

Mental Ill Health in the Adult Single Homeless Population

A review of the literature

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Crisis

Crisis is the national charity for single homeless people. We are dedicated to ending homelessness by delivering life-changing services and campaigning for change.

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Foreword

Mental ill health has always been closely correlated with homelessness being both a cause and consequence of the loss of accommodation for far too many.

That being so, Crisis, as the national charity for single homeless people has looked at the issue of mental health on a number of occasions. This latest report reviews research literature from Great Britain and overseas on the extent of mental ill health amongst homeless people, service issues and accommodation approaches.

The evidence is clear, whilst progress has been made, too many homeless people still experience mental ill health, and we have not yet got right the frameworks and services to respond to their needs. We also need to recognise the full spectrum of mental health problems from common mental health issues to psychosis; the differing needs of particular groups of homeless people; and to ensure services and approaches are tailored accordingly.

2009 provides us with an excellent chance to step-back and reassess where we are. The very welcome commitment of the Government and the Mayor of London to end rough sleeping by 2012 will require many things but, in particular, it will not be achieved without a clear focus on tackling the mental ill health of those who are homeless and ensuring the right services and support are provided in the right places, and always centred around the needs of the client.

Leadership and resources will be required from central government, as was first demonstrated with the establishment of the Homeless Mentally Ill Initiative in the early 1990s. And the issue needs to be a real priority for the NHS from the setting of budgets and strategies at the top right down to the local GP practice and community mental health team. But much will also need to be done at a local level with local authorities, their voluntary sector partners, PCTs and mental health trusts all working together to identify need, to plan and commission services accordingly and, most importantly, to deliver the joined-up services and solutions homeless people need to escape their homelessness and improve their mental health and well being.

I hope this report will remind us of some of the challenges we face and help to kick off a debate and renew our determination to tackle these issues once and for all.

Leslie Morphy
Crisis Chief Executive

Executive Summary

It is commonly accepted that mental health problems are much more common among homeless and vulnerably housed people than in the general population. In many instances mental health problems played a significant part in the circumstances which caused those persons to lose their accommodation. The mental health problem may then be exacerbated by the stresses associated with being homeless, which in turn will make it even harder for that person to achieve stability in their housing.

The majority of research into homelessness and mental health considers large urban populations and studies concentrate on the street and shelter populations. Less is known about the mental health of those who live in temporary accommodation or who are part of “the hidden homeless” in unsatisfactory or unstable accommodation or who are outside the main cities of London, Birmingham, Edinburgh and Belfast.

The extent of mental ill health in people who are homeless

- The most quoted and most authoritative source on the extent of mental ill health in the adult population in the UK suggests that the prevalence of common mental health problems is over twice as high and of psychosis 4-15 times as high amongst the homeless population compared to the general population.
- This is worse among street homeless people, who may be 50-100 times more likely to have a psychotic disorder than the general population.
- Serious mental illness is often accompanied by alcohol and/or substance misuse problems. Most studies suggest that around 10-20% of the homeless population would fulfil the criteria for dual diagnosis.
- Homeless people, in particular those with mental ill health, have higher mortality rates than the general population. They are up to nearly 5 times more likely to die than the equivalent age group of the general population.
- Rates of reported personality disorder are also high. In a recent survey of homeless services in England, staff estimated two thirds of their clients presented with characteristics consistent with personality disorder, many of whom were thought to be undiagnosed.
- Among people who are in touch with psychiatric services there is a significant minority that is homeless. A recent European study found that just under a third of the British sample of patients with schizophrenia had experienced homelessness in their lifetime, with over a tenth having experienced “rooflessness.”
- Overall research shows that as the stability of housing increases then rates of serious mental illness decreases.

- Women experience some risk factors (such as physical and sexual violence as a child) for both mental illness and homelessness to a greater extent than men. The rates of mental health problems – including deliberate self-harm (DSH) and suicidal ideation also seem to be higher in homeless women than in men.
- The proportion of homeless people who are mentally ill from BME groups is disproportionate in relation to their proportion in the general population.
- Refugees and asylum seekers also have high rates of mental disorder and are at risk of being in unstable housing.

Support and services

- Research suggests that homeless people may place a low value on health generally in the face of poverty and their day-to-day difficulties. They often do not access health services; few are registered with GPs; and many use emergency services for both physical and mental health care.
- In terms of service provision for this group there can be an inevitable tension between the views of housing providers who want tenants that are perceived not to be a “problem” and mental health providers who want stable housing outcomes for their service users.
- There is an ongoing debate about the models of interventions that will most help this population. Tentative conclusions suggest assertive models of psychiatric care closely linked with housing provision can achieve both good mental health and housing outcomes. There is also some support from US research for approaches that do not insist on initial engagement in treatment programmes in order to access housing.

Gaps in knowledge include:

- The mental health of subgroups of the street/hostel populations, such as women and black and ethnic minority groups.
- The mental health of the hidden homeless and of rural populations.
- A greater understanding of what triggers or contributes to homelessness among those with existing mental ill health and personality disorders, alongside a better understanding of outcomes for this population.
- Effectiveness and acceptability of different approaches to intervention.

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1 Introduction

This report reviews the national and international literature on mental ill health in the adult, single homeless population, with an estimate of the prevalence of mental ill health among adult single homeless people in the UK and commentary on housing interventions in this group.

2 Definitions of Homelessness

Homelessness is defined in different ways in different countries and this fact complicates analysis of the data and the literature on homelessness. Definitions range from the broad and imprecise: “anyone who lacks adequate shelter, resources or community ties”, to the more complex, based on:

- Temporal - the frequency of the person being without a home;
- Geographical - based on types of accommodation that homeless people may use or;
- Typological classifications - based on the characteristics of those that are homeless (Scott 1993).

These systems inevitably overlap and none provide for all cases. What is certainly true is that there is a very small proportion of homeless people who are literally without accommodation (roofless) such as those sleeping on the streets, a larger group, but still a minority of the total homeless population, that use direct access hostels or shelters, a significant group who are housed in temporary accommodation such as B&Bs and the majority of the homeless population, the “hidden homeless,” who are in unstable accommodation, with friends or family or otherwise without their own home.

Few countries collect routine data systematically on any but the narrowest definition of homelessness – that of rough sleeping. Based on a broad assessment of available data sources and country experts it has been suggested that in the most recent decade homelessness, particularly rough sleeping, is decreasing in England and Germany (Fitzpatrick & Steven 2007). This is in comparison to the period from the 1980s, where homelessness rose in major UK cities and the profile of the population changed with increasing numbers of under-25s, women and individuals from ethnic minority groups (Craig & Timms 2000). In other EU countries homelessness appears to be on the increase or staying the same (Fitzpatrick & Steven 2007).

3 Definitions of Mental Health Ill Health

Mental ill health includes both common mental health problems and psychotic disorders. Common mental health problems include generalised anxiety disorder, mixed anxiety and depressive disorder, depressive episode, phobias,

obsessive-compulsive disorder and panic disorder. Psychotic disorders include schizophrenia, schizotypal and other delusional disorders, manic episodes and bipolar affective disorder and other affective disorders with psychotic symptoms.

4 The research literature

Worldwide there is a very extensive literature on homeless people, in particular homeless people who are mentally ill. A search of the main databases was conducted (see Annex 5 for search strategy). We initially limited the search to the UK only but found that this excluded significant work in a number of areas, consequently international literature is also commented on here. What follows highlights the major findings of the review.

4.1 General comments

- Internationally the majority of research is from the USA, although with an increasing contribution from the UK over the past 15 years. There are also research contributions from Canada and Australia. European literature published in English, other than from the UK, is relatively sparse with contributions from Germany, Spain and France. There is also some Scandinavian literature. This may reflect a relatively greater problem with or interest in homelessness in Britain than other European countries.
- Methodologically many studies have limitations, limiting the capacity to make robust comparisons between studies. Definitions of homelessness vary, as do methods of case ascertainment for mental disorder. Many studies have used standardised protocols for making diagnosis or diagnosis has been made by non-clinicians. Sample sizes are often relatively small and comparator groups are not always included. This makes it difficult to comment on whether findings are related to homelessness itself or other aspects of social adversity.
- Most research is concentrated on large urban populations. Internationally, New York City, St. Louis, Sydney; in the UK, London, Edinburgh, Belfast and Birmingham. Very little has been written about rural homelessness or urban homelessness outside significant conurbations.
- The majority of research covers the homeless population that are street homeless or in direct access hostels. Considerably less research looks at those in second stage accommodation, temporary housing or in unstable accommodation. This of course means that we have much less information on the majority of the homeless population.
- The single homeless population on the streets or in hostels is predominantly male, approximately 20% are women. There is relatively less research on single homeless women.

- Black and minority ethnic (BME) groups are overrepresented in homeless populations. However much research on homelessness and mental ill health does not consider ethnic differences.
- Given the relative increase in younger individuals in the homeless population there has been a significant expansion in this literature. This has not been reviewed separately, but is commented on where of interest as youth research often includes young adults up to 25, as well as teenagers.
- In addition to methodological differences hampering research comparisons, international comparisons are inevitably also limited by socio-economic, cultural and welfare policy differences. This is particularly the case between the UK and the US, but also between the UK and other European countries. Even within countries there are differences in the types of accommodation available to house those that are homeless and access criteria vary. For example, whether access to housing requires a diagnosis of mental illness or whether individuals who continue to use drugs and/or alcohol are eligible.

4.2 Findings

In this section general findings on the prevalence of disorder in homeless populations are discussed, including consideration of homelessness in populations in touch with psychiatric services. This is followed by sections looking at trends over time and specific findings for single women, BME and migrant groups.

4.2.1 Rates of disorder

All studies, internationally and in the UK, report a higher prevalence of mental disorder in the homeless population in comparison to the general population. The prevalence of serious mental illness (including major depression, schizophrenia and bipolar disorder) is reported as being present in at least 25-30% of the street homeless and those in direct access hostels (Folsom 2002; Scott 1993; Fischer 1991; Craig 1995; Buhrich 2003). A recent systematic review of the literature estimated the prevalence of psychosis among homeless people more generally at 11%, with higher rates in women, young people and the chronically homeless (Folsom 2002). Generally, there seem to be higher rates reported in the US than in European studies. This may be a reflection of difficulties accessing psychiatric services in the USA health insurance system (Philippot, et. al. 2007).

Other international differences are seen particularly with respect to substance use (Teesson 2003). Examples of the types of studies include:

- Belfast hostels and B&Bs: based on hostel workers assessment of functioning, the researchers concluded that the homeless population were comparable to the most disabled in a local mental health day hospital (McGilloway 2001).

- Sydney refugees: rates of disorder four times that in the general population were found, with prevalence rates of schizophrenia of 23% for men and 46% for women (cf. 0.5% in the general population) and 20% of men and 29% of women having two disorders (Teesson 2003).
- Tübingen: a census of all homeless men: 73% had at least one psychiatric disorder; 74% had alcohol dependence; 34% had drug dependence; 26% had anxiety disorder; 15% had affective disorder; 15% had schizophrenic disorder and 67% had more than one diagnosis (Langle 2005).

Levels of drug and alcohol use and dependence is very high, both as a single or combined problem. For example, in a survey of street homelessness and hostels in London, 83% reported using drugs in the month before interview, 68% had used alcohol (cf. 3-20% drug usage in the general population). Polydrug use was common and two-thirds reported dependence on the main drug used and a third reported alcohol dependence. Usage and risk of injecting increased alongside length of homelessness (Fountain 2003).

Rates of dual diagnosis with substance use and other mental disorder are also high. It is important to note, however, that the range found in studies is wide – from 4-26%. The majority of studies suggest around 10-20% of the homeless population would fulfil the criteria for dual diagnosis. This applies a strict definition for disorder – many more individuals will have a diagnosis of mental illness and have a co-existing substance use problem, not amounting to the threshold for diagnosis. It is often the co-existence of these problems that make resettlement and engagement particularly difficult (Drake 1991; Craig 1998).

Rates of deliberate self-harm (DSH) and attempted suicide are also high. For example:

- Emergency presentation of DSH to an inner London hospital showed that 15% of patients were of no fixed abode (Cullum 1995).
- Using data from the Oxford Monitoring System for Attempted Suicide analysis of emergency department presentations between 1988 and 2002 (10,346 individuals) showed 3.6% were of no fixed abode – accounting for 10% of presentations. This group were more likely than those in accommodation to be male, have a history of psychiatric care, previous and future episodes of DSH, personality disorder (although not other psychiatric diagnoses), substance use problems and to have a higher subsequent mortality from all causes (Haw, 2006).
- A Canadian survey of 15-25 year olds living on the streets showed 15% of men and 30% of women had attempted suicide at least once in the preceding year as compared to 2% and 6% in the general population (Public Health Agency of Canada 2006).

Rates of reported personality disorder are equally high. For example, in an Edinburgh sample 70% had at least one diagnosable personality disorder and 40% two or more (Murphy, et. al. 2002). Similarly, in a recent UK review staff from a range of services estimated that two thirds of their homeless clients presented with characteristics consistent with personality disorder, many of whom were thought to be undiagnosed (Middleton 2008).

More qualitative data is also of interest. For example, a recent telephone survey of providers of day centres, direct access hostels and second stage supported accommodation in England suggested that, in all settings, workers felt that approximately half of their clients had some sort of mental health problem. As the stability of housing increased then this proportion decreased, so that in day centres the proportion was higher than in second stage accommodation (Survey of Needs and Provision, 2008; see Annex 3). Similarly, analysis from CHAIN (Combined Homelessness and Information System), which collects data on rough sleeping in London, suggests that 52% of people contacted have an alcohol problem, 41% have a drug problem, 39% have a mental health problem, and 25% have multiple needs (Broadway 2008). Whilst these estimates were made by housing (as opposed to health) staff, they reinforce the picture of very high substance use and mental health needs particularly in the street homeless.

4.2.2 Rates of homelessness in those in touch with psychiatric services

An alternative approach to considering mental ill health amongst homeless people is to determine whether individuals with a specific diagnosis have an increased risk of homelessness or to more generally to consider the issue of homelessness in those who are in touch with psychiatric services. Findings in psychiatric populations include:

- European Schizophrenia Cohort found that 32.8% of the British sample had experienced homelessness in their lifetime, with 13.2% having experienced 'rooflessness'. This was in comparison to 8.4% having experienced homelessness in Germany and 12.9% in France (Bebbington 2005).
- A study of admission to a large psychiatric hospital in South London showed that half of all patients were revolving door with more than 3 admissions in a year. This group were significantly more likely to live alone in private accommodation on admission and more likely to be discharged to homeless hostels. They were also more likely to have longer psychiatric histories and problems with substance use (Langdon 2001).
- In Dublin an analysis of all psychiatric assessments over a 6 month period showed that 13.8% were homeless (using a broad geographical definition). This group was more likely than others to self-refer to emergency departments, to be living in hostel accommodation, to be male with a forensic history and diagnosis of substance use. Nearly 20% had a diagnosis of

schizophrenia, and 16.5% had a dual diagnosis of substance use and other mental illness (O'Neill 2007).

- A Canadian comparison between homeless people who are mentally ill and the housed mentally ill who had been in contact with psychiatric services showed that those who were homeless were more likely to be male, have greater problems with self-care, greater problem severity with respect to depression, aggression and anti-social problems – including contact with the criminal justice system and problems with substance misuse. The housed group were more likely to be older, female and have a diagnosis of schizophrenia. This differs from findings in the US and may reflect the fact that those with schizophrenia may be able to access housing more easily in Canada than in the US (Forchuk 2008; Folsom 2005).
- A US community survey of 400 people with schizophrenia showed a fifth had no fixed address – 2.4 times higher than for major depression (Folsom 2005).
- In San Diego County analysis of 10,340 adults in touch with specialist mental health services showed that of those who were homeless: 20% had schizophrenia, 17% had bipolar disorder and 9% had clinical depression (Folsom 2005).

4.2.3 Trends over time

There continues to be debate about whether there has been a change in the numbers of mentally ill in the homeless population, particularly in relation to the closure of the large psychiatric institutions and the continuing fall in the numbers of psychiatric beds. A number of studies seem to suggest that the prevalence of major disorder is fairly constant, despite changes in service provision, but that the prevalence of substance misuse is increasing:

- UK studies suggest that those with serious mental illness who become homeless are not ex-patients from the large institutions that closed, rather they are a younger group of service users. Their presence in the homeless population may reflect the inadequacy of community-based mental health services to provide for a sub-section of the psychiatric population with complex needs (Craig & Timms 1992; Leff 1993). Many studies internationally do however suggest that homeless people who are mentally ill have had contact with psychiatric services at some point in their lives.
- A US comparison of prevalence between 1990 and 2000 in homeless people in St Louis (rough sleepers, hostels and short stay hotels) suggests that the prevalence of schizophrenia remained stable at around 20%; alcohol use was similarly prevalent across the decade. However, drug use increased significantly particularly for cocaine usage and particularly amongst women. There was also an increase in the prevalence of major depression, which was the largest single diagnostic group after schizophrenia (North 2004).

- In inner-Sydney refugees rates of schizophrenia were compared between 1983 and 2001, no significant difference was found in men or women across these time periods. During this time significant numbers of inpatient psychiatric beds were closed (Buhrich, et. al. 2003). In Madrid similar conclusions were made (Vazquez et. al. 1997). However, in Sweden estimates suggest that between 1993 and 2000 there was an increase in mental health problems in the homeless population from 17% to 40% (The National Board of Health and Welfare 2001).

4.2.4 Women

Generally, women's risk of street homelessness is less than it is for men (Marpasat 1999). Women's potentially more fragile socio-economic circumstances, which might predispose them to loss of accommodation, seems to be counter-balanced by their potentially greater access to services, particularly for single mothers. Consequently, they make up a significantly greater proportion of the population in temporary housing, being given priority if they are caring for children. This latter group is outside the scope of this review. Women may also be more likely to stay with family or friends on losing accommodation, about which there is relatively little written (Robertson 1996).

Women experience some risk factors for both mental illness and homelessness to a greater extent than men. Histories of physical and sexual violence as a child, prior, and subsequent, to becoming homeless are common and more likely in women, although this is also an issue for men (Vostanis 2001; Wenzel 2000). Child sexual abuse is known to be an independent risk factor for the development of adult mental ill health. Domestic violence, significantly more common in women, is also associated with high rates of mental and physical disorder. Women are more likely than men to give relationship breakdown and violence as a reason for becoming homeless than are men.

The body of research looking at the mental health of single homeless women is relatively small. However, most studies suggest that women are likely to have greater levels of disorder than men. Findings include:

- In inner London hostels 60% of women had been previously admitted to psychiatric hospital and a similar proportion had a diagnosis of schizophrenia – higher than similar studies have found in men (Marshall 1992). A later study in London hostels found a lower prevalence of schizophrenia, but still found half the women had had contact with psychiatric services and half had a diagnosis of bipolar disorder, schizophrenia or major depression (Tacchi 1996).
- In inner Sydney a definite or probable diagnosis of schizophrenia was found in over a third of women in refugees in separate studies in 1989 and 2003. Despite this apparent increase this trend was not significant given the relatively small numbers in the study. Rates in men over the same period were 16-26% (Buhrich 2003, Teesson 2003).

- Secondary analysis of the ONS surveys showed that a third of women living in temporary accommodation (statutorily homeless) had neurotic disorders (mainly depression and anxiety) – twice the rate found in the general population. Rates of depression were particularly high in the younger age group, most of whom were women. However, the majority of these women had children, hence their status as statutorily homeless. For the relatively smaller numbers who were single these differences were not seen. Although not commented on in the study it seems that the number of cases of depression and anxiety in single women was higher in the housed population. (Sims 1999).
- Rates of DSH and suicidal ideation seem to be higher in homeless women than in men (Public Health Agency of Canada 2006).
- Similarly, in line with the high rates of histories of abuse, ongoing traumatic events and revictimisation, rates of post traumatic stress disorder have been found to be high in both adult and youth homeless, particularly in the female population (Taylor & Sharpe 2008; Stewart et. al. 2004; Gwadz 2007). For example, in Seattle youth 21% of girls and 15% of boys showed evidence of disorder whereas figures of less than 10% might be expected in the general youth population (Gwadz 2007; Stewart 2004). In the US, rates of lifetime PTSD amongst homeless adults were 18% in men and 34% in women (North 1994).
- Homeless women report using drugs and alcohol as a means to cope and that homelessness itself is a cause of deteriorating mental health (Reeve 2006).

4.2.5 Black and Ethnic Minority Groups

Most studies suggest that although the largest group of homeless are white men, the proportion of homeless people who are mentally ill that come from BME groups is disproportionate in relation to their proportion in the general population (Austin 2008). This seems to be less true in the UK for Asian sub-groups, perhaps reflecting the increased likelihood of strong familial bonds within the community. Although a consequence of this maybe an increased likelihood of overcrowded housing.

4.2.6 Economic Migrants

As patterns of immigration change this is likely to be reflected in the homeless population. Similarly, as the economic climate changes then this may also have an impact on employment amongst migrant workers and on their capacity to maintain housing. Day centres, being open access and drop-in, are often the first to pick up emergent trends within the sector. Accordingly, a recent small study of London day centres and shelters suggested an increase in the number of A8 nationals not seen in other levels of provision (Homeless Link 2006; see also Broadway 2007).

Homeless Link also carries out a survey of Central and Eastern European rough sleepers in London every year and estimates that 25% of the people currently sleeping rough in the capital (126 out of 508) are from Central and Eastern Europe (Homeless Link 2009). This represents a 7% rise from the previous year.

4.2.7 Refugees and asylum seekers

Refugees and asylum seekers are known to have high rates of mental disorder, particularly depression and post-traumatic stress disorder (Ryan 2008). This is particularly the case for those that have survived war or torture. The research literature is complex: many screening instruments are not validated in these populations; cultural considerations in interpreting results are complicated; medicalisation of grief and loss may not be appropriate and the impact of immigration on loss of social status, isolation and the uncertainty of the future need to be considered (Tribe 2005; Turner 2003). However, despite such complexities, this group does seem to have significant rates of disorder that in many cases is still present years after resettling (Marshall 2008).

Refugees and asylum seekers are also at risk of homelessness given the constraints on their working or claiming benefits for example (Palmer 2006). Interestingly there is some suggestion that for other immigrant groups who are not refugees their mental health status may be equally poor, perhaps reflecting their experience of discrimination and marginalisation in the host society. For example a comparison of Indochinese refugees, British and Pacific Island immigrants in New Zealand suggested that the Pacific Island immigrants' mental health status was more comparable to that of the refugees than it was to the British immigrants (Pernice 1994).

5 Service delivery and homeless people who are mentally ill

This literature review focused on reviewing the epidemiology of mental disorder in homeless people, it did not set out to specifically evaluate what interventions or service models work for those with mental illness who are homeless. However, a significant amount of epidemiological data is associated with the service delivery literature. As a result a few generalisations are made here as being potentially useful in understanding patterns of service usage and to give some idea of the sorts of approaches to provision of accommodation that may be effective. It is always worth bearing in mind however the inherent difficulties of research in this field. Assessing complex interventions in populations with complex needs is not easily amenable to scientific gold standards of randomisation for example.

5.1 What happens to homeless people who are mentally ill?

Here we consider the outcomes for a given population with or without interventions. There are a number of studies that look broadly at outcomes for this population. For example:

- There is some evidence to suggest that the reasons for homelessness amongst the mentally ill are similar to other groups of homeless people – at least in the USA. Nearly 3000 individuals were asked about the reasons for their most recent loss of housing. Most in both the mental illness group and others reported that this related to insufficient income, unemployment and/or lack of suitable housing (Mojabai 2005).
- Studies from North America, Australia and Europe all show that homeless people, in particular those with mental ill health, have mortality rates higher than the general population. Standardised mortality rates (SMRs) reported vary from 1.83- 4.7, i.e. this population are up to nearly 5 times more likely to die than the equivalent age group of the general population (e.g. Beijer 2007; Fichter 2005).
- Follow-up of men on the streets or in emergency shelter hostels in Munich showed considerable improvements in housing status and mental ill health at 3-years. A quarter of individuals were in privately rented accommodation and only 25% on the street or in unstable accommodation with friends. There was a decrease in mood disorders from 20% to 12%, in anxiety disorders from 11% to 5% and substance use from 70% to 55%, although levels of psychotic disorder remained stable at 4% and 6%. Mental health status at the first assessment did not predict housing outcome at follow-up. However, poor housing outcome was associated with inpatient alcohol treatment during the follow-up period, no psychiatric care during this time and less years of education. Psychiatric treatment reduced the risk of staying homeless by about one third. An initial diagnosis of substance use disorder increased the risk of mental illness at follow-up by five fold; inpatient psychiatric treatment during follow-up decreased it by the same factor (Fichter 2005).

- A similar, though smaller, study looking at youth homeless in London with a one year follow-up period also showed that initial psychiatric disorder was not associated with housing status at follow-up. However, rates for disorder were still high overall: 62% initially and 55% at follow-up (Craig 2000).
- Findings from a 5-year follow-up of homeless men with mental disorder in contact with an outreach team in Stockholm showed less favourable outcomes: three quarters were still homeless at follow-up, 20% had died (mainly associated with substance use), and mental disorder had increased by 17% in those surviving (Beijer 2007).
- A UK case control study of homeless people with psychotic disorder compared to a group of never homeless with psychotic disorders suggested that key differences between the groups were loss of contact with childhood carers and substance misuse (Odell 2000).

5.2 What do we know about service usage?

A number of generalisations can be made about service usage by homeless people:

- Few homeless people are registered with a GP: some estimates suggest that this is 40 x less likely than in the general population (Crisis & MORI 2002).
- Numerous studies show high rates of use of emergency services for both physical and mental health care – both generic emergency department care and mental health specific psychiatric emergency services. This was found even where specific homeless services were present. Some studies suggest that the use of emergency services by homeless people is higher than that seen in other deprived populations.
- Homeless people with mental illness are more likely than those in housing to be admitted to psychiatric or substance use services (Adams 2007; Folsom 2005).
- As mental health problems increase there maybe a perverse impact on service usage with some suggestion that individuals maybe less likely to access services (Kim 2007).

Research suggests a number of reasons why homeless people, particularly those with mental illness do not access services:

- A sense that they can solve their own problems (Kim 2007).
- A low priority given to health generally in relation to the pressures of extreme poverty, i.e., the greater need to find food over the need to access health care or simply perceptions about the things that will improve their life. For example half the individuals in a German census of homeless people replied ‘a job or

vocational training' in answer to what would improve their situation, despite high levels of mental disorder being present (Langle 2005).

- A lower priority given to mental rather than physical health problems (Bhui 2006).
- The stigma associated with mental illness and psychiatric diagnosis. That is, it might be regarded as a mark of strength, in a world where this is valued, not to be labelled as 'crazy' (Kim 2007).
- Low levels of awareness of illness and/or motivation to change. In the same German study quoted above nearly all participants reported that they were moderately or completely satisfied with their mental health, despite three quarters of the sample having at least one mental disorder (Langle 2005).
- System barriers such as separation of physical and mental health care and separation of housing, employment and health interventions.
- Financial barriers such as no access to free transport or no access to free medication, and in some countries, lack of health care insurance.

5.3 Accommodation approaches

During the closure of the large psychiatric institutions much of the move-on accommodation for those discharged was run, or at least was closely linked to, health services. Over the years this has shifted, alongside efforts to ensure that the mentally ill have the opportunity to access provision that helps them to live normal lives. Consequently, a wider range of supported housing options have developed and it is increasingly likely that the housing provider is at a relative distance to mental health provision. For many people with mental ill health this maybe an effective option. However, for those with substance misuse and dual diagnosis or other complex needs such housing options are more limited and outcomes are not as good.

There is an increasing body of research that suggests that close integration between housing and health care providers may help create sustainable accommodation for those with the most complex needs. For example, a US randomised control trial of integrated and parallel housing options in Washington suggests that outcomes were improved for those with severe mental illness in the former approach. In the integrated programme both health case management and housing services were provided by teams within the same agency, whilst in the parallel approach case management was provided by mobile assertive community treatment teams and housing by community-based landlords. Greater housing stability and general satisfaction was found at 18-month follow-up for those individuals assigned to the integrated approach. This was particularly true for men (McHugo 2004).

These findings are in line with earlier UK research, where it was clear that interventions that tackled either mental health or housing alone were not sufficient to prevent subsequent service failures. Only 10% of clients that showed improvement in mental health and accommodation status defaulted from care (Craig 1995).

Alongside the integrated versus parallel approaches described above, the other big debate in service delivery terms relates to “housing first” and ‘treatment first’ approaches. Again, this is a particular issue for those with dual diagnosis. In housing first options abstinence (or at least engagement with treatment programmes), is not a prerequisite for access to stable accommodation. In treatment first options they are. In addition, in many treatment first approaches there may be other rules such as curfews, which, if broken may lead to loss of accommodation. There has been an increasing movement, particularly in the US, for housing first options. Evaluation of treatment first options generally shows modest results in achieving housing stability. This is improved by the close integration of housing and healthcare providers. However, findings from the New York Housing Study suggests that a housing first approach can create significantly more stable housing outcomes for homeless people who are mentally ill with no significant differences in quality of life, mental health or substance use outcomes at 4-year follow-up (Tsemberis 2004, 2005). A recent review of controlled evaluations of housing and psychiatric support studies showed that the best outcomes were for programmes that combined housing and psychiatric support through assertive community treatment (Nelson 2007).

Alongside the evaluation of homeless interventions, since the early 1990s, there has been an increasing number of mental health service initiatives specifically aimed at the homeless population in urban areas. These have varied – from dedicated inpatient units to specific outreach teams for the street homeless and assertive case management approaches. For example 12-month follow-up of clients from the four specialist mental health teams in London that comprised the Homeless Mentally Ill Initiative showed that over half the clients had improved their accommodation status and the number of direct access hostel dwellers and rough sleepers had halved (Craig 1995).

However, few of the more recent references are from the UK. A recent meta-analysis (a way of looking at the results of a number of studies together) of assertive community treatment studies showed that this offers significant advantages over standard case management in reducing both homelessness and symptom severity (Coldwell 2007). A literature review in 2005 suggested similar results with coordinated treatment programmes showing better results for improving psychiatric symptomatology than treatment as usual (Hwang 2005).

There are likely to exist many other variables that can influence housing stability such as social networks and community integration (Yanos 2007). For example, a multi-site US study, the Access Project, showed the importance of family support in maintaining housing in homeless people mentally ill (Pickett-Schenk 2007).

6 Concluding remarks

Homeless people are not a distinct social entity – they share a social proximity to other people living in conditions of poverty and economic insecurity, who are not homeless. (Cohen 1995; Philippot 2007). Homeless people have multiple physical, mental health and other needs and research findings show a clearly increased prevalence of mental disorder over the general population. However, in comparison with other deprived populations these findings are not so stark (Toro 1995). Homeless people who are mentally ill may share more in common with other homeless people than with housed psychiatric service users. This reinforces the importance of longitudinal studies that can capture the changes in the social and economic circumstances that create homelessness (Sullivan 2000; Forchuk 2008).

There is a clear shift in the prevalence and nature of disorder as the acuity of homelessness changes. Those in most unstable accommodation - the streets or direct access accommodation - have higher rates of psychotic illness, substance misuse, co-morbidity and severity of symptomatology. As the stability of housing improves then so does the severity of symptomatology, substance misuse lessens and the relative prevalence of non-psychotic disorders increases.

However, we have very little robust data on the mental health needs of those in second stage accommodation and none has been found that considers the needs of the truly “hidden homeless.” The UK ONS data gives us some indication of prevalence rates in the private leased accommodation sector and hostels with psychosis rates 4 and 15 times higher than the general population respectively.¹ The prevalence of common mental disorder was found to be twice as high. In comparison to the research literature then the estimates for common mental disorder may be fairly robust, if on the low side. However, the estimate for psychosis is low as it does not include the street and overnight hostel homeless, where research suggest that rates of psychosis maybe up to 50-100 times that in the general population. Other groups that find themselves in temporary accommodation, such as women with histories of domestic violence or young people who have left home or care are at a higher risk of mental ill health wherever they are housed.

The gaps we have in the availability of data emphasises the importance of local needs assessment which is discussed further in Annex 4.

In terms of service provision for this group there is an inevitable tension between the views of many housing providers who want tenants that are perceived not to be a “problem” and many mental health providers who want stable housing outcomes for their service users. This is particularly true for those where homelessness is the greatest risk, such as those with dual diagnosis, and therefore exactly the group who could be perceived as a “problem” by housing providers. This tension is also present in research as to whether housing or mental health outcomes are emphasised in design and analysis.

1. See Annex 1, p. 17

Outcomes for homeless people who are mentally ill are particularly poor when substance misuse is also present and as co-morbid mental illness and substance use disorder maybe “the rule rather than the exception and this creates major problems for treatment and rehabilitation” (Craig 1998). Hence services need to be designed to ensure that the needs of this particular group of the homeless population are addressed. This seems more likely when there is close integration of housing, substance misuse and mental health providers and assertive case management approaches are used. It is debatable whether insisting on engagement with treatment services in advance of provision of housing produces better clinical outcomes this group.

Looking to the future, therefore, there are still significant gaps in our knowledge, particularly with respect to sub-groups of the street/hostel homeless such as women or those from BME groups. There is a real absence of literature on the mental health of the hidden homeless and very little looking at rural populations. Further time trend analysis to look at both the antecedents to homelessness in the mentally ill and the longer term outcomes for a variety of interventions would also help to design appropriate care pathways and housing solutions for this particularly deprived group.

Annex 1: Estimating the number of mentally ill people with experiences of homelessness

1.1 The number of homeless people

Routine data sources have significant limitations (see Annex 2). Crisis has estimated the numbers of single homeless people in Great Britain using a number of differing data sources. This estimate used information on the following groups: rough sleepers; people staying in hostels and shelters; people staying in bed and breakfasts and other boarded accommodation; squatters and concealed households – those residing with friends or family, but without any explicit right to do so and in accommodation, which was in some way unsatisfactory. Using this approach there is estimated to be between 310,000 and 380,000 single homeless people of which around a quarter are in hostels, B&B accommodation or facing imminent threat of eviction on the grounds of debt. The remaining three quarters form concealed households (Crisis & NPI, 2003). Inevitably, there are limitations to the robustness of such estimates. However, this is the most recent and complete national estimate and will be used in conjunction with national psychiatric morbidity data to give an estimate for the size of the homeless population who are mentally ill.

1.2 The number of mentally ill in the population

The Office for National Statistics' (ONS) OPCS Surveys of Psychiatric Morbidity in Great Britain, are the most quoted and most authoritative source on the extent of mental ill health in the adult population in England.

The ONS carries out the OPCS surveys on an ad hoc basis to estimate the prevalence (i.e., the number of people with a given condition in the population at any one time) of common mental ill health and psychotic disorders.² Interviews use standardised scales to assess mental ill health at a point in time. Currently, data are available from the 2000 and the 1994 surveys. The 1994 Survey included a sample of homeless people.

The 2000 Survey sampled almost 16,000 addresses to identify private households with at least one person aged 16 to 74 eligible to be interviewed. Of those approached 69% took part. The resulting estimates for mental ill health in the general population are shown in Table 1 and Figure 1.

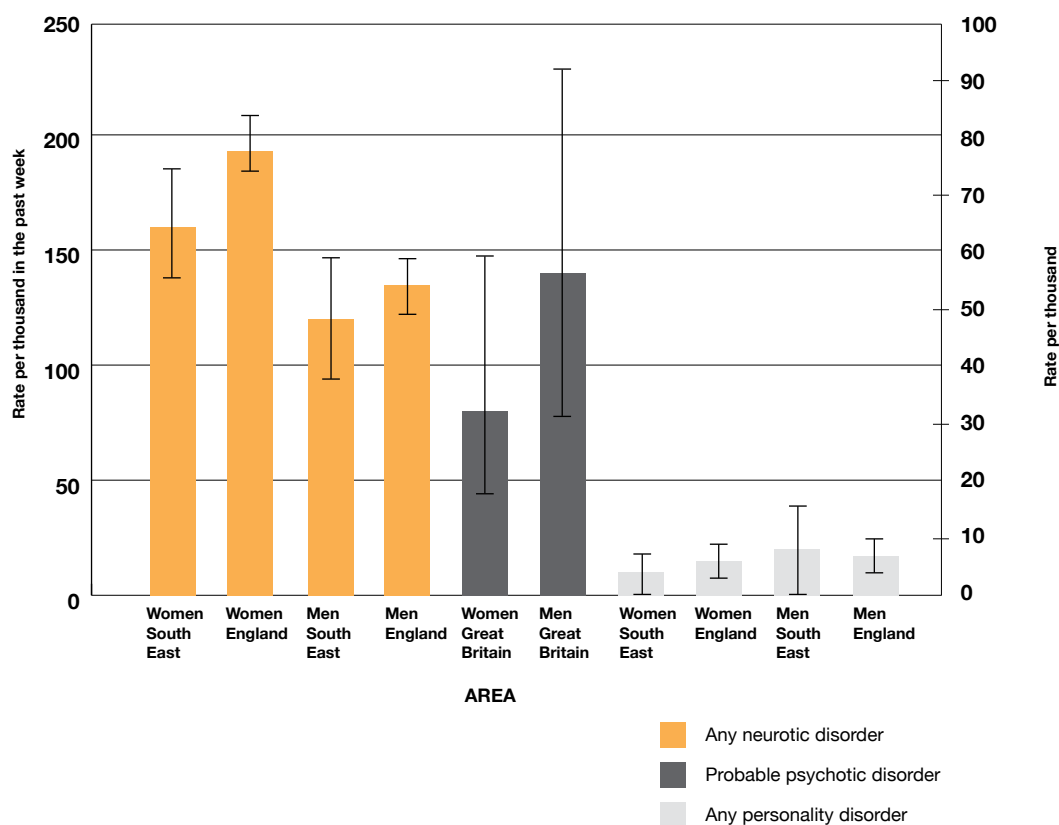
2. For definitions of common mental ill health and psychotic disorders see pp. 1-2.

Table 1: Prevalence of mental ill health among people aged 16 to 74 in Great Britain³

	Estimate	95%	CI
Prevalence of common mental health problems in week before interview	16.4	15.4	17.4
Prevalence of probable psychotic disorder in the last year	0.5	0.4	0.7

Source: ONS, Survey of Psychiatric Morbidity Among Adults Living in Private Households, 2000.

Figure 1: Prevalence of neurotic, personality and probable psychotic disorders among people aged 16 and over in the South East, England and Great Britain 2000



Source: ONS Psychiatric morbidity among adults living in private households, 2000

3. Confidence intervals are used to indicate the reliability of an estimate i.e. how close to the 'true' population the estimate is. If samples are taken repeatedly from the same population, and a confidence interval calculated for each sample, then a certain percentage (confidence level) of the intervals will include the unknown population estimate. We have used the most common confidence level of 95% throughout this report. Where results are presented as charts we show the confidence range with a vertical line that extends above and below the bar on the chart. Generally speaking the smaller the bar, the more certain we can be that the estimate (the bar) is close to the 'true' but unknown number. Where it is larger, we are less certain. This is usually because we have less information to base the calculation on. When we are comparing groups in a population e.g. men and women who are homeless, we look for any results where not only are the bars different but there is no overlap in the confidence intervals (range) – this is usually referred to as a 'significant' result because it is unlikely to have happened by chance.

Neurotic disorders broadly speaking are equivalent to those common mental disorders described on page 1 above. The prevalence of neurotic disorders is measured as a rate per thousand in the past week. Prevalence of personality disorders and probable psychotic disorders are measured as a rate per thousand in the past year. Psychotic disorders are listed on pages 1-2.

The standard error bars represent 95% confidence intervals. These indicate that the prevalence estimates for any neurotic disorder and probable psychotic disorders for England are reliable. The smaller numbers in the South East mean that the confidence intervals are quite wide and the estimates are more uncertain.

1.3 The number of mentally ill in the homeless population

ONS Survey results

The 1994 ONS OPCS Survey of Psychiatric Morbidity in Great Britain sampled 1,166 homeless people aged 16 to 64. Homeless people were defined as:

- people living in hostels, private sector leased and short life accommodation;
- adults staying in night shelters;
- people sleeping rough (sampled through day centres). ⁴

This gave estimates for mental ill health in homeless people shown in Table 2.

Table 2: Prevalence of mental ill health among homeless people aged 16 to 74 in Great Britain

	Estimate	95%	CI
Prevalence of common mental health problems in week before interview	36.5	33.7	39.3
Prevalence of probable psychotic disorder in the last year	5.0	3.7	6.3

Source: ONS, Psychiatric Morbidity Among Homeless People, OPCS Survey 1994

4. In the Office for National Statistics' (ONS) (2000, 1994), Surveys of Psychiatric Morbidity, London. It is important to emphasise, however, that the survey does not provide robust estimates for street homelessness and the prevalence of personality disorders.

Table 3: Estimates for the prevalence of mental ill health in the homeless population

Crisis estimates 2000/2003 data	Count	95%	CI
Rough sleepers, people staying in hostels, shelters or bed & breakfasts	78,000		
Estimated number of people with common mental health problems	27,677	25,572	29,762
Estimated number of people with probable psychotic disorder	3,790	2,842	4,738

Source: Psychiatric Morbidity Among Homeless People, OPES Survey 1994

The prevalence of neurotic disorder (mainly anxiety and depression) was similar in both hostel and private sector leased accommodation (PSLA) residents at 35-38%. The PSLA findings however are less relevant to this review as the residents tended to be families; predominantly women who were pregnant or who had young children. The prevalence of psychosis was estimated as 2% amongst PSLA and 8% amongst hostel residents. No direct estimates of neurosis or psychosis were made in those staying in night shelters or visiting day centres. However, a likely psychiatric diagnosis was found in 60% of these populations. In addition, approximately half were alcohol dependent and up to a quarter drug dependent. Substance use was considerably lower for PSLA and hostel dwellers: PSLA residents showed 3% alcohol and 2% drug dependency and hostel residents 16% alcohol and 6% drug dependency (Gill 2003). These data suggest that the prevalence of common mental health problems is over twice as high and of psychosis 4-15 times as high amongst the homeless population compared to the general population.

Estimates of numbers of homeless people who are mentally ill

We applied the ONS prevalence estimates to the Crisis estimates of “hidden” single homeless people (i.e., rough sleepers, hostel residents, shelters and B&B accommodation) in order to obtain an estimate of the number of this population with mental ill health. This is shown in Table 3.

It should be stressed that these are rough estimates and are likely to underestimate the numbers with severe disorder. This is owing to the fact that no direct estimates of disorder were made for the night shelters and day centres populations where the highest rates would be expected, albeit that these groups are a minority of the total homeless population. However, these are as robust estimates as is possible from existing data sources. Inevitably, they do not reflect the fact that at a local level there will be considerable differences in the type and extent of the homeless population. These findings need to be considered alongside the broader research literature reviewed in the main body of the report.

Annex 2: Routine data sources

2.1 Statutory homeless

Statutorily homeless are households which meet specific criteria of priority need set out in legislation, and to whom a local authority has accepted a homelessness duty. Such households are rarely homeless in the literal sense of being without a roof over their heads, but are more likely to be threatened with the loss of, or are unable to continue with, their current accommodation.

Each local housing authority is required to consider housing needs within its area, including the needs of homeless households, to whom local authorities have a statutory duty to provide assistance. Housing Acts of 1977 and 1996, and the Homelessness Act 2002, placed statutory duties on local housing authorities to ensure that advice and assistance to households who are homeless or threatened with homelessness is available free of charge. A “main homelessness duty” is owed where the authority is satisfied that the applicant is eligible for assistance, unintentionally homeless and falls within a specified priority need group. Such statutorily homeless households are referred to as “Acceptances”.

2.1.1 Households in priority need

The priority need groups include households with dependent children or a pregnant woman and people who are vulnerable in some way due to ill health, including mental illness or physical disability. In 2002 an Order made under the 1996 Act extended the priority need categories to include: applicants aged 16 or 17; applicants aged 18 to 20 who were previously in care; applicants vulnerable as a result of time spent in care, in custody, or in HM Forces; and applicants vulnerable as a result of having to flee their home because of violence or the threat of violence. Where a main duty is owed, the authority must ensure that suitable accommodation is available for the applicant and his or her household. Where households are found to be intentionally homeless, or not in priority need, the local authority must make an assessment of their housing needs and provide advice and assistance to help them find accommodation for themselves.

Statutory homeless data are available quarterly:

- Number of households accepted by a local authority as homeless and in priority need;⁵
- Number of “accepted” households living in temporary accommodation.

It is likely that statutory homeless data underestimate the numbers of the homeless population and in particular the adult single homeless population. Hence, Crisis work with NPI to calculate the full extent of single homelessness.

5. A household comprises one person living alone, or a group of people living at the same address who either share at least one meal a day or share living accommodation, that is, a living or sitting room.

2.2 Rough sleepers

Rough Sleepers are defined as people who sleep in the open air (such as on the streets, or in doorways, parks or bus shelters) or in buildings or other places not designed for habitation (such as barns, sheds, car parks, cars, derelict boats, stations, or “bashes”).

Communities and Local Government has collected annual data on rough sleepers since 1998. Local authorities in partnership with local homeless agencies conduct rough sleeping counts. Street counts provide a useful snapshot of the number of people sleeping rough in a given geographical area on a single night.

According to the most recent National Rough Sleeping Estimate, which includes counts carried out from January 2007 to June 2008, 483 people were sleeping rough on the streets of England on any single night, with half of them in London.

It is important to note, however, that one-night counts do not reflect the realities of the numbers sleeping rough. According to data gathered by homeless agencies, in London alone over 3000 people slept rough at some point over the last year (CHAIN, 2008).

Annex 3: Survey of Needs and Provision (SNAP)

Homeless Link and the Resource Information Service (RIS) carry out the Survey of Needs and Provision (SNAP) on a yearly basis to map the services available in England to single people or couples who are homeless (SNAP 2008).

The research involves three key elements:

- Analysis of Supporting People (SP) provider data about hostels and supported accommodation and of SP client records;
- Analysis of Homeless UK data about day centres, direct access hostels and second stage supported accommodation;
- A telephone survey of 151 day centres, direct access hostels and second stage supported accommodation.

Of particular interest for this work is the telephone survey which, among other things, asked service providers to make estimates of the numbers of their clients who have mental health problems, personality disorders or substance misuse problems.⁶

The survey found that:

- 93% of projects reported having clients with mental health problems and in just over a quarter of projects a majority of clients did.
- 64% of projects reported having clients with personality disorders and in 7% that more than half of all clients did.
- The majority of mental health support is available by referral to an external agency. Out of the services available in-house, talking therapies are most common, but only 26% of projects have this available, either delivered by an external agency or by the projects' own staff.
- In general, accommodation providers are more likely to have mental health services available than day centres. Yet, even where services are available, 21% of all respondents (25% of those where services are available) felt that the therapies are inadequate or inaccessible to their clients.

6. It is important to note, therefore, that the findings here are not of diagnosed conditions, but of staff perceptions of prevalence of disorder.

Annex 4: Local needs assessment

Needs assessment is inevitably not a science. It is most productive when data/information from different sources is considered to determine the needs of the population. Information may come from direct assessment of need through local surveys, extrapolation of national or research data to local populations, use of proxy data such as service usage or through judicious use of opinion for example from local service providers or community leaders. In order to effectively assess the needs of the mentally ill homeless it is likely that a combination of all these approaches will be necessary.

As there is an obligation for local authorities (LAs) and commissioners of health services to conduct joint strategic needs assessment (JSNAs) and for LAs to develop a local housing strategy, these processes should provide the vehicles for assessing and delivering strategies to address the needs of the mentally ill homeless. The work subsequent to the JSNA should have an impact on the relevant PSA target for housing stability in the mentally ill.

Exactly what data is available locally will vary, in many cases service data may not specifically consider the mental health needs of service users and local surveys, censuses or audits may need to be conducted. Consideration of the availability of the following would be of help:

- LA housing data on basis of medical need;
- Aggregation of care planning information on housing need for service users in touch with specialist mental health services;
- Delayed discharges from specialist mental health services secondary to housing need;
- Service usage data from local mental health homelessness services where they are present;
- Service usage data from homeless service providers, both specialist provision for the mentally ill, generic services and refuges for women at risk of domestic violence;
- Specific consideration of local immigrant populations, particularly refugees and asylum seekers – local surveys and views from service providers and local community leaders.

Annex 5: Search strategy

The following databases were searched: Medline, Psyc INFO, Embase, CINAHL and, HMIC. This provides good coverage of the clinical and social science literature, but does not include housing specific research literature and the work is not a comprehensive or systematic review.

An initial search looking at the past 15 years and using the terms homeless/ness and mental disorder (exploded to include the range of more specific terms such as depression etc) and adults resulted in 805 abstracts. All abstracts for mental disorder and homelessness for the past 5 years were reviewed (352 abstracts).

In addition, the databases were searched using the terms temporary accommodation/ hostels in conjunction with mental disorder and separately for refugees/asylum seekers and mental disorder resulting in 360 abstracts which were reviewed.

Arising from these searches 172 full articles were reviewed.

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