core curriculum in the education of psychiatry trainees in order to make them aware of holistic concepts of recovery, including new values such as housing stability, citizenship, social inclusion and social justice. Housing associations and voluntary agencies should be involved in developing research and service evaluation ideas further as well as providing input into training. This approach may raise the possibility of raising adequate resources to provide efficacious and accessible services to vulnerable mentally ill homeless individuals.

Declaration of Conflicting Interests

Authors have no potential conflict of interest in drafting this editorial.

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Antonio Ventriglio[1,2], Massimo Mari[2], Antonello Bellomo[1] and Dinesh Bhugra[3,4]
[1]Department of Clinical and Experimental Medicine, University of Foggia, Foggia, Italy
[2]Department of Mental Health, Regione Marche, ASUR, Area Vasta 2, Jesi, Italy
[3]Institute of Psychiatry, Psychology & Neuroscience, King's College London, London, UK
[4]World Psychiatric Association, Geneva, Switzerland

Corresponding author:
Antonio Ventriglio
University of Foggia, V.le Pinto presso Ospedali Riuniti di Foggia, U.O. Psichiatria 71100 Foggia, Italy.
Email: a.ventriglio@libero.it