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 **Foresight**

**Mental Capital and Wellbeing:
Making the most of ourselves in the 21st century**

**State-of-Science Review: SR-B6
The Mental Ill-Health of Homeless People**

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Summary

This review examines the mental ill-health of homeless people, including an analysis of the risk factors, associated disability and wider consequences. There is growing concern over the relationship between homelessness and mental ill-health. It is difficult, for methodological, definitional and analytical reasons, to measure accurately the rates of psychiatric morbidity among homeless adults. These will also vary according to the type of homelessness: sleeping rough; using a night shelter; staying in special hostels; and using temporary, leased accommodation. Alcohol and drug dependence are very prevalent, especially in the first two of these groups. The most prominent disorders experienced by homeless people are depression, affective disorders, psychosis including schizophrenia, and personality. All epidemiological studies point to a high level of co-occurrence of these conditions. The causal link between homelessness and mental ill-health is the subject of an ongoing debate. Some argue that the psychiatric problems of many of the homeless may result directly from their poverty and associated lack of accommodation. Others contend that the majority first experienced their symptoms of mental disorder before becoming homeless. The homeless suffer a variety of physical health problems, especially TB, asthma, bronchitis and HIV infection. Most are smokers. Some groups also have high rates of injecting drug use. Stressful life events influence their mental health. Marital breakdown, relationship issues, bereavement, and problems with the police are associated with mental ill-health, often cumulatively over time.

1. A complex problem

In 2005, 163,000 households in England were officially recognised as homeless (Statutory Homelessness England, Statistical Releases). In 2004/5, 40,000 households were officially recognised as homeless in Scotland (Statistical Bulletins on Housing, Scottish Executive) and in 2004, 16,000 households were officially recognised as homeless in Wales (Housing Statistics, National Assembly for Wales).

Because the visibility of homeless persons congregating in urban areas has increased since the 1980s, the relationship between homelessness and mental illness has caused more and more concern (Ducq, Guesdon and Roelandt, 1997). Most of the studies investigating the mental health of homeless people have tended to be carried out in particular cities: Aberdeen (Sclare, 1997); Belfast (McAuley and McKenna, 1995); Dublin (Holohan, 2000); Glasgow (Kershaw, Singleton and Meltzer, 2003); London (Tacchi and Scott, 1996); Los Angeles and Madrid (Munoz et al., 1998); Melbourne (Herrman et al., 2004); Munich (Greifenhagen and Fichter, 1997); Northampton (Holland, 1996) Paris (Kovess and Mangin Lazarus, 1999); St Louis (Smith et al., 1993); Sydney (Teesson, Hodder and Buhrich, 2004); Toronto (Stergiopoulos and Herrmann, 2003); and Utrecht (Martens, 2001; Reinking, Wolf and Kroon, 2001).

However, in Great Britain, a national survey of the mental health of homeless people has been carried out, based on data from over a thousand individuals living in short-term, private sector accommodation, hostels, night shelters and on the street, and including men and women, young and old, in both urban and rural settings. (Gill et al., 1996).

Some attempts have been made to review all the previous studies through literature searches to get an overall rate of psychiatric morbidity among homeless people. (Abdul Hamid, Wykes and Stansfeld, 1993; Scott, 1993; Slegers et al., 1998; Martens, 2001; Kamieniecki, 2001).

All these studies reach the same conclusion: that it is difficult to get an accurate measure owing to the disparity of epidemiological methods in assessing the type and extent of mental illness among homeless adults. The conceptual, methodological and analytical differences include: the lack of a consensual definition

of homelessness; the type of homeless people surveyed (men, women, adolescents); the choice of different settings in which the research is organised (on the street, health centres, hostels, night shelters, day or feeding centres); the sampling strategies within each setting; the use of diverse instruments of psychiatric evaluation mainly the CIDI (Robbins et al., 1988) and the GHQ 12 (Goldberg and Williams, 1988) response rates; and the extent of clinical input.

2. Prevalence of mental disorders

The latest review reported that the prevalence of mental disorders among homeless individuals varied from 80%-95% in the USA, Australia, Canada, Norway, and Germany to 25%-33% in Ireland and Spain. The most prominent mental disorders among the homeless, which varied from country to country, were depression, affective disorders, substance abuse, psychotic disorders, schizophrenia, and personality disorders (Martens, 2001).

A systematic review has also been carried out focusing only on studies of the prevalence of schizophrenia in homeless persons (Folsom and Jeste, 2002). From an inspection of 33 published reports, the rate of schizophrenia in homeless persons representing eight different countries ranged from 2% to 45%.

Both these reviews highlight the difficulty in surveying homeless people and the fact that different methodological approaches, particularly definitions of homelessness and sample sizes, can lead to widely different estimates of psychiatric morbidity. In general, the broader the defining criteria used, the higher will be the observed prevalence rates.

For this review, information on the mental ill-health of homeless people, the risk factors which influence it, and its associated disability and wider consequences will be presented from the national survey carried out in Great Britain (Gill et al., 1996) and, where appropriate, reference will be made to the research carried out in other countries.

In the GB survey, a distinction was made between four groups of homeless people: sleeping rough; using night shelters; staying in hostels for the homeless; and staying in temporary, private sector leased accommodation. The last group mainly comprised couples with young children or young single women, about half of whom were from the South Asian minority ethnic population.

The rate of psychosis varied considerably between the four groups. Between 40%-50% of those sleeping rough or staying in night shelters screened positive for psychosis on the Psychosis Screening Questionnaire (Bebbington and Nyani, 1995). This rate of psychosis (assessed by SCAN interview) fell to 8% among those staying in hostels and 2% in leased accommodation. (Gill et al., 1996). All of these rates are far higher than in the private household population: about a half of one per cent (Meltzer et al., 1995).

About 60% of those sleeping rough and users of night shelters had a score of 4 or more on the GHQ12 (Goldberg and Williams, 1988), indicative of neurotic psychopathology, while nearly 40% of the other two groups were assessed as having a neurotic disorder based on the Revised Clinical Interview Schedule (Lewis et al., 1992). The rate in the private household population was about 16% (Meltzer et al., 1995; Singleton et al., 2001).

Alcohol and drug dependence were also very prevalent – around 25%-35% of the first two groups were alcohol dependent and 15%-25% were drug dependent. Rates were far lower in hostels and fell to 5% alcohol dependent and 1% drug dependent among those housed by local authorities in temporary accommodation (Gill et al., 1996).

The GB survey, however, did not cover personality disorder. It has been argued that, among the homeless, many features of antisocial personality may be artefacts of homelessness and that strict application of the diagnostic criteria may be insensitive to social and cultural factors in this group. However, North, Smith and Spitznagel (1993) found that most adult symptoms of antisocial personality disorder among homeless people were significantly associated with the number of childhood conduct disorder symptoms and that the onset of symptoms of antisocial personality disorder usually preceded the onset of homelessness.

Suicidal thoughts or, more importantly, suicide attempts, are rarely assessed in surveys of homeless people. However, Eynan et al. (2002) specifically looked at this issue and found that 61% of their homeless sample reported suicidal ideation and that 34% had attempted suicide, with the rate among women being twice that of men.

All studies, whether national surveys, local studies or reviews, irrespective of methodology, indicate a considerable degree of co-occurrence of mental disorders. From the UK, Scott (1993) reports co-morbidity of mental illness and substance abuse occurring in 20% of the homeless population. Reinking, Wolf and Kroon (2001) describe a so-called double diagnosis for 27% of the homeless population in Utrecht, whereas Teesson, Hodder and Buhrich (2004) found that, in Sydney, 40% of the men and 50% of the women had at least two mental disorders. Even among homeless adolescents, Whitbeck et al. (2004) found that they were six times more likely than same-aged, private household survey respondents to meet diagnostic criteria for two or more disorders. There also seems to be a consensus that women have more addiction problems and higher rates of more serious mental illness than men, irrespective of age.

3. Relationship between homelessness and mental disorder

There are two main propositions relating to the direction of the causal relationship between homelessness and mental ill-health.

Abdul Hamid, Wykes and Stansfield (1993) argue that homelessness is a product of the lack of housing provision to the poorest section of society and that the psychiatric needs of many of the homeless might be a direct result of poverty and homelessness.

On the other hand, Munoz et al. (1998) found that the majority of the homeless people in their sample, both in Madrid and Los Angeles, first experienced symptoms of their mental disorders before becoming homeless.

McAuley and McKenna (1995) found that approximately 25% of the homeless in Belfast hostels had a diagnosed mental disorder, suggesting that hospital closure had a direct effect on the size of this percentage. Smith et al. (1993) found in their study in St Louis that nearly one in three homeless women had a history of substance abuse, with drug abuse being more prevalent than alcoholism, and that one in four had received in-patient psychiatric care.

Pathways to homelessness, then, are complex. Deinstitutionalisation may be only one possible cause of the increase in the number of homeless people (Scott, 1993).

The debate on causality in the relationship between mental health and homelessness may be complicated by different scenarios being evident in different countries. In the study that compared homeless people in Madrid and Los Angeles, the only significant difference was that all of the depressed adults in Madrid experienced depression prior to first becoming homeless, whereas this was the case for only 59% of depressed homeless people in Los Angeles (Munoz et al., 1998)

4. Physical health

Homeless persons suffer frequently from physical health problems, most commonly tuberculosis, asthma, bronchitis, HIV infection. As a consequence, they run an increased risk for premature mortality (Martens, 2001). The GB national study of the mental health of homeless people found approximately a half of those with a mental disorder living in private sector leased accommodation, hostels or staying in night shelters reported physical health problems, about twice the rate of those with no mental disorder.

Homeless people sleeping rough did not follow this pattern. They reported the highest rates of physical health problems, but proportions did not vary greatly between those with or without a mental disorder. Among all the homeless people in the survey, respiratory system complaints were very common. The survey also showed that 80%-90% of homeless people were smokers, and about half of them were classified as heavy smokers. However, the most prevalent physical health problems were musculo-skeletal complaints.

In Glasgow, one in five homeless people aged 25 to 34 reported an infectious or parasitic disease, a group which includes hepatitis and abscesses, reflecting the high rate of injecting drug use among these individuals. A sizeable proportion of this age group (45%) suffered from constipation and 61% reported loss of appetite which, again, may be a consequence of drug use. Among all the homeless people in Glasgow, about a fifth had eaten food only once in the day before interview and 5% had consumed no food at all. (Kershaw, Singleton and Meltzer, 2003).

5. Stressful life events

The GB survey included a list of questions on stressful life events, but these were only asked of those staying in hostels and temporary accommodation. Overall, about 70%-80% of these two groups reported at least one event, with the proportions slightly higher among those with mental health problems. Smith et al. (1993) reported that a third of their homeless sample in St Louis met lifetime criteria for post-traumatic stress disorder, and DeMallie, North and Smith (1997) found that PTSD was more prevalent in younger homeless people.

Within the GB national sample, there were some quite large differences in the proportions experiencing particular events, according to whether or not they were categorised as having a mental health problem. Among homeless people in hostels, those with a mental disorder were far more likely than other residents to have had: a break up of a marriage or relationship; valuable possessions lost or stolen; a serious problem with a close friend; the death of a close relative; and problems involving the police or appearing in court. In a study of homeless people staying at missions in East Baltimore, Fischer et al. (1986) reported that these homeless people had higher rates of arrests as adults than domiciled men (58% compared with 24%), including multiple arrests (38% compared with 9%) and felony convictions (16% compared with 5%).

Looking at particular life events can often mask the real significance of the cumulative effect of stressful events. Among the homeless living in hostels in Great Britain, 29% of those with a neurotic disorder reported having experienced four or more stressful life events, compared with 8% of those without the disorder (Gill et al., 1996).

6. Conclusions

Despite the considerable challenges to investigating mental ill-health among homeless people, a picture does emerge of severe mental health problems among the majority of this population. The combination of mental disorders, alcohol, drug and tobacco abuse exacerbates the situation.

However, just as the health of the private household population varies by biographic, socio-demographic and socio-economic characteristics, the mental health of homeless people also varies by age, sex, ethnicity, cause of homelessness and where homeless people sleep. Consequently, their health needs also differ.

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