into primary care. “It was clear that there had to be a move away from purely institutionalised care—we had to prove that mental health could be part of primary health care”, he recalls. WHO-coordinated research done in the Philippines, Senegal, India, and Colombia showed that primary care practitioners, given short periods of training, could indeed provide effective mental health care; this provided the basis for the recommendation that mental health services should be community based, and that primary health care should be actively involved in the provision of mental health care. 5 years later, the Alma-Ata Conference on Primary Health Care recommended that the promotion of mental health should be an essential component of primary health care.

Sartorius left WHO in 1993 and joined the University of Geneva as Professor of Psychiatry, coinciding with a new avenue as President of WPA. Sartorius, convinced that the lives of people with mental illness and their families will not improve unless the stigma of mental illness is reduced, launched Open the Doors, an anti-stigma programme involving more than 20 countries, to challenge stigma in mental health. The advocacy work continues, with the latest international conference on stigma and mental health taking place in Singapore in October, 2019.

Sartorius believes strongly that psychiatry needs to become better integrated within medicine. “The separation between the two is increasing with the growing number of specialties of medicine. The very fact that liaison psychiatry exists illustrates this point”, Sartorius says. “It is not the few specialists of liaison psychiatry who should work with other branches of medicine, but all psychiatrists. This calls for a change of the description of the tasks of psychiatry and of the education of health personnel. The ways of dealing with anxiety that many patients experience in cardiac surgery, for example, should be taught in the cardiac ward, not in the psychiatric department”, he says.

After more than half a century in psychiatry, Sartorius can reflect on a remarkable life, personally and professionally. His wife Vera and their daughter Danielle’s family are close by in Geneva and, on the rare occasions when he is not working, Sartorius can be found browsing in a bookshop, teaching his granddaughters about nature, or participating in public speaking engagements. But psychiatry remains at the centre of his life. “Psychiatry is about all of medicine, and much more than medicine, it needs to be fully integrated with appropriate care for people in all ways and at all levels, from the ward to the outpatient clinic, in primary care, in public life, at work, and in people’s homes. Much work remains to be done”, he says.

Richard Lane

**Feature**

**Housing crisis, part 1: on the streets**

On London’s Oxford Street, the UK’s homelessness crisis is very visible. Among bustling commuters and shoppers, men and women shelter in doorways, under bridges, and outside shops, bundled in sleeping bags and coats. It is summer, so the weather is relatively mild. But as the nights grow colder, winter sharpens inequality, and no group is more vulnerable to freezing weather than people sleeping on the streets.

Colin was living in private rented accommodation when he lost his job at a manufacturing centre in the UK. No longer able to pay his rent, he ended up losing his apartment and staying on a friend’s sofa while applying for jobs. Eventually, the friendship broke down and he began sleeping on the streets. He was spotted by a member of the public who called StreetLink, the UK’s national helpline for people sleeping on the streets, and an outreach team found him without any kind of shelter. He had developed depression and started to have suicidal thoughts, and although he had gone to a hospital accident and emergency department, he was not offered immediate care, but was told to make an appointment with a doctor. It wasn’t until he was supported by the homelessness charity St Mungo’s that he was able to get accommodation and treatment.

**Homelessness and mental health**

With the UK experiencing rising levels of homelessness, Colin is one of many who have fallen on hard times and ended up living on the streets. According to official figures, there were 4677 people recorded as sleeping rough in England in 2018. Although this represents a fall of 2% from 2017, it marks a staggering increase of 165% since 2010. There are clear parallels in the USA. 552 830 people were experiencing homelessness on a single night in 2018, according to the United States Department of Housing and Urban Development’s annual Point-in-Time Count. These figures are probably only the tip of the iceberg, campaigners say, with actual numbers most likely much higher.

Homeless Link, a UK homelessness charity, highlights that 45% of people experiencing homelessness have been diagnosed with a mental health problem—double that of the general population. Four of five people said that they had an issue with their mental health while they have been homeless. Rick Henderson, chief executive of the UK-based charity, says: “In particular, the rates of depression among people who are homeless is substantially higher and most likely much higher.

For more on UK homeless data see https://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN02007
who are homeless are nine times more likely to take their own lives.”

“We are not building enough genuinely affordable homes, and recent changes to our benefits system, which is meant to be there to support people when they’re going through hard times, mean that people often don’t have enough money to cover the cost of life’s necessities, while also being able to pay their rent and stay out of debt”, he explains.

These structural issues are compounded by personal factors, with people who end up homeless or sleeping rough more likely to have experienced childhood trauma, violence, or abuse. Many women who are homeless have fled abuse or violence at home. For those already experiencing financial hardship and increasing private rents, the breakdown of a relationship, a bereavement, or losing a job can be the final straw.

Street psychiatry
For many people sleeping on the streets, accessing health care is difficult. Sometimes, people might only come into contact with services when they are in a crisis—when they are suicidal, self-harming, or experiencing psychosis—which is far too late. Things that many of us take for granted, for example, being able to drive to a doctor’s appointment, become challenging for someone without money or resources. It is not easy to pick up a prescription if you have no fixed address.

Dr Ana Turner, an assistant Professor at the University of Florida College of Medicine and a community psychiatrist, explains that people living on the street might not have a working phone or calendar to keep track of the date or time, which can make it difficult to stick to appointments. “For many typical providers, they work on a busy schedule and can’t be flexible and so a lot of it is a lack of access or difficulty accessing for various reasons”, she says.

One potential answer to the problem is so-called street psychiatry, a concept that brings treatment directly to those sleeping rough. It is rare though, Turner says, because “the majority of people who go into psychiatry like having a nine to five office job.” Working on the HOPE medical outreach programme at the Sulzbacher Centre in Jacksonville, Florida, Turner heads out to people sleeping on the street to assess their needs and, if possible, deliver treatment. Crucially, care is delivered in the patient’s own environment, whether that is in an alleyway or under a bridge. “It involves going out to the people, where they are”, she explains. “We have two case managers who go out every day on the HOPE team and they try to orient people to the Sulzbacher service to come into our clinic and get a hot meal, and then if they identify someone who possibly has a mental health issue, then they say ‘let’s bring Dr Turner in’ and I go with them.”

“As a psychiatrist, I’m able to provide counselling as well as psychiatric medications, including long-acting injectable medications that are given once a month so that a patient doesn’t have to remember to take a pill each day”, Turner says. She also provides basic medical care when needed, such as antibiotics for a skin infection. “One of our case managers is also an [emergency medical technician] so he is able to draw blood work or administer injections”, she adds.

When treating people on the street, a relationship between the physician and patient is usually built over numerous meetings, which are often informal. “Our HOPE team has a white van that goes out, and they’re just passing out sandwiches—they’re harmless”, Turner says. “And so now if I go in the van, I am just OK by association. Sometimes, you can build trust in an indirect way.” One of the main benefits of delivering care on the street is that it lowers boundaries for homeless people with mental health problems. “If my clinic is backed up, it’s hard for someone who is acutely psychotic to wait or sit in a small area full of other people. It gives people a little more control, which is what makes them feel more comfortable”, she adds. “If they don’t want to talk to me, then I don’t talk to them. The ball is in their court.”

However, like all programmes, street psychiatry comes with challenges. Informed consent around treatment is key, and caution must be taken when providing medicines, particularly those that might leave someone more vulnerable while on the street. “We definitely have to be careful with sedation, along with medications that could cause medical problems if the patient gets dehydrated, especially in the Florida heat”, Turner says. It can also be difficult to keep track of people so the team can continue delivering treatment to them when they move around. “The follow-up is the hardest—we work really hard to keep finding people”, Turner says. “We look for a period of several months but then we eventually find them again. There are always challenges you have to predict and plan for. Safety can be a concern, so we go out in groups. But I have never felt like I am in an unsafe environment, because it is voluntary—if they don’t want to do it, we don’t do it.”

Although the concept of street psychiatry is in its infancy, it is growing. An organisation called the Street Medicine
Institute now operates programmes across 15 countries, delivering psychiatric care alongside general health care for homeless populations. Community psychiatrists—as part of Street Medicine teams—visit people where they live to provide diagnostic assessments and deliver treatment. Importantly, however, the Street Medicine Institute recognises that health care delivered on the street is not adequate primary care by itself. Rather, as the organisation itself highlights, it is “best viewed as a form of intermediate home care” and efforts “should be made to identify and refer patients to a comprehensive, longitudinal primary care relationship.” That being said, it is still an effective way to support homeless people.

“I have had several cases of people living on the streets for years, and with regular and persistent outreach from our team [they] have been able to come to our shelter for showers, meals, and, over time, case management, and medical and psychiatric care that have helped them obtain and remain in housing”, Turner says. Interventions like these are essential and long overdue to provide support for people living on the streets. But the fact remains that unless we address the underlying issues with housing, poverty, and access to mental health care, the problem will continue to grow.

Lydia Smith

Essay

The metamorphoses of wild swimming

Last May, one month into a rural lifestyle renting a cottage on a farm beside a river, I splashed into the swimming hole for the first time. This is one thing about wild swimming—when you have a place, a spot, a regular go-to, it becomes yours. So, one year on, this is my swimming hole, even though many have swum in it before me, even though the welcoming neighbours and landlord told us about it. Even though, occasionally on hot days, we walk across the horsefield and hear the telltale splash, the great offence, of other people enjoying a swim.

Anyway, I tell myself, they don’t know the best way in. Anyway, they can’t come here at any time of day, morning, evening, or weird weather where you don’t necessarily want to go in. They probably haven’t seen the kingfisher, the evidence of otters, the mass of mayflies lifting off the river like breath. I live here. Anyway, the swimming hole (despite being mine) doesn’t belong to anyone—or, if it does, it belongs, unequivocally, to the river.

Ruth Fitzmaurice writes about her special swimming spot in a lyrical stream-of-consciousness narrative, I Found my Tribe. The memoir is, in part, about living with her husband’s advanced motor neurone disease—how the family must adapt, survive, and even thrive when he becomes so incapacitated he can only blink his eyes. But the memoir is also, perhaps more so, a love letter to the sea, an homage to wild swimming at Greystones, County Wicklow. This becomes her spot: “This is my cove. No really, it’s actually mine. So says an old lady who rolls up on a flowery purple pushbike one day…”

Another thing about wild swimming is that it yanks you out of yourself, rather, thrusts you back into yourself—you out of your worried thoughts, and slaps you into the cold wet bodily reality of freezing water, taking your breath, and your capacity for complaint, away. My boyfriend and I went down to the swimming hole recently, fretful, sharing a funk about jobs and Brexit. I said, now we must go in. Within two minutes we were whooping with the cold and admiring the old stone bridge, the lush green riverbank, and the flickering of damselflies, the haze of worry whisked away by the current.

Victoria Whitworth makes a commitment to the cold in Swimming with Seals—she wild-swims in Orkney, all year round. The swimming changes, throughout her narrative, from a kind of self-punishment to a form of self-medication: “The physiological response to sudden immersion in cold water is very like that of a panic attack, in which your heart pounds, your breath shortens, you are hyper-aware of perceived threat. There are doctors who recommend cold-water swimming as a therapy for patients who present with depression or anxiety… Because at the same time as all this is going on my system is coursing with joy, crackling with energy. I feel every little electrical jolt as my nerves high-five across the synapses. The cold-water plunge brings me so close to the pleasure/pain boundary that my body reacts with the painkillers it keeps stowed away for crisis: dopamine, serotonin, endorphins.”

Both Whitworth and Fitzmaurice come to wild swimming late, finding groups of people with whom to swim. For Fitzmaurice, it is The Tragic Wives’ Swimming Club—two of the women in the group have husbands who have become severely, abruptly, and unexpectedly disabled. For Whitworth, it is the Tingwall Polar Bear Club, which she and a friend initiate, creating a community within a new, small town where she feels otherwise isolated, as well as offering an endorphin-boosting swim.

But for some, swimming is part of who you are, and wild swimming feels like a form of coming home, into your proper element. My brother and I joke that we grew up more underwater than above it. My mom calls us part fish. We were both competitive swimmers through high