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Evidence Review

Good practice and innovation in care co-ordination and service provision for people with experience of homelessness, mental health and addiction

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Contents

Executive summary

This evidence review considers good practice, innovation and information about 'what works' and 'what works less well' in care co-ordination and service provision for people with experience of homelessness, mental health and/or addiction. It will inform the redesign of services by the ADP and Homeless Programme: Reducing Harm Improving Care (RHIC) by identifying evidence reviews and syntheses; national guidelines on best practice; and new ways of working to support people with lived experience of homelessness, mental health and addiction during and after COVID-19.

What do people who experience homelessness, mental health and addiction need from services?

Good practice and innovation in services working for people with experience of homelessness, mental health and addiction must take into account what they need from services. Research indicates a number of shared themes on perspectives which include:

- flexible and person-centred support[1 2 3]
- autonomy to make decisions[1 2 3]
- empathy and non-judgmental staff attitudes[1 2]
- trust and supportive relationships with staff[3 4 5]
- integrated and coordinated care[1 3 6]
- recognition that abstinence can be difficult[1 6]
- equal access to health services[6 7]

Findings

Evidence is limited on interventions and approaches to reduce harm and support stability in people with experience of homelessness, substance use and mental health[4 8]. However, there are a number of housing, harm reduction, and psychosocial support interventions identified in systematic reviews as effective. Evidence from these reviews presented below also includes identification of aspects of the intervention and/or its context that contribute to its effectiveness.

Integrated and coordinated care pathways

Evidence indicates that access to and delivery of healthcare and housing is better when services are integrated and coordinated around the people that use them, giving them

autonomy in decision-making[2 4 8 9]. There are two sets of standards in Scotland applicable to people experiencing homelessness or accessing drug and alcohol services:

- the Health and Homelessness Standards (2005)[10]; and
- the Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol Services (2014)[11]

Two sets of guidelines were identified that can also be applied to this population:

- the World Health Organisation (WHO) Continuity and coordination of care: a practice brief to support implementation of the WHO Framework on integrated people-centred health services: eight priorities for intervention and action in continuity and coordination of care in people centred health services[12], and;
- NICE guidelines on coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings[13].

Interventions

Evidence of the effectiveness of a number of interventions was assessed through systematic reviews. They are presented as follows: housing; harm reduction; and psychosocial interventions. Some interventions work across these categories and an integrated approach is seen as fundamental to their effectiveness.

Housing interventions

Housing interventions which support longer housing tenures are linked to a decrease in substance use, relapse and a reduced use of health services[8 14]. There is a need for a range of housing options that address individual needs and preferences[4]. Approaches should be made quickly and be led with an offer of suitable housing. It is important for accommodation to be available when this offer is made[2].

Housing interventions showing effectiveness include[2 5 8 15 16 17]:

- Housing First
- Critical Time Intervention
- No Second Night Out (NSNO)
- case management and assertive community treatment
- personalised services
- housing provision as part of hospital discharge planning for homeless people with mental illness
- residential rehabilitation

More limited evidence is found for:

- street outreach and assertive outreach
- social impact bonds

Housing interventions where there is little evidence to assess effectiveness are as follows:

- supported accommodation (in the UK)
- reconnection
- Common Ground
- Making Every Adult Matter (MEAM)
- residential communities

Housing interventions seen as lacking in effectiveness, especially compared with other interventions, include:

- hostels and shelters

Harm reduction interventions

Pharmaceutical interventions used in harm reduction approaches have been found to be effective in reducing mortality, morbidity, and substance use, but this does not necessarily impact on retention in treatment, mental illness and access to care[18]. These include: opioid replacement therapy

- take home needle and syringe provision
- supervised injecting sites
- take home naloxone
- alcohol harm reduction/managed alcohol programmes

Psychosocial interventions

Of the different psychosocial interventions available, there is not enough evidence to provide strong support to a specific intervention method that would benefit people with co-occurring mental illness and substance use disorders. Approaches that show benefit include[4]:

- cognitive behavioural therapy
- psychologically informed environments
- integrated mental health and addiction services

Interventions to end homelessness during the COVID-19 pandemic

There is currently little published evidence on the effectiveness of interventions to end homelessness during the COVID-19 pandemic. Interventions in Scotland and the UK where there is evidence of effectiveness include the following[19 20 21]:

- 'Everyone in'
- increased access to naloxone provision
- telephone and online support (provision of smart phone and data, or access to laptops)
- assertive outreach, and
- quick and easy access to opiate substitute therapy

Information on government and third sector websites on interventions from elsewhere in Scotland includes:

- postal delivery of injecting equipment provision
- home delivery of needle and syringe provision direct to service users' homes

Issues underpinning these interventions include government policy changes, for example, provision of naloxone. Reduced administrative barriers meant there was more freedom for services to make decisions and be creative, for example, low threshold opiate substitute therapy, and the easing of competition between services for funding due to the level of the crisis.

Effectiveness of services and interventions for specific subgroups

There is less evidence on what is effective specifically for subgroups such as women, young people, minority ethnic, LGBTQ and transgender people, particularly for the latter three population subgroups[4 18].

Discussion

Due to the breadth of this review, the evidence presented here is not conclusive, especially in relation to new interventions introduced during COVID-19 as information and evaluation is still emerging.

The underlying themes across interventions and approaches emphasise the need for a holistic approach with the individual patient needs at the centre. Scottish Health and Homelessness standards[10] and the Quality Principles and Recovery Policy[11] for drug and alcohol Services, plus the guidelines from WHO and NICE on care coordination[12 13] will support this, however, the potential impact of issues such as services competing for funding, and wider issues including housing availability and waiting lists for social housing must be noted.

It should also be noted that few of the identified reviews consider evaluations in mental health interventions in any depth. There is a need to identify evaluations of interventions during COVID-19 for people experiencing homelessness, including mental health and provision of alcohol harm reduction services.

Conclusion

Despite the limits and gaps in evidence on the effectiveness of interventions, there is a consensus that success is more likely when the approach suits the needs of the individual with a range of available options across housing, addiction and mental health services. There is no single intervention that suits all clients. There is also a consensus on the fundamental need for collaborative working and an integrated approach that links across housing, mental health and addiction services.

Introduction

This evidence review focuses on good practice, innovation and information about 'what works' and 'what works less well' in care co-ordination and service provision for people with lived experience of homelessness, mental health and addiction.

The aim of the review is to inform the redesign of services by the ADP and Homeless Programme: Reducing Harm Improving Care (RHIC) by providing examples of good practice and guidelines across homelessness, mental health and addiction services; care co-ordination and pathways; and new ways of working to support this group of people during the COVID-19 pandemic.

The purpose of the evidence review is to:

- support a broader understanding of what information is available regarding the current landscape
- inform service redesign and new models of care pathways
- be used as a knowledge base for key issues in redesign work for the RHIC programme.

Due to time constraints and limited published literature in the above areas, the focus is on identification of evidence reviews and syntheses and UK best practice guidelines.

What do people with lived experience of homelessness, mental health and addiction need from services?

Good practice and innovation in services working for people with experience of homelessness, mental health and addiction must take into account what users of services need. While an individual's priorities may evolve depending on personal circumstances, research indicates a number of shared themes on perspectives. These include:

- **flexible and person-centred support**: flexible and person-centred support involves help to make decisions and can include advocacy in accessing benefits or setting up utility payments, or someone to accompany them to healthcare appointments. Most importantly the individual can self-direct their support and at a speed that suits them[1 2 3].
- **autonomy to make decisions**: being able to make their own decisions (with or without support) and to make choices about their next steps reflects being treated as, and acting as, an individual and helps build self-worth[1 2 3].

- **empathy and non-judgemental attitudes from staff**: the negative impact of stigma around homelessness and addiction was felt strongly by service users. Staff who are friendly, non-condescending and treat them with respect and empathy are valued, and this encourages engagement and sustained engagement with services[1 2].
- **trust and supportive relationships with staff**: service users value unconditional support and for this support to be from someone they trust so that there is consistency and understanding of their needs. Good relationships with people they feel they can trust are cited by service users as helping to facilitate and maintain engagement. Along with this are feelings of being safe and comfortable when using a service[2 3 4 5 20 21].
- **integrated and coordinated care**: people experiencing homelessness alongside mental health and addiction issues frequently report being referred around different services, with no one service taking responsibility because they cannot address all of the individual's needs. This can cause deep frustration and a lack of engagement with services. Integrated and coordinated care which addresses all the client's issues with the client placed at the centre of the care is necessary. Specialist services are welcomed when available[1 6].
- **recognition that abstinence can be difficult**: service users can find it difficult to sustain abstinence in drug or alcohol rehabilitation hostels. For this reason help through agencies or workers would be more effective if it was not contingent upon abstinence[1 3 4].
- **equal access to health services**: despite the fact that a permanent address is not necessary to register with a GP, some service users report difficulties accessing primary care. Experiences of judgmental staff and perceptions of stigma are also reported in accessing healthcare services. Not identifying as homeless was seen as making access to healthcare easier. In addition, transport and financial issues can create barriers in physical access to healthcare services for people experiencing homelessness[6 7].

Literature search strategy

The literature search focused on identifying systematic reviews on good practice and interventions with individuals with experience of homelessness who had multiple and complex needs, such as problem substance use and/or mental illness (see Appendix 1 for search criteria and results).

Sixteen review papers were identified that focused on interventions for people with experience of homelessness, addiction, and other issues including mental health. Six papers reviewed evidence on the effectiveness of interventions[2 4 8 14 17 22]; two papers focused on health system contexts and mechanisms that allow for homeless populations to access healthcare[3 9]; one review focused on the factors that influence acceptability of social and

health interventions among persons with experience of homelessness[5]; one on substance use interventions for homeless and vulnerably housed persons[18]; one provided an overview of evidence on the relationship between homelessness and substance and alcohol abuse[22]; one reviewed evidence on peer support and overdose prevention[23]; and four on specific interventions: Housing First[16 24], residential treatment for substance use[15] and treatment with naloxone[22].

There are two sets of standards in Scotland relating to homeless, drug and/or alcohol services: the Health and Homelessness standards[10]; and The Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol Services[11]. No reviews focusing on evaluations of care coordination and/or care pathways in the homeless, drug and/or alcohol services were identified.

Guidelines setting out the key principles of care coordination in general from the World Health Organisation (WHO)[12]; and NICE guidelines on coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings[13] are outlined below.

Little published evidence was identified on new interventions arising from the COVID-19 pandemic. A rapid review of emerging evidence from Europe highlighted new services in response to COVID-19[19]. Two papers presented a case study of interventions implemented in a centre in Edinburgh supporting those with experience of homelessness[20 21].

Findings

Evidence is limited on interventions and approaches to reduce harm and support stability in people with experience of homelessness, substance use and mental health. Designing interventions to improve health and housing for this population is difficult due to the complex interplay of factors such as substance use, mental and physical health issues[2 14 8].

Integrated and coordinated care pathways

While evidence indicates that access to and delivery of healthcare and housing is better when services are integrated and coordinated around the people that use them, giving them autonomy in decision-making[2 4 8 9] there is a lack of published evidence reviewing evaluations of care coordination and care pathways in homeless, health and social care in the UK. What the literature is clear on is that integration should ensure that services collaborate and connect with practitioners across services, and patient care pathways need to be clear and easily understood by users and supported by peer advocates or staff when necessary[2 8 9].

No reviews of evaluations of care coordination and care pathways for people in the UK with experience of homelessness and mental health and/or addiction issues were identified. However, there are two sets of standards in Scotland applicable to our population group: the Health and Homelessness standards[10]; and The Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol Services[11].

Health & Homelessness standards: Implementation of the Health & Homelessness standards is the responsibility of NHS Boards. The standards underline a holistic approach to helping people out of homelessness and include the need for individuals experiencing homelessness to have equal access to health services and that individuals do not need to be alcohol or drug free to access services[11].

- Standard 1: The Board's governance systems provide a framework in which improved health outcomes for homeless people are planned, delivered and sustained
- Standard 2: The Board takes an active role, in partnership with relevant agencies, to prevent and alleviate homelessness
- Standard 3: The Board demonstrates an understanding of the profile and health needs of homeless people across the area
- Standard 4: The Board takes action to ensure homeless people have equitable access to the full range of health services
- Standard 5: The Board's services respond positively to the health needs of homeless people
- Standard 6: The Board is effectively implementing the health and homelessness action plan.

Quality Principles and Recovery Policy: the Quality Principles and Recovery Policy focus on the needs and expectations of care and support from drug and alcohol services[11]. The key points of the Recovery Policy are:

- You should be seen as capable of changing and becoming positively connected to your local community
- You should have access to information on the different pathways to recovery, including long-term recovery. This information should be provided in ways that you can understand
- You should be able to set your own recovery goals, working with others to develop a personalised recovery plan based on accurate and understandable information about your health, including a wide-ranging, holistic assessment of your needs and aspirations
- You should receive support from organisations or health and social care providers that are positive about recovery
- You should be treated with dignity and respect. If you relapse and begin treatment again, services should welcome your continued efforts to achieve long-term recovery

- You should be able to access services that recognise and build on your strengths and needs and coordinate their efforts to provide recovery-based care that respects your background and cultural beliefs
- You should be represented by informed policymakers who remove barriers to educational, housing and employment opportunities once you are on the road to recovery
- You should be able to access respectful, non-discriminatory care from all service providers and to receive services on the same basis as anyone else who uses health and social care and third sector services
- You should have access to treatment and recovery support in the criminal justice system that is consistent and continues when you leave
- You should have the choice to speak out publicly about your recovery to let others know that long-term recovery is a reality

(see Appendix 2 for Quality Principles and Recovery Policy in full).

Other relevant guidelines are the World Health Organisation (WHO) [12] which set out the key principles of care coordination in general; and NICE guidelines on coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings[13], both outlined below.

The World Health Organisation (WHO) state eight priorities for intervention and action in continuity and coordination of care for people centred health services[12]. These are:

- continuity with a primary care professional
- transitional or intermediate care
- collaborative planning of care and shared decision-making
- comprehensive care along the entire pathway
- case management for people with complex needs
- technology to support continuity and care co-ordination
- co-located services or a single point of access
- building workforce capability in delivering continuity and care coordination

NICE guidelines on coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings provide recommendations from first contact with services, through to care planning and a collaborative approach by a care needs coordinator to involve multiple agencies covering physical health, social care, housing and other support needs[13].

These recommendations include[13]:

- an emphasis on a multi-agency approach and partnership working to include physical health, social care, housing and other support services
- the client's right to be involved in discussions and to make decisions around their care, such as their care plan
- services to meet the immediate needs of the client when they present at services, recognising multiple needs and potential difficulties in accessing services due to stigma
- support to clients to stay engaged in services and to access other necessary services
- to ensure clients are not excluded from services due to substance use
- a person centred approach, to include a care coordinator to develop a care plan with the client to identify needs and support, and to work with services to implement the plan
- care plans to include a multi-agency review and discharge plan with strategies for getting back in contact with services, housing support and a crisis/contingency plan
- to ensure referrals and follow up care take place and that existing health and social care services meet the needs of clients with co-existing mental illness and substance use issues (rather than create a specialist 'dual diagnosis' service)

Key elements in providing support to people with experience of homelessness, mental health and addiction

Before focusing on the evidence on specific interventions, it is useful to note key elements highlighted across all of the reviews in providing support to people with experience of homelessness, mental health and addiction. These reflect the findings presented in 'What people with lived experience of homelessness want from services' and are:

Person-centred care

Cross sector collaboration should form the basis of a client focused approach and commissioning of services. Person-centred support that embeds choice is effective in helping long-term rough sleepers into housing and contact with healthcare services[2 25]. The person-centred approach also appears beneficial in relation to wider needs as well as accommodation. While costs are higher than for standard outreach, it is expected that the longer term costs in supporting individuals out of rough sleeping will be lower and wider impacts higher[2].

Flexibility, trust, good relationships and a lack of stigma are necessary[4 8 18]. Services should be expert led, empathetic and non-judgemental. Services should be inclusive and flexible to work with the patient's lifestyle and practitioners should work with patients to ensure that decisions focus on the patient's choice and needs[2 8 18].

Staff experience, training and expertise

Staff should have the relevant experience, training and expertise to understand the complex issues around homelessness and to know and take the appropriate action when presented with multiple healthcare needs. This should include trauma-informed practice and understanding of behaviour that is a result of trauma[4 9 14].

Funding

Long-term and secure funding for services is necessary for sustainability and staff retention and, as a result, engagement of service users[4 9]. Miller et al [4] cites evidence that longer term treatment of substance use in the homeless population (which generally would require long-term funding) is linked to better outcomes.

Early intervention

While outside this paper's focus on long term homelessness and complex needs, early intervention is noted as important in assisting individuals before they become homeless. Several such leverages can be schools; alcohol and drug services; social services and the criminal justice system. Young people especially can benefit from early intervention[2].

Availability of suitable accommodation choices

Fundamental to success of most interventions is the availability of suitable and acceptable accommodation. The lack of social housing and restricted availability of private rented accommodation impacts on offers of support[2 8].

Interventions

Housing Interventions

Provision of housing interventions which support longer housing tenures are linked to a decrease in substance, relapse and reduced use of secondary care health services[8 14]. There is a need for a range of housing options that address individual needs and preferences for example neighbourhoods, privacy, non-restrictive eligibility criteria[5].

CRISIS[2] in a rapid review on interventions to end rough sleeping, state that approaches should be quick and led by an offer of suitable and settled housing. However, the authors also note the importance of long term accommodation availability when offered. While temporary accommodation can be found for many clients, providing more permanent accommodation is challenging.

Housing provision as part of hospital discharge planning for homeless people who have mental illness helps them maintain stability in both housing and treatment[8 14].

Housing First

Housing First has been increasingly used in Europe, North America and the UK. The review by McAuley[26] notes the need to be aware of differences in operational context and ethos between countries and thus differences in implementation of Housing First. The review notes that key elements of Housing First, including a focus on service user choice, harm reduction and flexibility, were being used in the UK before Housing First as such was implemented, and this should be taken into consideration when looking at evidence from North America and Europe on effectiveness which may be in comparison to inflexible, abstinence-based services. This is reflected in the review by Public Health England (PHE)[8] which notes the effectiveness of Housing First models when client-led, involving harm reduction, a secure tenancy, an offer of open ended support and access is not conditional on compliance with treatment or behaviour change. PHE state that Housing First should not replace existing homelessness services. This is backed up by Miler et al[4] who found that while Housing First showed positive benefits in housing outcomes amongst other housing interventions, these other interventions also showed positive benefits.

To be effective in meeting the needs of people experiencing homelessness, Housing First must be part of an integrated homelessness strategy with preventative services, a range of other homelessness services and interagency working[26]. A key barrier in provision of Housing First is finding suitable and affordable accommodation[8]. High quality, intensive, flexible, and multi-disciplinary support is necessary[2].

Two systematic reviews of randomised controlled trials on Housing First compared with treatment as usual found that housing stability and quality of life improved[11 16]. Likewise, McAuley[26] and the CRISIS[2] rapid review on interventions to end rough sleeping found that Housing First had approximately 80% success in clients retaining their housing. However, evidence supporting improvements for mental illness and substance use is mixed[4 14 16]. PHE[8] suggests that there is a need for additional support for individuals to address addiction and treat mental illness. Outcomes vary across other factors in the lives of individuals in Housing First, for example addiction, mental and physical health, and social and economic integration[2 4 26]. It may result in lower non-routine use of healthcare services[16].

Evidence suggests that Housing First is effective with the majority of single homeless people with high support needs, young people and people from minority ethnic groups[2 26]. McAuley[26] also notes that although evidence is limited, intensive service provision for single homeless individuals with high and complex needs can achieve similar results to Housing First. An example is the Tenancy Sustainment Team model which provides practical support to people in the form of accompanying them to appointments, liaising with landlords and helping them access benefits when moving into their own accommodation. Miler et al[4] note that Housing First's flexible and choice led approach and the inclusion of clear and realistic setting of client goals may benefit other housing interventions.

The costs of Housing First were noted but are seen as offset by the potential long-term savings, for example in health and criminal justice systems[2].

CRISIS[2] note little evidence of whether scatter-site and congregate models of housing are more effective but suggests that there are no significant differences in housing retention or health outcomes across the two. Congregate models tend to have higher co-occurring factors such as substance misuse, and recovery may be influenced by the behaviour of other residents. Scatter site models are generally preferred by most homeless people although loneliness is more likely than in congregate models.

Residential treatment

A single systematic review of residential treatment for substance use was identified[26]. de Andrade et al found that evidence indicates residential treatment may be effective in reducing substance use and there are positive outcomes for co-existing substance use and mental health disorders. Evidence also indicates that treatment may improve criminal justice and social outcomes. In considering the impact of length of treatment, de Andrade et al found some evidence to indicate a significant impact on substance use can occur in a 28 day programme. A clear need for integrated health treatment was noted. The inclusion of psychological therapy in residential treatment in the majority of the studies in the review suggests that psychological support should be included in treatment (this includes cognitive behavioural therapy, mindfulness and/or motivational interviewing). Authors note a lack of consensus based best practice treatment guidelines[15].

The effect of residential treatment on housing is reported as under-researched by de Andrade et al[15]. Likewise, by Menzies et al in a systematic review on interventions to prevent homelessness and increase residential stability in homelessness, however Menzies et al do report that when compared to usual services, residential treatment for clients with mental health or substance use issues may reduce homelessness and increase housing stability[17].

No second night out (NSNO)

Two reports, PHE[8] and CRISIS[2], discuss evidence on the effectiveness of NSNO. NSNO varies in how it is implemented but generally consists of assertive outreach, public engagement, support to access temporary accommodation and/or reconnection[2]. PHE[8] state that NSNO should be seen as one of a number of models and approaches to tackle multiple and complex needs of individuals who sleep rough or on the street. There is evidence of effectiveness of supporting some rough sleepers into temporary accommodation and in improving services and partnership working around rough sleeping although success is mainly with new rather than long term rough sleepers[2 8]. Evidence mainly focuses on short term housing outcomes[2].

Challenges with NSNO are stated as getting buy-in from all partners, time-limited funding and resources, including staff[2 8]. CRISIS[2] also report evidence of dissatisfaction from some service users of the level and type of support provided, for example offers of 'substandard' accommodation. Alongside this is the lack of availability of suitable and affordable accommodation.

Case management

There is evidence that homelessness can be reduced along with an improvement in psychiatric symptoms when there is case management with assertive community treatment or other forms of high intensity case management[17]. Assertive community treatment is specified as a multi-disciplinary team, available 24 hours in the community and with caseloads that allow staff to spend the time that is needed with each client. This is in comparison with standard case management in the homeless with severe mental illness[12 26 25].

Case management results in reduction of substance use in people with lived experience of homelessness compared with treatment as usual[4].

Critical Time Intervention

Critical Time Intervention is an example of case management. It involves the provision of intensive support to an individual during transition from accommodation or service, such as prison or hospital, who is at risk of homelessness. Critical Time Intervention involves direct support, identification of the individual's needs and the resources available to help them, time to adjust to the support systems and transfer of care into the community. Support is decreased over time[4].

Critical Time Intervention is noted as a promising intervention by Menzies et al[17] and Miler et al[4], with the proviso that there is a lack of evidence at present comparing its effectiveness with other interventions. Evidence from the USA and Denmark indicates its effectiveness for some individuals in the same way as other forms of flexible support or specialist accommodation based services[4].

Hostels and shelters

The nature of emergency and temporary accommodation provided by hostels and shelters varies widely[2]. CRISIS[2] review states that most evidence on its effectiveness focuses on larger-scale emergency accommodation where there is limited support and moving on arrangements are frequently challenging. While some people do find their way onwards to independent accommodation, hostels and shelters have high abandonment and eviction rates.

While they provide a place to sleep there is a risk of increased or onset of drug use, increase in mental illness and other health issues, and as a result many people experiencing

homelessness refuse to use hostels and shelters. Concerns are expressed particularly around women, young people, transgender people and those with multiple and complex needs who struggle to cope with rules.

Overall hostels and shelters are not seen as an effective intervention due to the often dangerous environment; unsuitability for many including those with complex needs; and the challenging environment which means they can be difficult to staff[2].

The Homeless Person's (Unsuitable Accommodation) (Scotland) Order (UAO)[27] states that no homeless households can be placed in temporary accommodation for more than seven days if it is unsuitable as defined by the legislation. Hostels and shelters are among the types of accommodation that in practice fall into the definition of 'unsuitable'.

There was no significant evidence on the effectiveness of supported accommodation in the UK (referral-only, high support units in purpose-built buildings run by professionally trained staff)[2].

Personalised services

Personalised services focus on the strengths and preferences of individuals and place them at the centre of their care and support with use of personal budgets in social care and personal health budgets in the NHS. PHE[8] notes evidence of the effectiveness of personalised approaches in engaging rough sleepers previously difficult to reach and supporting them through services to move off the streets. The effectiveness of this model stems from giving people the ability to have a choice, flexibility in approaches and trusting relationships with staff. These elements support rough sleepers to engage with other local services[7 8].

Personal budgets have been used to support long term rough sleepers to identify their needs with help from a support worker. Evidence cited in the CRISIS report[2] is limited to pilot projects which report that approximately 40% to 60% of clients secure and maintain accommodation. Potential impacts may also include improved health, reduction in substance misuse, more appropriate access to health services and improved engagement with services. There was no analysis in relation to subgroups of people experiencing homelessness.

Personal budgets are seen as potentially cost effective in the long term. Barriers to effectiveness include bureaucracy around budget payments, an increased workload for support workers compared to standard outreach, and the availability of accommodation and specialist support. Effective collaborative working is necessary[2].

Street outreach and assertive outreach

Street outreach is found in some form in interventions such as Housing First, NSNO and personalised budgets which aim to help rough sleepers. It includes assertive outreach which

targets the most difficult to engage rough sleepers with complex needs[2]. Street outreach aims to end homelessness by providing multi-disciplinary persistent and assertive support.

The CRISIS[2] report states there is limited evidence on the impact of assertive outreach. Evidence from Rough Sleeper services in the UK indicates that it can significantly reduce the number of rough sleepers but there is little evidence on wider support needs and service costs. It has been found that outreach which results in permanent accommodation has higher tenancy sustainment than temporary accommodation. Accommodation in shared or congregate housing appears to have less successful outcomes and is less desirable than separate self-contained accommodation. CRISIS[2] note no evidence on long term impact of assertive outreach.

Assertive outreach appears most effective when the approach and support is intensive and tailored to the individual. Enforcement should be used as a last option. Assertive outreach has been linked to reconnection approaches[2].

As with other approaches to addressing homelessness, effectiveness of assertive outreach is dependent on the availability of permanent accommodation suitable for the individual client and multi-disciplinary support. There are reports of negative perceptions by rough sleepers about outreach, however, the CRISIS[2] report indicates that assertive outreach is viewed as a key intervention for individuals with most complex needs.

Making Every Adult Matter (MEAM)

MEAM was reported as a number of pilot projects to coordinate existing local services to improve the provision of support to individuals suffering from multiple needs and exclusions. PHE[8] report there is little conclusive evidence on this intervention. No other systematic reviews with evidence of this intervention were identified.

Common Ground

Common Ground is congregate site supported/supportive housing for highly vulnerable rough sleepers placed within a community of people on low to moderate incomes with no lived experience of homelessness. The accommodation is newly built with a concierge service available 24 hours and health and social support, leisure facilities and shops on-site. Rules and surveillance can be restrictive for some clients[2].

The evidence base on this intervention is very limited[2]. Identification of evidence around its impact has been complicated by it sometimes being included under Housing First.

Common Ground began in the USA and has become common in Australia. Evidence on retention rates indicate these vary, possibly due to this model not being suited to all clients. Evidence on health improvement is mixed, CRISIS[2] noting that mental health outcomes do not appear as good as for Housing First. There is little evidence on substance misuse which indicates it does not decline. The Crisis[2] review notes generally positive outcomes relating to

quality of life and social integration for most clients. Some evidence suggests divisions between supported and unsupported tenants, with a lack of interaction between the two.

Challenges include effective partnership working to provide the appropriate level of support to clients[2].

Social impact bonds (SIBs)

SIBs use private investment to fund specific providers to deliver a social service or programme. These are usually already in place and evidence based. SIBs have been used to address homelessness in countries including the USA, Canada, Australia and Portugal and on a trial basis in the UK[2].

The CRISIS[2] review states limited evidence on the effectiveness of SIBs and no other systematic reviews were identified that assessed the evidence base of this intervention.

Evidence from an SIB in London indicated that stable housing outcomes were reported for 64% of clients who were still participating by the end of the programme and evidence of a positive effect on housing sustainment[2].

The programme reported better results than expected on full time employment although outcomes on part time employment and volunteering were not as good. No long term evaluations were identified.

The complexity of the SIB model is stated as a challenge as it includes requirements around outcomes and targets. However, SIBs were reported as supporting positive outcomes for long term rough sleepers, more personalised services and access to funding for service expansion[2].

Residential communities

Although residential communities are for people experiencing homelessness, they predominantly focus on other areas of people's lives. The CRISIS[2] review notes residential Therapeutic Communities (TCs) which support clients to recover from substance misuse, and Emmaus communities, where residents live and work in self-financing communities.

TC approach: there is evidence supporting this approach although further research is required on its effectiveness in homeless shelters (as implemented in the US)[2]. Evidence indicates the TC approach is effective in reducing substance misuse and mental health problems, however, attrition rates within communities are high. There appears to be little evidence of impact on housing outcomes for TCs or Emmaus communities[2].

Emmaus communities: evidence is limited and indicates that the benefit lies in the provision of a sense of purpose and skill development. These communities appear to suit those with little work experience or education, people who like communal living, ex-offenders and people with mild learning difficulties. There are seen as less suitable for the most chaotic

street homeless, women, young people and ethnic minorities. There are a number of rural Emmaus communities in the UK[2].

Reconnection

The CRISIS[2] report has the only identified review of evidence on Reconnection, which returns rough sleepers to their 'home' area (international and domestic). There appears to be little evidence of its effectiveness and outcomes. The type of support varies from intensive assessment and support in moving to the recipient area to very little support at all. A single UK study found that outcomes range from accessing housing and support services to rough sleeping in the recipient area, return or refusal of the offer. Evidence from service users indicates that the process can be distressing especially when long term homeless or when there are reasons for not wanting to return to an area. Newly homeless or people who have only recently arrived in a new area, and/or have connections or have used services in the recipient area are most likely to experience an effective reconnection[2].

Intensive and individually focused support is necessary for reconnection to be successful, as is the need for adequate relevant services in the recipient area and willingness to return by the individual[2]. Reconnection, while seen as appropriate in specific cases, has raised concern over ethical issues for example potential denial of services to those with no recognised local connection. Concerns lie in particular around potential lack of support in the recipient area and the lack of a person centred focus[2].

Pharmaceutical interventions in harm reduction

Evidence on pharmaceutical interventions used in harm reduction approaches are summarised by Magwood et al[18] as effective in reducing mortality, morbidity, and substance use, but having a variable effect on retention in treatment, mental illness and access to care. Evidence suggests that harm reduction interventions may lead to less risky behaviour and fatal overdoses in people with problems with substance use[4]. Magwood et al[18] conclude that individuals experiencing homelessness and who have substance use problems need low threshold services in close proximity to where they live plus integrated housing services and support.

Mercer et al review the role and value of peers in creating trust in harm reduction services, for example overdose prevention interventions and education, and naloxone supply and administration[23]. This role includes helping people accessing opioid substitution treatment and supervised injection facilities to re-engage with the community. However, while reporting the value of peer support in harm reduction services, Mercer et al stress the need for appropriate training and support (which recognises the realities of having lived or living experience of substance use) and appropriate renumeration for work)[23].

Opioid replacement therapy

The reviews by Luchenski et al[14] and Miler et al[4] note the effectiveness of opioid replacement therapy (methadone and buprenorphine although methadone maintenance appears more successful in sustaining people in treatment). Evidence on detoxification indicates that many patients will relapse[14].

Treatment with opioid replacement therapy should consider the preferences of the individual patients and characteristics including risk factors such as mental illness, unstable housing or homelessness and lack of social support that makes them vulnerable to dropping out[4 28].

Take home needle and syringe provision

Miler et al note evidence of the effectiveness of needle and syringe programmes which provide clean injecting equipment to reduce unsafe injecting and the resulting potential for contracting blood borne viruses by sharing used syringes[28].

Supervised injecting sites

Injectable heroin under intensive clinical supervision is supported for long-term heroin users who continue to use heroin while on opioid replacement. While supervised injecting sites do not appear to lead to a decrease in people injecting drugs, Luchenski et al[14] and Magwood et al[18] note evidence that supports supervised injecting sites in reducing deaths from overdose. Supervised injecting sites also reduce calls to ambulances, public injecting, needle sharing and discarded needles[4 14 18]. Evidence also indicates that supervised injecting sites can act as a link to health and social care services[18].

Take home naloxone

Evidence on the effectiveness of take home naloxone programmes indicates a strong benefit in reducing deaths from overdose but there is a lack of systematic reviews of studies looking at naloxone use in homeless or vulnerably housed populations[4 19 26]. Magwood et al[18] state that recent studies suggest that take-home naloxone programmes may be feasible in current homeless services.

Alcohol harm reduction

The systematic review by Magwood et al[18] states evidence that managed alcohol programmes reduce or stabilize alcohol consumption and that few studies report deaths. Evidence on the use of naltrexone to prevent relapse in people with previous alcohol dependence is insufficient to support its use in treatment[14].

There is some evidence around housing interventions that require the client to abstain from using alcohol and/or drugs compared that those that do not require this, with signs that abstinent-contingent housing may have a greater impact on sustained abstinence[8]. Interventions that provide support with abstinence are also seen as more effective in

reducing substance use than usual treatments, PHE[8] identifying post-detoxification stabilisation, abstinent-contingent work therapy and an intensive residential treatment programme.

Psychosocial interventions

Luchenski et al[14] state there is little evidence to say that one psychosocial intervention is best for people with severe mental illness and substance use disorders. There is evidence that cognitive behavioural therapy in combination with motivational interviewing can support improvement in mental health and reduce drug use.

PHE[8] notes Psychologically Informed Environments, a concept that considers the emotional and psychological factors in a client's life to enable them to make changes, usually behavioural or emotional, in their lives. Psychological frameworks include: humanistic; psychodynamic; cognitive behavioural therapy; and dialectic.

For people experiencing co-occurring serious mental health problems, homelessness and alcohol/drug use (COSMHAD) Miler et al[4] state the need for integrated mental health and addiction services but again, research is required to identify what aspects of such services and programmes are the most beneficial for service users. More detailed discussion of the impact, effectiveness and limitations of these interventions is presented in the following publications:

- Ending rough sleeping: what works? An international evidence review: Crisis, December 2017[2]. Mackie, P., Johnsen, S., Wood, J.
- Evidence review: Adults with complex needs (with a particular focus on street begging and street sleeping) Public Health England, January 2018[8]. For further reading: Section 9 explores interventions that may support efforts to prevent and reduce homelessness.

Effectiveness of services and interventions for specific subgroups

There is some evidence on what is effective specifically for subgroups such as women and young people, but less for minority ethnic, LGBTQ and transgender people. Evidence for women and young people highlights the need to feel safe and secure in services and accommodation. Parenting and family interventions are effective for women. For both women and especially for young people, trust in staff and services is key[4 5]. This underlines the need for a range of approaches and options depending on the circumstances and combination of needs of the individual. Mental health and stigma are particular issues for women and young people who may have frequently experienced violence and poverty[2 4 5]. While early intervention is important for all homeless people it is noted as particularly key

with young people experiencing homelessness[2 5 8]. Cognitive behavioural therapy is reported as beneficial with women and young people[14].

Interventions to end homelessness during the COVID-19 pandemic

There is currently little published evidence on the effectiveness of interventions to end homelessness during the COVID-19 pandemic. Interventions in Scotland and UK-wide[19 20 21] include the following:

'Everyone in'

The swift rehousing of individuals living on the street into hotels was perceived as a successful response to the immediate issues of protecting rough sleepers against COVID-19 despite some challenges in placing a number of people with complex needs within the same hotel. This allowed services to identify new homeless people in need of support, including those with no recourse to public funds. It provided the opportunity to facilitate engagement with other services for example health and social care. For some individuals this has supported the possibility for being housed[19 20 21].

Parkes et al[20 21] published two papers on a case study of a service in Edinburgh. These papers report interventions put in place during the pandemic to support clients. In addition to rehousing of people experiencing homelessness in hotels and hostels (see 'Everyone in' above) the following interventions are discussed (see also: How the Covid-19 pandemic is fast-tracking the move to digital platforms within addiction services (nhsapa.org) for example of how the pandemic led to digital technology being used in addiction services):

Telephone and online support: Clients who did not have smart phones or were unable to go online were provided with smartphones and data (via various sources of funding). This enabled staff to be proactive in supporting clients and enabled groups to meet online. Feedback from service users indicates appreciation of regular phone calls to check up on them (or a chat) and of the continuation of groups online. Smartphones and online access (hostels provided laptops) enabled Community Psychiatric Nurses to make contact with individuals. The fact they were provided and trusted with smartphones was also reported as facilitating trust from service users and strengthening relationships with staff. Smartphones and online support was feasible and acceptable to service users[20 21].

Opiate substitute therapy: Access to methadone was simplified. The homeless centre in the Parkes et al[20 21] case study was able to initiate and provide methadone easily and quickly via a multi-disciplinary health prescribing service located on the premises (some in person contact continued at the service during the pandemic once the appropriate restrictions and equipment were in place). The threshold for beginning medically assisted harm reduction was lowered, and the paper states evidence of individuals accessing opiate substitute

therapy for the first time. Additional staff training was established in the opiate substitute therapy and injecting equipment provision services[20 21].

The Harm Reduction Team at Spittal Street, Edinburgh set up a Rapid Access Clinic, a quick access same day and multi-disciplinary Opioid Substitute Therapy clinic to provide access to treatment for substance users who might not be accessing their GP at this time[29]. The clinic was staffed by a GP with Special Interest, a prescribing pharmacist and a harm reduction specialist nurse. Opioid substitute therapy was initiated on the same day as presentation and assessment, if appropriate. BBV testing, naloxone training and supply, injection equipment provision and harm reduction advice was also provided[29].

Naloxone provision: Prior to COVID-19 access to naloxone was only through the drug treatment service. Parkes et al[20 21] note that the centre worked together with services to enable distribution of naloxone, provision of injecting equipment and to enable swift access to the multi-disciplinary health clinic.

Scottish Families affected by Alcohol and Drugs set up an online 'Click and Deliver' take-home naloxone service which enabled anyone living in Scotland aged 16 years or more who might witness an opioid-related overdose to order a naloxone kit[30]. Training was provided with the kits, if needed. The service began in May 2020 and by 19 August had sent out 86 kits across 21 area drug partnership areas. Feedback was reported as positive[30].

Assertive outreach: An assertive outreach approach was used in taking services to people for example setting up a multi-disciplinary health clinic within the service and providing quick and easier access to opiate substitute therapies.

Issues underpinning these interventions include government policy changes for example provision of naloxone. Reduced administrative barriers meant there was more freedom for services to make decisions and be creative, for example low threshold opiate substitute therapy. An increase in integrated work to address healthcare and social needs is reported.

Parkes et al[20 21] note strong and supportive management within the service in the case study, and staffing which includes people who have lived experience. Although online and telephone support was beneficial, service users valued one to one contact and the comfort of the physical space of this service. It was perceived as a 'safe' setting and one that is non-medical.

The authors also note that funding sources and potential competition for funding between services do not encourage partnership working in non-COVID times. The easing of this competition due to the level of the crisis helped services to work closely[20 21].

There was a lack of provision of alcohol harm reduction services for the homeless and/or alternatives during lockdown. A Managed Alcohol Service is amongst the papers' recommendations[20 21].

While it has proved difficult to identify evaluations of interventions implemented during COVID-19, information on government and third sector websites on interventions from elsewhere in Scotland includes:

Postal delivery of injecting equipment provision: postal delivery of injecting equipment was carried out during COVID-19 to provide safe injecting equipment during lockdown. While guidelines recommended this method of provision[31] prior to the pandemic, it had not been implemented. The Scottish Drugs Forum (SDF) website[32] reports trials in Grampian, Highlands and Tayside (with additional provision via home delivery and naloxone by post also being offered by some services).

No evaluation of this has been identified to date, but the SDF state that early reports found the service well received, helping people living in rural areas access safe injecting equipment and reducing stigma around picking equipment up in person from services. Potential challenges noted were the disposal of used needles and syringes and fewer opportunities for services to engage users face to face in harm reduction interventions[32].

Home delivery of needle and syringe provision direct to service users' homes: home delivery of needle and syringe equipment could be organised by phone, text message or during video consultations. The NHS Substance Misuse Provider Alliance website[33] states that this was delivered pre-packaged and with additional paraphernalia provided in case the service user ran out before the next delivery. It could also be collected directly from the service (with arrangements in place to minimise contact during lockdown restrictions). Telephone support was available.

Peer distribution of needle and syringes was encouraged by asking service users if they knew of anyone else who needed this service, and additional equipment provided for distribution. Service users were also offered naloxone at the point of contact with the service. No evaluation was identified.

Discussion and conclusion

Due to the breadth of this review, the evidence presented here is not conclusive, especially in relation to new interventions introduced during COVID-19 as information and evaluation is still emerging. Few of the identified reviews consider evaluations in mental health interventions in any depth. There is a need for identification of evaluations of interventions during COVID-19, including mental health and provision of alcohol harm reduction services.

The underlying themes across interventions and approaches emphasise the need for a holistic approach, removal of stigma and choice and control for individuals. The Health and Homelessness standards[10], the Quality Principles and Recovery Policy[11] and the WHO and NICE guidelines on care coordination[12 13] will support this. However, the potential impact of

duplication of services, services competing for funding, and wider issues including housing availability and waiting lists for social housing must be noted.

Despite the limits and gaps in evidence on the effectiveness of interventions, there appears to be a consensus view that:

- success is more likely when the approach suits the needs of the individual who has access to a range of available and integrated options across housing, addiction and mental health services
- there is no single intervention that suits all clients
- there is a fundamental need for collaborative working and an integrated approach that links across housing, mental health and addiction services.

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Appendix 1

Methodology:

Search criteria:

Keywords:

1. homeless AND multiple complex needs; homeless AND addiction AND mental illness; homeless AND substance use AND mental illness; homeless AND COVID-19
2. care coordination; care co-ordination; care pathways; care coordination AND homeless; care co-ordination AND homeless; care pathways AND homeless

Database search record	
Database:	**Search strategy** (inc. limits and filters)
Cochrane library	Homeless care coordination 0 Homeless complex care ~~10~~ 0 Care pathway ~~44~~ 0 Care coordination ~~45~~ 0
BMJ Best Practice Evidence Summaries	Homeless and COVID 0 Homeless 0
CEBM	Homeless AND COVID 0 Homeless 0
Evidence Aid	2
ProQuest Public Health	Limits: 2010 -2021, English language only To include: journals, evidence based healthcare, literature review, report Homeless complex needs ~~16~~ 7 Homeless AND care coordination 0 Care coordination ~~4~~ 0 Homeless pathway ~~129~~ 10 Rough sleepers ~~10~~ 1 Mental health homeless 9,883 Mental health illness ~~6132~~ Limits as above 5
EMBASE Sept 03 HMIC OVID Medline 1946 – Sept 03, 2021	Homeless AND complex needs Limits as above ~~61~~ 0 Homeless AND care coordination ~~182~~ 0

Grey literature sources in alphabetical order:

AHRQ	Kings Fund	Public Health Scotland
CRISIS	LGIU	SCIE
Groundswell	NCBI	Scottish Drugs Forum
Health Foundation	NHS England: Improvement Hub	Scottish Government
Healthcare Improvement Scotland	NHS Substance Misuse Provider Alliance	Shelter
Heriot Watt University	NICE	St Mungos
Housing First - Homeless Network Scotland: we are all in	Pathway – Healthcare for Homeless People	University of Stirling
Joseph Rowntree Foundation	Public Health England	University of York Centre for Housing Policy

Limits: search limited to systematic reviews, evidence reviews, rapid reviews and literature reviews from peer reviewed journals and grey literature; past 10 years only; initial search UK only, widened to include reviews of international literature, English language only

Scope: syntheses of key findings

- national guidelines and standards
- national level literature for overview of best practice. initial search to be UK only
- COVID-19 innovations – March 2020 onwards
- evidence on living experience identifying service user need

One researcher carried out the initial search. A second researcher ran a search as a check and to identify further papers. Ten systematic, evidence or rapid reviews were selected; two peer reviewed papers were identified on COVID-19 interventions; one report of COVID-19 response across Europe. Follow up of links identified web-based evidence of two COVID-19 interventions.

Appendix 2

Drug and Alcohol use

[The Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol Services - gov.scot (www.gov.scot)](#) August 2014

RECOVERY PHILOSOPHY

1. **You should be seen as capable of changing** and becoming positively connected to your local community.
2. **You should have access to information on the different pathways to recovery**, including long-term recovery. This information should be provided in ways that you can understand.
3. **You should be able to set your own recovery goals,** working with others to develop a personalised recovery plan based on accurate and understandable information about your health, including a wide-ranging, holistic assessment of your needs and aspirations.
4. **You should receive support from organisations or health and social care providers that are positive about recovery.**
5. **You should be treated with dignity and respect.** If you relapse and begin treatment again, services should welcome your continued efforts to achieve long-term recovery.
6. **You should be able to access services that recognise and build on your strengths and needs** and coordinate their efforts to provide recovery-based care that respects your background and cultural beliefs.
7. **You should be represented by informed policymakers** who remove barriers to educational, housing and employment opportunities once you are on the road to recovery.
8. **You should be able to access respectful, non-discriminatory care from all service providers** and to receive services on the same basis as anyone else who uses health and social care and third sector services.
9. **You should have access to treatment and recovery support in the criminal justice system that is consistent and continues when you leave.**
10. **You should have the choice to speak out publicly about your recovery** to let others know that long-term recovery is a reality.

THE QUALITY PRINCIPLES

1. You should be able to quickly access the right drug or alcohol service that keeps you safe and supports you throughout your recovery.
• The majority of people should wait no longer than three weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.

- Nobody should wait longer than six weeks to receive appropriate treatment and support. If you are experiencing a wait that is approaching six weeks, contact your referring agency or local Alcohol and Drugs Partnership

2. You should be offered high-quality, evidence-informed treatment, care and support interventions which reduce harm and empower you in your recovery.

- You should be treated fairly and equally, with respect and dignity, as a person able to make your own choices.
- You should be able to easily access safe, secure and comfortable surroundings when engaging with the service.
- The choice of interventions should be based on the best available evidence and agreed guidance.
- You should have access to a range of recovery models and therapies which should help improve different areas of your life and move forward at your own pace.
- You should have access to harm reduction advice which might include safer use, managed use and abstinence.
- With your agreement, your information may be shared with other services and it should be made clear to you when this might happen without your agreement.

3. You should be supported by workers who have the right attitudes, values, training and supervision throughout your recovery journey.

- Workers should be welcoming, work in a person-centred way and believe in your ability to change and recover.
- Workers should provide timely, evidence-informed treatment and support that is right for you.
- Workers should provide support that is trauma-informed and recognise any current or previous trauma you are dealing with.
- Workers should provide you with harm reduction advice, this may include safer use, managed use and abstinence.
- Workers should support you to set your own recovery goals and to manage your own care and support.
- Workers should talk to you about plans and arrangements for you moving through the service and/or reducing/ending your current contact with the service.
- Workers should encourage and help you to connect with a recovery community or mutual aid group.

4. You should be involved in a full, strength-based assessment that ensures the choice of recovery model and therapy is based on your needs and aspirations.

- Your assessment should be based on your strengths, taking account of your recovery capital.
- Your assessment should be done in a sensitive and supportive way.

- Your assessment should identify any traumatic events in your life which may have affected you.
- You should be told about the range of treatment options available to you.
- Your views should be listened to and used to develop your personal recovery plan.
- Assessment is part of an ongoing process and could be carried out over more than one session. This should not be a barrier to accessing services quickly.
- You should be told about the reasons for, and benefits of, your worker recording information about your recovery journey on local and national data systems. With your consent, your information may be shared with other services and it should be made clear to you when this might be done without your permission.

5. You should have a recovery plan that is person-centred and addresses your broader health, care and social needs, and maintains a focus on your safety throughout your recovery journey.

- Your recovery plan belongs to you; the actions laid out in it are achieved in partnership between you and services.
- Your recovery plan should be reviewed regularly, at a time agreed between you and your worker.
- Your recovery plan should include information on reducing harm.
- Recovery plans should aim for stable recovery beyond treatment into aftercare.
- Recovery plans should detail further services you may need to access as part of your progression through treatment and care back to the wider community.
- Recovery plans should look towards you moving on from the service, in line with your aspirations, at a time agreed by you and your case worker. Support for this should include relapse prevention advice and assertive engagement with a local mutual aid group or recovery community.
- If you relapse you should be treated with the dignity and respect that welcomes your continued effort to achieve your recovery goals.
- You should be offered a copy of your recovery plan.

6. You should be involved in regular reviews of your recovery plan to ensure it continues to meet your needs and aspirations.

- Your review should include an assessment of your strengths and recovery capital.
- Your review should include an assessment of the effectiveness of your current treatment to help you achieve your recovery goals.
- As you progress on your recovery journey, your personal plan should be reviewed to reflect the changes in your situation.
- Improving your situation should involve discussing areas in your life such as your aspirations for the future, wider health needs, family, children, finances, education, employment and housing, and the services or supports which could help you achieve these.

• If you need to, you should be supported to access wraparound services such as housing, volunteering, employment etc. Providers of these services should treat you with dignity and in a non-discriminatory way.
7. You should have the opportunity to be involved in an ongoing evaluation of the delivery of services at each stage of your recovery.
• You should have the opportunity to have your say in how services are delivered. • You should be told about your responsibilities and what you can expect from the service (supported by the Recovery Philosophy). • You should be told about how to complain if you are unhappy with the service. • You should be told about independent advocacy services that can help you be heard.
8. Services should be family inclusive as part of their practice.
• Family can mean those people who play a significant role in your life. • Family members can only be involved in your recovery journey if you want them to be. • You may want to involve other people who can support your recovery. The service should encourage and help you to do this. • The service should help you minimise the impact that your drug or alcohol use may have on those around you. • If you have children, their needs and wellbeing will be a primary concern. • The service should be aware of the needs of members of your family and those you live with and, if needed, seek support for them.

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Improvement Hub
Healthcare Improvement Scotland

Edinburgh Office	Glasgow Office
Gyle Square	Delta House
1 South Gyle Crescent	50 West Nile Street
Edinburgh	Glasgow
EH12 9EB	G1 2NP
0131 623 4300	0141 225 6999

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