Working with Homeless Men in London: A Mental Health Service Perspective

James Duffy and Andrew Hutchison

Introduction

2016 marked the 50th anniversary of Jeremy Sandford and Ken Loach's powerful drama, 'Cathy Come Home'. This seminal film (released in 1966) was shocking on many fronts; not least because it depicts a family's descent into poverty and homelessness. In doing so, the film challenged many of the commonly accepted beliefs and assumptions about those affected by homelessness and its underlying causes. The characters depicted, a woman and her family, were a far cry from the stereotypical 'tramp', 'hobo', or 'vagrant' of popular culture and parlance, and were not who the viewer might have expected to end up outcast by society.

50 years on, in the era of 'I, Daniel Blake', homelessness in the UK shamefully remains a huge social issue and is linked to the broader housing crisis and welfare reforms depicted in the film. In fact, the government has recently been directly implicated in rising rates of homelessness and accused of taking a 'light touch approach' to resolve the situation (National Audit Office 2017).

J. Duffy (✉)
South London and Maudsley NHS Foundation Trust, London, UK
e-mail: james.duffy@slam.nhs.uk

A. Hutchison
Derbyshire Healthcare NHS Foundation Trust, Derbyshire, UK
e-mail: andrew.hutchison1@nhs.net

© The Author(s) 2019

J. A. Barry et al. (eds.), *The Palgrave Handbook of Male Psychology and Mental Health*,
https://doi.org/10.1007/978-3-030-04384-1_26

Homelessness has now taken on different guises, with new terminology, which includes less visible groups, i.e. 'the hidden homeless' and 'sofa surfers'. This makes it harder to estimate numbers, and in fact, there are no national figures for the total number of homeless people within the UK; though evidence reveals that numbers continue to rise and are estimated at over 250,000 (Shelter 2016).

It is now particularly important to be specific about what populations and homeless groups we are referring to, as there may be very significant differences between the problems faced, the reasons for becoming homeless, and the possible solutions to help people. This chapter will focus on the most extreme form and most at risk group, those who are rough sleepers.

Recent rough sleeping estimates for England published by the Department for Communities and Local Government (DCLG 2016) suggest that the number of people sleeping rough has more than doubled since 2010. Within London, data recorded on the Combined Homelessness and Information Network (CHAIN[1]) for 2016–2017 reveal a 25% rise in rough sleeping since 2013–2014.

Different populations are increasingly ending up being forced onto the street. These include the young, people from other countries, and women. Although the overall gender split has reduced, male rough sleeping still vastly outweighs women. Of the total number of rough sleepers recorded in London during 2016–2017, 85% were men. These figures were also reflected in a recent audit by START, a specialist mental health service for street homeless people in South London, who found a near identical breakdown of gender for the rough sleepers under their care, with 82% men.

While the figure of 85% is widely reported by organisations working with street homeless people across the UK (e.g. St Mungo's 2016a), there is little published literature to explicitly explore the underlying reasons linked to this observed gender imbalance.

A storm of social factors has multiplied the numbers of rough sleepers over recent years: shortages of housing and the rising costs of renting; cuts to services including funding for Supporting People; welfare reforms, e.g. the so-called 'bedroom tax' and caps on Housing Benefit; as well as other international factors, such as the expansion of the European Union, global instability, and prolonged wars that have forced mass migration.

[1]CHAIN—a multiagency database for recording information about rough sleepers and the wider street population within London.

However, it is not only sociopolitical factors that have directly contributed to the increase in rough sleeping. Available data highlight the significant proportion of people within the homeless population who are classed as having additional support needs. For example, CHAIN's annual report for the year 2016–2017, published by The Greater London Authority (2017), revealed that 47% of rough sleepers in London were found to have additional mental health needs. Forty-four per cent were found to have alcohol-related support needs, and 35% drug-related supported needs. Despite this, access to specialist services is typically very limited within the rough sleeping community, and people's support needs often remain unmet (St Mungo's 2016b). Consequently, there is clearly a need for better service provision to support the needs of the UK's growing rough sleeping population.

Based on the observations highlighted above, this chapter aims to explore both the issue of male homelessness and the challenges associated with meeting the support needs of people within the homeless community. This will be achieved by presenting and reflecting on the work of START. Specifically, a detailed account of male homelessness will be presented and discussed with reference to relevant literature throughout. Attempts will be made to consider how existing evidence/literature might explain the higher rates of homelessness in men compared to women, and the clinical implications of this will be explored. By introducing the work of START and presenting a clinical case example, this chapter will also highlight the importance of specialist service provision within the homelessness sector.

Introducing Tony

Throughout the course of this chapter, readers will be told the story of Tony, a 48 year old man with a history of entrenched rough sleeping and significant mental health difficulties. Although all of the issues highlighted, are based on a true account of male homelessness, all names, locations and other potentially identifying information have been changed to protect the anonymity of the person involved. It is written using a combination of Tony's own personal account of his experiences and the account of those involved in his care. As the chapter progresses, you will learn about a number of Tony's early life experiences, the subsequent difficulties he experienced and his contact with services, including the support he received from the START team.

Understanding the Range of Issues That Can Contribute to Homelessness—The Role of Trauma

In recent years, it has become increasingly well accepted that entrenched homelessness is not just related to a housing shortage or the result of unfortunate unforeseen circumstances, but rather the consequence of long-standing social exclusion, personal violations, and disrupted attachments (Cockersell 2015). Therefore, the problems of rough sleepers will not be solved by simply offering someone accommodation (Maguire et al. 2009). As Seager (2015) stresses, 'a house devoid of 'empathy, warmth and genuineness' is of no more use to a homeless person than it is to a developing child' (P20).

Unfortunately, a large section of homeless people have not had that necessary consistent empathy, warmth, and genuineness at any stage of their life. Rates of childhood abuse or neglect in homeless people have been found to be over 80% (Torchalla et al. 2012). This raises the question, what do these groups of homeless people associate with being housed? It is perhaps not the same warm feelings of safety, security, and connection, or the pleasant sense of nostalgia that many of us experience when within our own 'four walls'.

Not only have most rough sleepers had disrupted, neglected, and unpleasant early lives, but the majority have experienced further trauma that can be associated with additional barriers to them accessing and maintaining a home. Traumatic life events have been experienced in over 90% of homeless people (Buhrich et al. 2000), and homelessness in itself will often expose people to further trauma, victimisation, and learned helplessness (Torchalla et al. 2014). In addition, the high prevalence of violence experienced on the streets may prolong entrenched rough sleeping further (Kim et al. 2010).

Despite trauma and historic abuse being commonplace in the lives of homeless men, research in this field has primarily focused on women. It has been suggested that the exclusion of men from studies could be related to additional barriers to engaging homeless men in research, including males tending to lead more isolated lives, enduring more severe mental health problems, and presenting with particular presentations of post-traumatic stress related to military involvement (Kim et al. 2010).

When considering gender as a factor, a cyclical hypothesis makes sense. This is because men vastly outnumber women as rough sleepers, so the likelihood of exposure to further trauma is higher. This cyclical process of repeated traumas is exaggerated by the fact that men in the UK are generally more at risk of being a victim of violence, with approximately 61% of

victims being male and 39% female (Office for National Statistics 2017). However, women who are rough sleeping are clearly at increased risk of violence and may not perceive sleeping out on the streets as a viable long-term option (Hill 1991).

One consideration in regard to gender is the types of trauma that men and women are exposed to. Males are more likely to experience physical violence and psychological traumas, while women are more likely to be subjected to sexual violence and domestic abuse (Jainchill et al. 2000; Tolin and Foa 2006; Sonne et al. 2003). Such differences can have implications into routes into homelessness and how people are supported by organisations.

Women may be housed sooner due to additional specialist services (such as women's refuges or services that address the specific needs of women). Additionally, some women will be (rightfully) considered priority status related to pregnancy or dependent children (see Shelter 2017).

Another reason that some women do not become entrenched rough sleepers and remain members of the 'hidden homeless' population is that they are exploited into sex or sex-working, which temporarily removes them from the street (Reeve et al. 2009; Homeless Link 2014). It is reported that significantly more homeless women (25% compared with 2%) turn to prostitution than men (St Mungo's 2014). Such women have been found to be at increased risk of turning to such desperate measures if they have been subject to previous sexual abuse (Simons and Whitback 1991).

Also of note is how different forms of abuse and trauma impact on people and the ways of coping that they develop to manage such intrusive and distressing experiences. Gender differences have been found, including more internalised and avoidant behaviours in women, and more externalised and 'fight or flight' responses in men, for example increased aggression or substance misuse (Torchalla et al. 2014).

There is, of course, debate as to whether males' tendencies towards aggression and problematic alcohol/substance use are biologically driven, or the result of social learning and adopting more socially accepted gender roles (e.g. Archer 2004; Wilsnack et al. 2000). However, such behaviours place men at increased risk of breakdowns in placements and facing further problems in being re-housed.

Many of the above issues are evident in Tony's story. He was born and brought up in a small town, where he lived with his parents and older sister. Although his recollection of his upbringing and early life experiences was somewhat unclear, he recalled not feeling close to any of his family and described often feeling unsafe as a child. He linked this to a constant threat of physical

violence from his father, who was a heavy drinker and someone who was often physically abusive towards his mother.

When Tony was 16, he moved away to work as an apprentice for a year. He described this as a positive experience, as it allowed him to escape some of the difficulties he had been experiencing at home. However, he also recalled starting to drink quite heavily at this time of his life. He suggested that alcohol gave him confidence, which was something he felt he lacked, as a result of his difficult upbringing. Tony also felt that his drinking provided a means of escaping some of the difficult memories of his past.

After a year, he moved away again to start studying for a National Diploma. However, he soon dropped out of this course, as he was spending increasing amounts of time drinking and smoking cannabis. He later started to use harder drugs such as crack and heroin. Although he never felt that he became physically dependent on substances, he recognised that he often used them as a way of managing stressful situations.

Complex Trauma and the Role of Personality with Homelessness

Parallels have been drawn between the frequently traumatising, disrupted, and abusive histories of homeless people and those who are diagnosed with 'personality disorder'.[2] The prevalence of this diagnosis in the homeless population is unclear, and there have been wide-ranging estimates of rates between 2.2 and 71% (Fazel et al. 2008), with 'anti-social' type (particularly associated with men) at between 10 and 40% (Ball et al. 2005).

Difficulties that define the construct 'personality disorder' such as problems with regulating emotion, impulse control, relating to others, and maintenance of relationships have been described as features of the heterogeneous homeless population and factors that place individuals at risk of breakdowns of accommodation and causing issues securing support (Ball et al. 2005).

The nebulous nature of these presentations can mean that it is challenging for services to decide who is in need of clinical interventions and may also serve as an excuse to avoid complex and ambiguous cases, particularly considering stretched resources and histories of non-engagement (Crane and Warnes 2001; Timms and Taylor 2015).

[2] This reflects the language typically used in the research literature but we recognise that some people have a preference for the term 'complex trauma'.

Men presenting with more significant mental health difficulties (including 'personality disorder' diagnosis) have been found to be particularly difficult to engage, partly because of higher rates of anti-social traits and forensic behaviours, and more common problematic alcohol or substance use (O'Brien et al. 2009).

Throughout his early twenties, Tony recalled leading quite a transient life, whereby he would regularly move around the UK, living in different cities. At the time, he was typically living in squats or staying with people he had got to know. While Tony had some brief relationships, he had difficulties getting close to people. He found it hard to trust them, expected them to let him down, and would often move on, protecting himself from further predicted pain.

Later in life (after a prolonged period of rough sleeping), Tony was eventually accommodated in various hostels. But he didn't like the crowded environments, started to have problems with other residents, and felt singled out by staff. He was referred to mental health services but did not think that they were of relevance to him; instead preferring to visit local hospitals when he really needed help. Placements broke down following fights, service-charge debts related to substance use, and spells in prison. Tony returned to sleeping rough and it was often assumed he was 'making a lifestyle choice,' rather than responding to a sense of threat by making the logical decision to remove himself from that situation.

Psychosis, Gender, and Issues with Housing

Rates of psychosis[3] are particularly high in the homeless population (Fazel et al. 2008, 2014). This is not necessarily surprising, as such difficulties are often associated with problems securing and maintaining accommodation (Lettner et al. 2016).

This, in part, explains why the START team have always primarily worked with rough sleepers presenting with psychosis, however ambiguous these presentations sometimes are (Timms and Taylor 2015). Unfortunately, over the years the team has had to adapt and prioritise this group (over people with less severe mental health problems or those that are in temporary accommodation) due to wider funding constraints and pressures on public

[3]The term 'psychosis' is a reference to the range of complex difficulties often experienced by the people who access our service. We take the position that such presentations are often rooted in adverse experience (i.e. trauma and abuse), which is highlighted by the clinical case example presented and wider literature.

and homeless services (see Timms and Taylor 2015 for further details on the history of the team). We are currently working with commissioners to consider other models of working that can improve access to rough sleepers with all significant mental health needs.

It is important to consider how difficulties linked to psychosis have the potential to make people actively turn away from support and societal structures or norms. Experiencing paranoid or grandiose beliefs, or associated experiences (e.g. commanding voices), can also put people at higher risk of abandoning accommodation if re-housed, or make it harder for people to sustain tenancies without the right support.

High prevalence rates for psychosis within the homeless population could also go some way to explaining the gender differences in the street homeless population. One initial explanation is that men may be at more risk of developing psychosis. Traditionally, it was understood that incidence and prevalence rates of psychosis were comparable across genders; however, more recent research suggests that incidence rates are significantly higher in men (Ochoa et al. 2012). Through large-scale reviews, estimates of ratios have been made at 1.4:1 (McGrath et al. 2004) and 1.57:1 (Saha et al. 2014). Therefore, if psychosis increases a person's vulnerability to homelessness, this may help explain the higher numbers of homeless men.

As well as incidence rates, another consideration is the age of onset of psychosis between genders. In relation to this, it is widely recognised that men have an earlier onset than women (Donoghue et al. 2014). This is of relevance because there is some evidence of homeless groups being younger when first hospitalised (Opler et al. 2001) and that more entrenched homelessness is associated with a younger age when first becoming homeless (Patterson et al. 2012).

While there is a significant body of evidence to suggest that males develop psychosis at an earlier age, the discrepancy in age of onset may not be as marked as previously believed. A meta-analysis by Eranti and colleagues (2013) looking into the diagnosis 'schizophrenia' found that the combined difference in age of onset was only 1.49 years. As well as methodological issues and diagnostic discrepancy, Eranti et al. (2013) suggest that there might be notable differences between genders in the speed of access to services from when they first experience psychosis. Therefore, this more recent review highlights that age of onset may be less relevant than first thought, but that males may be slower to engage with services.

Earlier age of onset and delays in seeking support in males could place them at greater risk of homelessness during the early stages of psychosis and

also later in life. In part, this could be related to disruptions in acquiring functional skills and social development, found to be deficits in men with psychosis, while women have been found to be much better at developing social support networks (Gayer-Anderson and Morgan 2013; Thorup et al. 2014; Vila-Rodriguez et al. 2011). Lee et al. (2016) found that cohabiters and renters (rather than those who were unsheltered or in institutions) were significantly more likely to be women and have experienced a shorter duration of homelessness. They inferred that social support appears to protect against street homelessness and that low levels of social support may increase the risk for becoming homeless immediately after losing rented accommodation.

A related factor associated with poorer functioning, social adjustment, and social support in men are so-called negative symptoms of psychosis. 'Negative symptoms' have been found to be more severe and common in males and are a predictor of poor outcome (Malla and Payne 2005; Morgan et al. 2008; Thorup et al. 2014; Willhite et al. 2008). These blunting and lethargic aspects of presentations are commonly seen in the homeless people that we work with and can be disabling, both to functioning and recovery. They can make planning and organisation more challenging and leave people more apathetic with tasks important to sustaining tenancies, such as organising finances and maintaining adequate care of accommodation.

After a further transient period of rough sleeping, Tony was eventually accommodated in a smaller hostel, and subsequently moved into a council flat. Initially this seemed to be a positive change for him. However, it was not long after moving into his own flat, that Tony started to become increasingly unsettled and became aware of things that he'd not noticed before. He described these experiences as if seeing into "another life" or an "alternative reality". He also recalled that the images contained references to real life past events. Tony described becoming increasingly distressed and threatened by these experiences. As a result, he abandoned the flat and went back to a nomadic rough sleeping lifestyle, as this felt safer for him.

He started to avoid contact with other people, who he was becoming increasingly suspicious of. He described feeling a general sense of fear and unease, but he also suggested that there were times when he felt a "buzz" and a sense of excitement. This seemed to be linked to the belief that he knew things that others did not and that he had some kind of "sixth sense". However, he has subsequently acknowledged that he became increasingly caught up in this alternative reality, to the extent to which he started to seriously neglect his own self-care.

Crisis Interventions of Specialist Teams

The importance and success of specialist community multidisciplinary mental health street outreach teams has been noted, particularly in re-housing entrenched rough sleepers with severe and enduring mental health problems (St Mungo's 2016a). As well as MDT engagement, social and psychological interventions, inpatient treatment can also be an important or sometimes essential intervention. This is particularly the case for those presenting with psychosis and may also be an important step towards more permanent accommodation. For example, Lettner et al. (2016) found that 74% of hospitalised clients with psychosis were subsequently housed, compared to 13% who were not admitted. As well as improvements in accommodation status, Timms and Perry (2016) found that previously homeless patients had positive outcomes in engagement with their clinical team and registration with a GP following compulsory admission from the street.

Street Mental Health Act Assessments pose many practical as well as ethical issues (Timms and Perry 2016). Admitting people to hospital wards against their will is clearly an extremely difficult decision for any mental health professional and has definitely felt very uncomfortable for us personally and professionally. These have often been decisions made out of extreme situations, where people have been at real risk of death and where people are not in a capable position to look after themselves safely, e.g. sleeping on the streets in winter months when temperatures will drop to below freezing.

There are also situations of more chronic homelessness, where we as psychologists have supported admissions to hospital. This has been on the grounds of enabling re-housing and giving people a better chance of recovery and a new life. While there are discourses of 'lifestyle choices' describing persistent homelessness in the UK, the conscious choice to isolate oneself and live among the risks and squalor of the streets is an anomaly (Seager 2015).

> Tony eventually came to the attention of services when staff at a homeless day centre became seriously concerned about his physical and mental health. Staff noticed that he was dangerously underweight and extremely guarded and suspicious of those around him.
>
> By having close working relationships with the local homeless day centres and street outreach teams, who provide invaluable support to members of the homeless community, START were able to respond to the concerns raised. This initially involved a mental health outreach worker from the team, visiting the day centre that Tony had sporadically started using. There was a need to

approach this assessment with caution, due to fears that he may abandon using the day centre and be lost to all services. Therefore, initial contact with Tony, involved attempts to engage him in informal conversation, often with support from staff at the day centre.

It quickly became clear that he was unwilling to accept any form of support and seemed unable to recognise any of the risks that others were highlighting. This prompted a formal mental health assessment to be arranged, which resulted in Tony being admitted to a psychiatric ward for further assessment and treatment. Tony recalled this as being a surreal experience, which at the time, he understood as him being singled out because of what he knew.

While on the ward, Tony was given a diagnosis of 'paranoid schizophrenia' and was treated with antipsychotic medication. Tony remains unsure about this interpretation of his difficulties and felt that the medication he was initially prescribed made little difference. However, he acknowledged that he felt physically stronger after six weeks in hospital. He was discharged into supported accommodation, where he continued to remain under the care of the START team. More recently Tony has spoken about the value of continuity and consistency in his care. He recognised that at that time he found it extremely difficult to trust people, through regular contact with the same worker in hospital and after discharge, Tony was able to overcome this to an extent.

Gender Differences in Relapse of Psychosis and Substance Use

Despite intervening with hospital treatment, it is common for people to again lose accommodation and return to rough sleeping. Zammichieli (1997) followed up 110 previously homeless people post-discharge for six months and found that 29% of the sample became homeless at some point during the follow-up period, whereas 5.5% were chronically homeless. Overall, it was found that more males became homeless than females and that homelessness was related to not engaging with treatment.

Other research has similarly found that men are more prone to relapse in psychosis (Haro et al. 2008 and Ochoa et al. 2012). This has been explained by findings that men are less likely to seek support, to not take medication as prescribed, and to not engage with therapies offered (Galdas et al. 2005; Thorup et al. 2014). Refusing medication has been found to be associated with homelessness in men but not women (Opler et al. 2001).

Substance use is also associated with relapse in psychosis (Blanchard et al. 2000; Gregg et al. 2007), and 'substance use disorders' have been described

as 'consistently the most prevalent mental health diagnosis amongst homeless populations in Western countries' (Burns and Whittaker 2015). Substance misuse is much more common in men (Brown et al. 2011; Hambrecht and Häfner 2000; Ochoa et al. 2012), and homeless men have higher rates of alcohol and 'substance use disorders', including more risky use (Linn et al. 2005).

Opler et al. (2001) found that substance misuse amongst homeless women was even lower than among men that had never been homeless. Not only is substance misuse much more prevalent in men presenting with psychosis but they are also less likely to engage with treatment and display less motivation and readiness to make changes (Brown et al. 2011).

As well as substance use triggering relapse, we frequently see people who become street homeless related to substance misuse and addiction as problems in their own right. People will often fall behind in service charge payments or get into significant debts to dealers. Tenancies are lost due to people not staying at accommodation (e.g. frequent use elsewhere or prison sentences) or due to breaches of tenancies (e.g. challenging or problematic behaviours related to their own substance use or that of their guests). Sometimes people are in vulnerable positions and can be exploited by others (e.g. properties being taken over and turned into 'crack houses').

After living in supported accommodation for approximately six months, Tony was moved to a flat in a different London borough; where he was encouraged to manage more independently with floating support. However, Tony described finding this transition very difficult as he was suddenly expected to take responsibility for a wide range of tasks, many of which he had no real experience of. Due to the change in his address, his mental health care was also transferred to a local CMHT, as he was no longer living in one of the boroughs that START was commissioned to work with. This meant that he was assigned a new worker, who was only able to visit him once every two to three weeks. Shortly after the move, Tony recalled gradually stopping taking his medication, as he didn't feel it was helping. He also started to smoke cannabis again to cope with the stresses of his new situation. He spoke about becoming increasingly aware of the same unusual experiences, he had described previously.

In the end, Tony's change in circumstances and the changes in his mental state prompted him to decide to leave the flat and he returned to sleeping rough and squatting. He had limited memories of this time in his life, and was surprised to hear that several months passed before his most recent contact with services. More recently, Tony has come to understand that this was because he was caught up in the beliefs and experiences previously described.

Specialist Homeless Mental Health Outreach Teams

Specialist assertive outreach teams have been found to improve engagement with complex client groups (O'Brien et al. 2009). With the homeless population, assertive community interventions have been found to shift crisis-oriented care to ongoing outpatient care, with better outcomes in housing, mental health, and life satisfaction (Lehman et al. 1997).

But community mental health services are under huge pressures (Gilburt 2015), and assertive outreach teams are now a rarity (Firn et al. 2013). Despite the positive outcomes of the specialist homeless outreach teams developed through the Rough Sleepers and Homeless Mentally Ill initiatives of the early 1990's, such services have been heavily cut or disappeared altogether (Anderson 2007; St Mungo's 2016a; Timms and Taylor 2015).

Not only are specialist outreach teams (such as START) able to provide the assertive outreach and street assessment skills to engage entrenched rough sleepers; they also have specialist knowledge of housing and hold long-standing links with other key homeless service providers.

START have worked for many years with the independent and invaluable local day centres (Ace of Clubs; Manna; Spires, and Webber St), as well as with the tireless street outreach teams (of St Mungo's). This partnership working enables us to help many more people than would ordinarily be possible. This is partly because a significant number of homeless people are wary of statutory services and those perceived to be in authority (Marshall and Bhugra 1996; Timms 1996), perhaps unsurprisingly given people's histories of abuse and mistreatment by people in positions of power.

Smaller, independent services and initiatives have greater flexibility, can adapt to the local needs of a population, and sometimes offer more appealing practical interventions (Bunce 2000). A good example is the fantastic work achieved by Caris Boxing Club, which engages homeless people through the camaraderie of the 'sweet science' of boxing. Young men, especially, are more likely to want to connect with others from their community in a positive and less pathologising or stigmatising environment. This is particularly pertinent considering recent findings that possessing a sense of social identity is associated with improved self-esteem and reduced paranoia and low mood (McIntyre et al. 2017).

True therapeutic interventions for the homeless have been described as mirroring good parenting, providing an attachment and emotional involvement over time (Seager 2015). In order to provide the necessary regular

and close contact to complex and often chaotic homeless groups, there has been the development of a new model of therapeutic community, termed 'Psychologically Informed Environments', or PIE (Johnson and Haigh 2011). Williamson and Taylor (2015) describe how 'living alongside' residents enabled greater depth of understanding and gradual engagement of a man who would not ordinarily link with a therapist. Where such resources are not in place, START have provided the indirect psychological component of a 'PIE' to support teams in making sense of people's presentations and think about ways to help sustain tenancies or plan transitions.

After Tony abandoned his flat, the local CMHT notified START who in turn notified the day centres and outreach teams. He was eventually spotted rough sleeping by street outreach services, who notified START immediately. This prompted a further assessment visit (at his sleep site) by his previous worker. On assessment, Tony was found to be extremely malnourished and it was clear that he'd severely neglected his self-care. Once again, he was guarded and unable to recognise any of the concerns that others were highlighting. Another Mental Health Act Assessment was deemed necessary because Tony was unwilling to accept any help and was clearly in a very poor state of physical health. Although Tony was admitted to hospital under section, he recalled this experience as being "confusing" rather than overly distressing. He has also subsequently suggested that having a familiar worker with him throughout made the process much less distressing for him.

After a period on the ward, where he received treatment in the form of medication and regular visits from his named worker, Tony's physical health improved significantly and he became much less preoccupied by his thoughts. START were able to reflect on their previous work with Tony and consider what changes may need to be made to reduce the risk of relapse and/or abandonment. Ultimately, this led to Tony being offered a longer supported accommodation placement in a local borough, which meant that START were able to continue to support him (alongside staff at the accommodation) throughout this time.

As well as meeting with Tony, his worker also regularly met with Tony's assigned key worker at the accommodation, to help support her in working with him. This led to significant improvements in Tony's ability to manage a wide range of new skills (e.g. money management, computer skills). Over time Tony was also supported in identifying specific interests/activities that he could be supported in pursuing (e.g. photography). Alongside this support, Tony also engaged in weekly psychology sessions, which were aimed at helping him develop a more complete understanding/formulation of some of his experiences/difficulties, as it was felt that this was an important part of minimising future risks.

Role of Psychology Within START and Tony's Care

Psychology has featured as part of START for over 10 years. The approach, of course, needs to be more flexible to that of traditional psychology services, with the model mirroring that of the team assertive outreach approach (Timms and Taylor 2015). As well as offering longer-term therapy, psychology plays a role in early assessment and formulation of new rough sleepers, as well as shorter pieces of work if it is agreed that people require briefer interventions from the team. Meetings are offered in locations that people are most likely to engage and can be more informal in style and model, often with longer periods of engagement. Sometimes one-to-one therapy is not possible or appropriate, so joint or indirect working is considered, with provision of supervision, consultation, or training offered to the team and partner agencies.

Through the psychology work, Tony began to develop an understanding of the relationship that often exists between a person's early life experiences and the ways they learn to cope or manage with difficulties. This allowed him to consider the possibility that he may have become more attuned to threat than others, as a result of the challenging early life experiences he described (i.e. living under the perceived threat of abuse). Specifically, this seemed to account for Tony's experience of having some sort of "sixth sense" or heightened awareness. While he continued to believe that a heightened awareness could be a positive thing, he also realised that it could be problematic. In relation to this, Tony recognised that there were times when he felt so "tuned into" or preoccupied by the potential for there to be something going on, that he ended up losing touch with reality. He also recognised that these instances of losing touch with reality seemed to coincide with him neglecting his physical health. Therefore, Tony felt that being too tuned-in could potentially be very risky. He also came to understand that a heightened sense of awareness had the potential to increase the chances of him misinterpreting events or attaching too much significance to them.

Tony came to recognise that his avoidance of people and sense of threat from others could be understood as a normal response to his early abusive environment (i.e. for good reason, he learned to be more vigilant and cautious around others). This prompted Tony to suggest that, from his late teens, he had always viewed life from a slightly different perspective. This is what he came to describe as a state of hyper awareness or a sixth sense, whereby he would often notice things that others may not have been aware of. Ultimately, this helped Tony to realise that living a more nomadic lifestyle, his use of

substances, and his aggressive tendencies may have become important ways of managing that heightened awareness or sense of threat, because it provided him with a means of escape and sense of control.

Through psychology work, Tony was also encouraged to reflect on some of the changes that had resulted from his contact with services. This led to him recognising that his decision to continue to take medication is the result of, what he described as, a trade-off. Specifically, he recognised that medication had definitely helped him to feel more relaxed and able to focus on the present. However, he also felt that it could sometimes feel a little strong and contribute to him experiencing a loss of clarity of thought. Based on this, he suggested that the correct dose is very important. Too little and he is prone to getting caught up in an alternative reality and become more fixated that there is something else going on. Too much and he experienced a loss of clarity of thought, which he found frustrating and would therefore be less likely to take as prescribed. This helped to create more of an open dialogue around Tony's medical treatment, which led to him feeling more actively involved/in control of his medical care.

Tony also came to recognise the importance of taking things at a steady and manageable pace. He revealed that, in the past, it had sometimes felt like he had been too led by services to achieve certain goals or attend to certain tasks. He also felt that this may have contributed to him disengaging from past support (i.e. stopping medication and abandoning his accommodation). Therefore, maintaining an appropriate pace, whereby he felt in control of things, didn't feel too pressured, and still had opportunities to experience a sense of freedom/independence, became important guiding principles of his on-going care.

Migration, Gender, and Homelessness

Although not relevant to the case of Tony, when understanding current rough sleeping trends in the UK, it is important not to overlook the impact of immigration. Within London, it is estimated that nearly 60% of rough sleepers are non-UK citizens (Department for Communities and Local Government 2016).

Shifting changes of nationality within the rough sleeping population appear associated with the expansion of the European Union from 2004. While rough sleeping has significantly increased generally in this time period, the numbers of Eastern European people sleeping on the streets have increased at an even more alarming rate, 77% compared to 23% over the same time period of 2011–2015 (St Mungo's or CHAIN).

Movement to the UK, following accession, is understood to have been driven by work opportunities, with fewer restrictions than in other EU countries (Lemos and Portes 2008). As well as those travelling voluntarily as part of economic migration, there are also concerning numbers of people who become homeless following being trafficked for forced labour (Homeless Link 2016). When men are unable to obtain work and find themselves on the margins of society, there can be additional burden from 'gender role discrepancy', where the social and internalised gender stereotypes of being a 'provider' is a mismatch with their position of poverty (Schindler and Coley 2007). This may be further exaggerated by certain cultural expectations; we have worked with some men who avoid returning to their native country or seeking support from family for feelings of guilt and shame of 'failure'.

It may be assumed that migration by men is much higher than women; however, this is not necessarily the case and distribution of migration by gender is a more complex topic (Jolly and Reeves 2005). This can be seen by looking at the breakdown of people arriving from the A8 countries. Perhaps surprisingly, in the year of Accession (2004) there was actually a lower proportion of male immigration. Males constituted an estimated 44% of inflows of A8 citizens (Gillingham 2010).

However, from the statistics available it is evident that there has been more immigration of Eastern European men than women. Of the A8 countries, there have been a higher proportion of males arriving since 2005 (International Passenger Survey 2005–2015). And with the A2 countries (Bulgaria and Romania), the gender split is more pronounced, with an estimated 69% of these arrivals being men in 2015 and 77% the year after accession. In comparison with total immigration (estimated to be 50.5%, IPS 2015), this gender divide is notably higher.

It is of importance that there is gender imbalance within these two migratory groups, as rapid increase of rough sleeping has also been seen. It is now estimated that Romanians make up approximately 20% of all rough sleepers in London (CHAIN). Though there is no known research into why high numbers are becoming homeless from this group, challenges arise managing such a rapid increase in homeless people from outside of the UK. There are firstly less statutory responsibilities to house people, meaning access to accommodation is much harder. The financial inequalities between the countries also mean that earning money can be a greater priority than having a roof over one's head, as there are reports of people turning down accommodation in order to avoid paying rent (St Mungo's 2016b). There are also noted cultural differences in the way that people seek help, for instance

a greater reliance on emergency services rather than accessing primary or secondary care (e.g. Health Protection Agency and Partners 2010).

Migrants can end up trapped in positions of limbo where they are not able to legally work or remain in the country but are afraid or unable to return to their home country, where they may be at serious risk or will be placed in an even worse state of destitution in their country of origin (Mostowska 2014).

Stringent measures have been introduced to reduce numbers seeking asylum and deal with those over-staying unlawfully (Steel et al. 2006). The 2017 BBC Panorama programme 'Undercover: Britain's Immigration Secrets' highlighted some of the horrific treatment that exists within UK detention centres. Related research suggests that both prolonged detention and temporary protection contribute substantially to the risk of ongoing depression, PTSD and mental health-related disability in refugees (Steel et al. 2006). If there are no other housing and support systems available for foreign people under our care, we would try to 'repatriate' them via schemes such as 'Routes Home' (St Mungo's), which help people to travel back to their country of origin in less traumatic ways.

Final Reflections

Throughout this chapter, we have touched on some of the key factors at the root of entrenched rough sleeping and also the reasons for the disparity of gender in this marginalised group. Topics have included: the role of trauma and different ways of managing the associated long-term distress; the impact of psychosis on engagement with support and ability to maintain tenancies; how crises of mental health can cause wider social breakdowns; and some of the issues of migration that leave men particularly vulnerable to homelessness.

As male clinical psychologists, we are a minority working within the profession, but perhaps less so within the wider workforce of those supporting the homeless. It is not particularly the case that we were attracted to working with or alongside other men. However, being able to offer a service to those who are at the fringes of society and those less likely to have the opportunity of psychological therapy was definitely a factor in our choice of clinical role.

Specialist services for rough sleepers are essential to the safeguarding of a sadly ever increasing group. However, it is the role of clinicians from all services to ensure that the people who depend on our care are not placed

in even more vulnerable positions of becoming homeless. This includes us making responsible clinical decisions around discharge and after-care, ensuring that social and support needs are met, as well advocating at appropriate levels the needs of those that are in such crisis.

References

Anderson, I. (2007). Tackling street homelessness in Scotland: The evolution and impact of the rough sleepers initiative. *Journal of Social Issues, 63*(3), 623–640.

Archer, J. (2004). Sex differences in aggression in real-world settings: A meta-analytic review. *Review of General Psychology, 8*(4), 291.

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

Blanchard, J. J., Brown, S. A., Horan, W. P., & Sherwood, A. R. (2000). Substance use disorders in schizophrenia: Review, integration, and a proposed model. *Clinical Psychology Review, 20*(2), 207–234.

Brown, C. H., Bennett, M. E., Li, L., & Bellack, A. S. (2011). Predictors of initiation and engagement in substance abuse treatment among individuals with co-occurring serious mental illness and substance use disorders. *Addictive Behaviors, 36*(5), 439–447.

Buhrich, N., Hodder, T., & Teesson, M. (2000). Lifetime prevalence of trauma among homeless people in Sydney. *Australian and New Zealand Journal of Psychiatry, 34*(6), 963–966.

Bunce, D. (2000). Problems faced by homeless men in obtaining health care. *Nursing Standard (Through 2013), 14*(34), 43.

Burns, L., & Whittaker, E. (2015). No place to call home: What homelessness means for people who use drugs. *Drug and Alcohol Dependence, 156,* e31.

Cockersell, P. (2015). The process of social exclusion. *Clinical Psychology Forum, 265,* 13–18.

Combined Homelessness and Information Network. (2017). *CHAIN annual report: June 2015.* The Greater London Authority.

Crane, M., & Warnes, A. M. (2001). The responsibility to care for single homeless people. *Health and Social Care in the Community, 9*(6), 436–444.

Department for Communities and Local Government. (2016). *Rough sleeping in England: Autumn 2015.* https://www.gov.uk/government/statistics/rough-sleeping-in-england-autumn-2015.

Donoghue, K., Doody, G. A., Murray, R. M., Jones, P. B., Morgan, C., & Dazzan, P., et al. (2014). Cannabis use, gender and age of onset of schizophrenia: Data from the AESOP study. *Psychiatry Research, 215*(3), 528–532.

Eranti, S. V., MacCabe, J. H., Bundy, H., & Murray, R. M. (2013). Gender difference in age at onset of schizophrenia: A meta-analysis. *Psychological Medicine, 43*(1), 155–167.

Fazel, S., Geddes, J. R., & Kushel, M. (2014). The health of homeless people in high-income countries: Descriptive epidemiology, health consequences, and clinical and policy recommendations. *The Lancet, 384*(9953), 1529–1540.

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

Firn, M., Hindhaugh, K., Hubbeling, D., Davies, G., Jones, B., & White, S. J. (2013). A dismantling study of assertive outreach services: Comparing activity and outcomes following replacement with the FACT model. *Social Psychiatry and Psychiatric Epidemiology, 48*(6), 997–1003.

Galdas, P. M., Cheater, F., & Marshall, P. (2005). Men and health help-seeking behaviour: Literature review. *Journal of Advanced Nursing, 49*(6), 616–623.

Gayer-Anderson, C., & Morgan, C. (2013). Social networks, support and early psychosis: A systematic review. *Epidemiology and Psychiatric Sciences, 22*(2), 131–146.

Gilburt, H. (2015). Mental health under pressure. *The King's Fund*. https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/mental-health-under-pressure-nov15_0.pdf.

Gillingham, E. (2010). Understanding A8 migration to the UK since accession. Office for National Statistics, 1–26.

Gregg, L., Barrowclough, C., & Haddock, G. (2007). Reasons for increased substance use in psychosis. *Clinical Psychology Review, 27*(4), 494–510.

Hambrecht, M., & Häfner, H. (2000). Cannabis, vulnerability, and the onset of schizophrenia: An epidemiological perspective. *Australian and New Zealand Journal of Psychiatry, 34*(3), 468–475.

Haro, J. M., Alonso, J., Bousoño, M., Suárez, D., Novick, D., & Gilaberte, I. (2008). Remission and relapse in the ambulatory treatment of patients with schizophrenia. Outcomes at 3 years. *Actas Espanolas de Psiquiatria, 36*(4), 187–196.

Health Protection Agency and Partners. (2010). Understanding the health needs of migrants in the South East region. London: Health Protection Agency. http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1284475770868.

Hill, R. P. (1991). Homeless women, special possessions, and the meaning of "home": An ethnographic case study. *Journal of Consumer Research, 18*(3), 298–310.

Homeless Link. (2014). *Supporting women who are homeless: Briefing for homelessness services*. http://www.homeless.org.uk/sites/default/files/site-attachments/Supporting%20women%20who%20are%20homeless%20March%202017_0.pdf.

Homeless Link. (2016). *Trafficking and forced labour: Guidance for frontline homelessness services*. http://www.homeless.org.uk/sites/default/files/site-attachments/Trafficking%20and%20Forced%20Labour%20guidance%20-%20May%202016.pdf.

Jainchill, N., Hawke, J., & Yagelka, J. (2000). Gender, psychopathology, and patterns of homelessness among clients in shelter-based TCs. *The American Journal of Drug and Alcohol Abuse, 26*(4), 553–567.

Johnson, R., & Haigh, R. (2011). Social psychiatry and social policy for the 21st century: New concepts for new needs-the 'enabling environments' initiative. *Mental Health and Social Inclusion, 15*(1), 17–23.

Jolly, S., & Reeves, H. (2005). *Gender & migration*. United Kingdom: Bridge.

Kim, M. M., Ford, J. D., Howard, D. L., & Bradford, D. W. (2010). Assessing trauma, substance abuse, and mental health in a sample of homeless men. *Health and Social Work, 35*(1), 39–48.

Lee, C. T., Guzman, D., Ponath, C., Tieu, L., Riley, E., & Kushel, M. (2016). Residential patterns in older homeless adults: Results of a cluster analysis. *Social Science and Medicine, 153,* 131–140.

Lehman, A. F., Dixon, L. B., Kernan, E., DeForge, B. R., & Postrado, L. T. (1997). A randomized trial of assertive community treatment for homeless persons with severe mental illness. *Archives of General Psychiatry, 54*(11), 1038–1043.

Lemos, S., & Portes, J. (2008). The impact of migration from the new Eastern Union member states on native workers. Department for Work and Pensions.

Lettner, B. H., Doan, R. J., & Miettinen, A. W. (2016). Housing outcomes and predictors of success: The role of hospitalization in street outreach. *Journal of Psychiatric and Mental Health Nursing, 23*(2), 98–107.

Linn, J. G., Brown, M., & Kendrick, L. (2005). Injection drug use among homeless adults in the southeast with severe mental illness. *Journal of Health Care for the Poor and Underserved, 16*(4), 83–90.

Maguire, N. J., Johnson, R., Vostanis, P., Keats, H., & Remington, R. E. (2009). *Homelessness and complex trauma: A review of the literature*. Southampton: UK University of Southampton.

Malla, A., & Payne, J. (2005). First-episode psychosis: Psychopathology, quality of life, and functional outcome. *Schizophrenia Bulletin, 31*(3), 650–671.

Marshall, E. J., & Bhugra, D. (1996). Services for the mentally ill homeless. In D. Bhugra (Ed.), *Homelessness and mental health* (pp. 99–109). Cambridge: Cambridge University Press.

McGrath, J., Saha, S., Welham, J., El Saadi, O., MacCauley, C., & Chant, D. (2004). A systematic review of the incidence of schizophrenia: The distribution of rates and the influence of sex, urbanicity, migrant status and methodology. *BMC Medicine, 2*(1), 13.

McIntyre, J. C., Wickham, S., Barr, B., & Bentall, R. P. (2017). Social identity and psychosis: Associations and psychological mechanisms. *Schizophrenia Bulletin, 44*(3), 681–690.

Morgan, V. A., Castle, D. J., & Jablensky, A. V. (2008). Do women express and experience psychosis differently from men? Epidemiological evidence from the Australian National Study of Low Prevalence (Psychotic) Disorders. *Australian and New Zealand Journal of Psychiatry, 42*(1), 74–82.

Mostowska, M. (2014). 'We shouldn't but we do…': Framing the strategies for helping homeless EU migrants in Copenhagen and Dublin. *The British Journal of Social Work, 44*(suppl_1), i18–i34.

National Audit Office. (2017). Homelessness. *Department for Communities and Local Government.* https://www.nao.org.uk/wp-content/uploads/2017/09/Homelessness.pdf.

O'Brien, A., Fahmy, R., & Singh, S. P. (2009). Disengagement from mental health services. *Social Psychiatry and Psychiatric Epidemiology, 44*(7), 558–568.

Ochoa, S., Usall, J., Cobo, J., Labad, X., & Kulkarni, J. (2012). Gender differences in schizophrenia and first-episode psychosis: A comprehensive literature review. *Schizophrenia Research and Treatment, 2012*, 1–9. https://www.hindawi.com/journals/schizort/2012/916198/.

Office for National Statistics: Overview of Violent Crime and Sexual Offences. (2017). https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/compendium/focusonviolentcrimeandsexualoffences/yearendingmarch2016/overviewofviolentcrimeandsexualoffences.

Opler, L. A., White, L., Caton, C. L., Dominguez, B., Hirshfield, S., & Shrout, P. E. (2001). Gender differences in the relationship of homelessness to symptom severity, substance abuse, and neuroleptic noncompliance in schizophrenia. *The Journal of Nervous and Mental Disease, 189*(7), 449–456.

Patterson, M. L., Somers, J. M., & Moniruzzaman, A. (2012). Prolonged and persistent homelessness: Multivariable analyses in a cohort experiencing current homelessness and mental illness in Vancouver, British Columbia. *Mental Health and Substance Use, 5*(2), 85–101.

Reeve, R., Casey, E., Batty, E., & Green, S. (2009). The housing needs and experiences of homeless women involved in street sex work in stoke-on-trent. *Centre for Regional Economic and Social Research, Sheffield Hallam University*. http://www4.shu.ac.uk/research/cresr/housing-needs-and-experiences-homeless-women-involved-street-sex-work-stoke-trent-pdf-41975-kb.

Saha, S., Whiteford, H., & McGrath, J. (2014). Modelling the incidence and mortality of psychotic disorders: Data from the second Australian national survey of psychosis. *Australian and New Zealand Journal of Psychiatry, 48*(4), 352–359.

Schindler, H. S., & Coley, R. L. (2007). A qualitative study of homeless fathers: Exploring parenting and gender role transitions. *Family Relations, 56*(1), 40–51.

Seager, M. (2015). Why long-term homelessness begins and ends with the mind. *Clinical Psychology Forum, 265,* 19–22.

Shelter. (2016). *Green book 50 years on: The reality of homelessness for families today.* http://www.shelter.org.uk/__data/assets/pdf_file/0003/1307361/GreenBook_-_A_report_on_homelessness.pdf.

Shelter. (2017). *Homelessness: Are you in priority need?* http://m.england.shelter.org.uk/get_advice/homelessness/help_from_the_council_when_homeless/priority_need.

Simons, R. L., & Whitbeck, L. B. (1991). Sexual abuse as a precursor to prostitution and victimization among adolescent and adult homeless women. *Journal of Family Issues, 12*(3), 361–379.

Sonne, S. C., Back, S. E., Zuniga, C. D., Randall, C. L., & Brady, K. T. (2003). Gender differences in individuals with comorbid alcohol dependence and post-traumatic stress disorder. *The American Journal on Addictions, 12*(5), 412–423.

Steel, Z., Silove, D., Brooks, R., Momartin, S., Alzuhairi, B., & Susljik, I. N. A. (2006). Impact of immigration detention and temporary protection on the mental health of refugees. *The British Journal of Psychiatry, 188*(1), 58–64.

St Mungo's. (2014). *Rebuilding shattered lives: The final report*. https://www.mungos.org/publication/rebuilding-lives-final-report/.

St Mungo's. (2016a). *Stop the scandal: An investigation into mental health and rough sleeping*. http://www.mungos.org/documents/7021/7021.pdf.

St Mungo's. (2016b). *Nowhere safe to stay: The dangers of sleeping rough*. http://www.mungos.org/documents/7353/7353.pdf.

Thorup, A., Albert, N., Bertelsen, M., Petersen, L., Jeppesen, P., & Le Quack, P., et al. (2014). Gender differences in first-episode psychosis at 5-year follow-up—Two different courses of disease? Results from the OPUS study at 5-year follow-up. *European Psychiatry, 29*(1), 44–51.

Timms, P. (1996). Management aspects of care for the homeless mentally ill. *Advances in Psychiatric Treatment, 2*(4), 158–165.

Timms, P., & Perry, J. (2016). Sectioning on the street—Futility or utility? *BJPsych Bull, 40*(6), 302–305.

Timms, P., & Taylor, K. (2015). Breaking down barriers: Clinical psychology and psychiatry in a mental health service for homeless people. *Clinical Psychology Forum, 265,* 28–32.

Tolin, D. F., & Foa, E. B. (2006). Sex differences in trauma and posttraumatic stress disorder: A quantitative review of 25 years of research. *Psychological Bulletin, 132*(6), 959–992.

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

Torchalla, I., Strehlau, V., Li, K., Schuetz, C., & Krausz, M. (2012). The association between childhood maltreatment subtypes and current suicide risk among homeless men and women. *Child Maltreatment, 17,* 132–143.

Vila-Rodriguez, F., Ochoa, S., Autonell, J., Usall, J., & Haro, J. M. (2011). Complex interaction between symptoms, social factors, and gender in social functioning in a community-dwelling sample of schizophrenia. *Psychiatric Quarterly, 82*(4), 261–274.

Willhite, R. K., Niendam, T. A., Bearden, C. E., Zinberg, J., O'Brien, M. P., & Cannon, T. D. (2008). Gender differences in symptoms, functioning and social support in patients at ultra-high risk for developing a psychotic disorder. *Schizophrenia Research, 104*(1), 237–245.

Williamson, E., & Taylor, K. (2015). Minding the margins: An innovation to integrate psychology in a homeless hostel environment. *Clinical Psychology Forum, 265,* 33–37.

Wilsnack, R. W., Vogeltanz, N. D., Wilsnack, S. C., & Harris, T. R. (2000). Gender differences in alcohol consumption and adverse drinking consequences: Cross-cultural patterns. *Addiction, 95*(2), 251–265.

Zammichieli, M. E. (1997). *Predicting homelessness following psychiatric hospitalization*. Doctoral dissertation, University of Maryland Baltimore County.