

# Are the Homeless Mentally Ill?

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## **Abstract**

In Australia, it is widely believed that most homeless people have mental health issues and that mental illness is a primary cause of homelessness. This paper uses information from a study of 4291 homeless people in Melbourne to investigate these propositions. The research found that 15 per cent of the homeless had mental health issues prior to becoming homeless. This challenges the community perception that mental illness is the primary cause of homelessness. The research also found that 16 per cent of the sample developed mental health issues after becoming homeless. Homelessness causes mental health issues for some people, particularly anxiety and depression. The claim that most homeless people are mentally ill sends the wrong message to policy makers about the services that are needed to assist homeless people.

**Keywords:** Homelessness, mental illness, prevalence, policy.

## Introduction

This article challenges the accepted view that mental illness is the primary cause of homelessness. We examine critically a series of Australian studies which have attempted to estimate the prevalence of mental health problems among the homeless population and argue that the definitions of mental illness often used tend to exaggerate the numbers. We then provide our own estimate, using a study of 4291 homeless people in Melbourne, and explore the important question of whether mental illness precedes homelessness or derives from it. Finally, we attempt to reframe the debate on mental illness and homelessness in the light of our findings and discuss the policy implications that arise from them.

## Estimating the prevalence of mental illness

In the international literature, it is widely recognised that people with mental health issues are over-represented in the homeless population, but there is considerable debate as to the extent of the over-representation (Snow, Baker, Anderson and Martin 1986; Wright 1988). There is a similar debate in the Australian literature, where some studies report that 72 to 82 per cent of homeless people are mentally ill, whereas others report that between 12 and 44 per cent have a mental illness.

Australian studies that report a low to moderate level of mental illness draw their samples in different ways and use different methods to assess whether or not people have a mental health issues. Studies that report a higher level of mental illness also draw their samples in different ways, but they have a common definition of mental illness and use a standardised diagnostic tool. First, we review six widely quoted studies to illustrate both approaches.

A large study by the Australian Institute of Health and Welfare (AIHW) (2007) examined the characteristics of 100 400 clients who used the Supported Accommodation Assistance Program (SAAP) in 2004-05. At that time, SAAP was the Australian Government's flagship program to provide accommodation and support services for homeless people. SAAP clients were classified as having a mental illness if they met one of the following criteria: they were referred from a psychiatric unit; they reported psychiatric illness as a reason for seeking assistance; they were provided with, or referred to, psychological or psychiatric services (AIHW 2007: 4). On this basis, the AIHW found that 12 per cent of SAAP clients had mental health issues.

A study by Rossiter, Mallett, Myers and Rosenthal (2003) interviewed 403 homeless young people aged 12 to 20 using SAAP services in metropolitan Melbourne. Young people were defined as homeless if they had left home for two days or longer without their parents' permission and were living in various forms of temporary accommodation, including emergency accommodation, staying with friends and relatives, and sleeping rough. Rossiter and colleagues used the Brief Symptom Inventory (BSI) to assess the teenagers' mental health. The BSI has 53 questions covering such issues as nervousness, feeling lonely,

and thoughts about death and dying. Rossiter and colleagues (2003: 17) found that 26 per cent of those surveyed 'reported a level of psychological distress indicative of a psychiatric disorder'.

A study by Flatau (2007) gathered information from 173 people aged 19 or older using 31 services in Western Australia. This included 18 services providing support to homeless people and 13 services providing support to people at risk of homelessness. A survey was used to assess the prevalence of mental health issues. The survey was 'completed by members of the research team or by agency case workers' who asked clients direct questions. However, the survey was supplemented by 'case notes and entry assessments' (Flatau 2007: 13). The research found that 44 per cent had a mental health condition, and depression was the most common form of mental illness (Flatau 2007: 14).

The three studies that reported a low to moderate level of mental illness varied in their operational definition of homelessness and they used different criteria to assess whether or not people had a mental illness. Importantly, none of the studies included people who had drug and alcohol issues as mentally ill, unless there was evidence of co-morbidity.

In contrast, three other Australian studies have found that between 72 and 82 per cent of homeless people have mental health issues. These studies also draw their samples in different ways, but they have in common that they use an agreed definition of mental illness and a standardised diagnostic tool which, importantly, included a measure of substance use.

The first study was undertaken in Melbourne by Herrman et al. (1989). They reported findings from a sample of 382 homeless people gathered at homeless shelters in Melbourne and boarding houses in the inner-city suburb of St. Kilda. Another study by Reilly et al. (1994) interviewed 34 young people who were residents of a supported accommodation program in Melbourne. The most well-known study was by Hodder, Teeson and Buhrich (1998) who interviewed a sample of 210 people gathered from eight emergency hostels in Sydney. They defined someone as homeless if they had spent the preceding night in: any space not designed for shelter; with a friend or relative where they could not stay permanently; in a hotel, motel or emergency shelter; or if they reported no permanent house or flat (Hodder et al. 1998: 13).

The three studies used the same clinical definition of mental illness, which included people with mood disorders (bipolar, depression etc.), psychotic disorders (schizophrenia, psychosis) and substance use disorders. This clinical definition also distinguished between substance abuse and substance dependence. Substance abuse refers to situations where the use of alcohol or drugs lead to a major disruption of social relationships, situations of self-harm, or other forms of extreme behaviour (ABS 2007). In contrast, substance dependence occurs when people use alcohol or drugs on a regular basis, and this 'takes on a higher priority for the person than other behaviours that once had greater value'

(ABS 2007: 25). As we subsequently demonstrate, the inclusion of people with substance dependence in the definition inflates the number of people classified as mentally ill.

The studies used a structured clinical interview from the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) to establish drug or alcohol dependence. We endeavoured to ascertain the criteria that were used to categorise someone as alcohol or drug dependent but this was not reported. However, Teeson, Hodder and Buhrich (2003: 467) subsequently revealed that they began testing for 'alcohol dependence' if people consumed 'more than 12 standard drinks in any one year'; and they began checking for drug dependence if people reported recreational drug use 'more than five times in the last 12 months'.

At what point people crossed from being 'at risk' (12 drinks in a year) to being 'dependent' is not made clear in any of the studies. However, all report very high levels of mental illness in the homeless population and in many cases this is attributed to alcohol or drug dependence. For example, Herrman and colleagues (1989: 1181) found that 72 per cent of their sample had a 'severe mental disorder' at some point during their lifetime. Of the 275 people who had experienced mental illness, 69 per cent had a substance related disorder (mainly alcohol dependence), whereas 35 per cent had a mood disorder and 30 per cent had a psychotic disorder. Thus the inclusion of people with alcohol and substance dependence significantly inflated the figures.

The study by Reilly and colleagues (1994) of 34 homeless young people in Melbourne found that 82 per cent of their sample had a mental disorder. Among mentally ill homeless youth, Reilly and colleagues (1994: 30) found that 68 per cent had alcohol dependence and 36 per cent had cannabis dependence, although most youth were also classified as depressed. In the Sydney study, Hodder and colleagues (1998) concluded that 75 per cent of their sample had mental health problems. Of the 158 people who had a mental illness, 38 per cent had schizophrenia, but 48 per cent had a drug use disorder and 55 per cent had an alcohol disorder, usually alcohol dependence (Hodder et al. 1998: 19-21).

While there will always be debate over sampling and definitional approaches, we believe that clinical studies consistently over-state the link between mental illness and homelessness. They do not make it clear what criteria are used to categorise someone as alcohol or drug dependent, and they appear to make the dubious inference that regular alcohol or marijuana consumption is in itself evidence of mental illness.

Although we would argue that they are misleading, these research findings have been highly influential. They have been widely cited by advocacy groups (for example, Council to Homeless Persons 2005: 3-4; Homelessness NSW 2007), and they are also cited approvingly in the policy literature (Department of Human Services (Vic) 2002; Mental Health Council of Australia 2009). For example, Robinson (2003: 1) notes that 'within the inner-city homeless hostel

system around three-quarters of homeless people have at least one significant mental disorder'. Similarly, the Mental Health Council of Australia (2009: 5) reports that the proportion of homeless people with a mental illness 'is certainly high, with estimates as high as 75 per cent'.

The influence of these studies extends into the media. In December 2004, *The Age* headlined a story: '80% of homeless have mental disorder'. This became the basis for subsequent articles in *The Age* and other media outlets. In March 2008, a doctor from St Vincent's Hospital, Sydney, stated: 'There is no doubt when you look at the homeless population you see the majority have either a severe alcohol and drug problems or a severe mental health problems and very commonly have got both' (7:30 Report, ABC Television, Thursday 6<sup>th</sup> March, 2008).

Reports such as these reinforce the public perception that most homeless people are mentally ill. In the broader community it is often assumed that the characteristics of the homeless are, in fact, the cause of their homelessness – mental illness is not just used to describe homelessness but to explain it as well (Fopp 1996; Bartholemew 1999). A 2005 survey of nearly 1000 people in Melbourne found that 81 per cent identified mental illness as a primary cause of homelessness (Hanover Welfare Services 2006). The clinical studies do not claim that mental illness causes homelessness, but they have contributed to the public perception that most homeless people are mentally ill. This in turn underpins the widely held view that mental illness is a primary cause of homelessness.

In this article we use case records of a sample of 4,291 people using homelessness services to explore these issues in more detail. First, we estimate the prevalence of mental illness in the homeless population using a definition of mental illness based on a combination of mental health service use and caseworker assessment. This definition, which we refer to as behavioural, is elaborated further below. Then we investigate whether mental illness preceded or followed homelessness. The argument that mental illness causes homelessness implies that mental health issues precede homelessness. Our findings suggest that this is often not the case. After that, we show that there was considerable variation in the experiences of people who had mental health issues, although the majority experienced long-term homelessness. Finally, based on our analysis, we discuss how policy should best respond to homeless people with mental illness.

## **Methodology**

The research was carried out at two high-volume services in inner Melbourne. Both agencies are generalist services that work with people who are 'at risk' of homelessness, as well as those who are actually homeless. The agencies work with a cross-section of homeless adults, but women escaping domestic violence were under-represented because they often go to specialist services.

A case file was kept on every client and we obtained permission from the RMIT University research ethics committee to read these case files. At one agency the protocol was that clients must give written consent for us to examine their case file. At the other agency the protocol was that clients could opt out of the research by signing a form. The case files could not be de-identified because they were currently in use, but clients' names were not recorded and each record was allocated a code for identification purposes.

The number of homeless people depends on the definition of homelessness that is employed. We used the 'cultural definition of homelessness' which the Australian Bureau of Statistics uses to enumerate the homeless population (Chamberlain and MacKenzie 2008). This well-known definition includes people sleeping rough, staying temporarily with friends or relatives, using emergency accommodation and living in boarding houses. We examined a total of 5526 case histories from January 2005 to June 2006 and coded each file on 30 variables. This examination resulted in information on 4291 people meeting our definition of homelessness.

There were more men than women in the sample (69 per cent compared to 31 per cent). Just over half of the homeless (52 per cent) were aged under 35; another 28 per cent were aged 35 to 44 and 20 per cent were 45 or older. Nearly everyone (96 per cent) was either unemployed or not in the labour force. Most people were single (81 per cent), nine per cent were with a partner and 10 per cent were in a family (at least one adult aged 18 or older and one child aged 17 or younger).

Housing workers in the agencies did not diagnose whether or not clients had mental health issues, but they did record what people told them about their medical history, as well as the reasons why they became homeless and their immediate needs. Records were kept so that housing workers remembered what clients had told them, and so that they could work with clients who had previously been assisted by someone else.

Our database consisted of agency files, so we could not interview clients or administer diagnostic tests. Instead, we coded people as having mental health issues if they met at least one of the following criteria:

- The individual had approached the agency seeking a referral to a mental health service;
- The individual was currently in, or had been in, a psychiatric facility;
- The case notes identified a mental health issue.

We refer to this as a 'behavioural' definition of mental illness because it included people who had received assistance from mental health services or wished to receive assistance.

This approach cannot distinguish between various forms of mental illness or the severity of the illness. However, other researchers interested in mental health and homelessness have used similar measures (AIHW 2007; Baldwin 1998; Piliavin, Westerfelt and Elliott 1989; Snow et al. 1986; Sosin, Piliavan and

Westerfelt 1990). Of course, we have concerns about the reliability of self report measures, and it is possible that some people did not report their mental health issues (Culhane et al. 2007; Padgett, Gulcur and Tsemberis 2006). Nonetheless, staff at both agencies endeavoured to make a broad assessment of the various factors that resulted in the person becoming homeless. We used information from this initial assessment, combined with information from other parts of the case history, to assess whether mental health issues preceded or followed homelessness. Our findings provide an indicator of the extent of mental illness among the inner city homeless, although there may be some underestimation. Similarly, our findings provide an indicator of whether mental illness preceded or followed homelessness, but relevant information may have been missing from some case files.

We also undertook 65 in-depth interviews to supplement our analysis. Agency staff recruited people who were or had been homeless and were willing to participate in the study. Approval was obtained from our university ethics committee. A cross-section of homeless people using the agencies was interviewed and they matched the main sample in terms of basic social characteristics such as age, gender and household type. On average the interviews lasted one hour and they were tape recorded and transcribed for qualitative analysis. We coded the material paying particular to whether mental health issues preceded or followed homelessness. People's names and various personal details have been changed to ensure confidentiality.

We illustrate our arguments using quotations from the interviews, rather than case notes, because interviews convey people's experience in their own words. Often, we use only one or two quotations to illustrate a particular point. However, the selection of interview data was informed by reading more than 1300 case files of people who had mental health issues. Our account is also grounded in extensive previous field experience of work and research in homelessness agencies.

## **Prevalence and temporal order**

Earlier we reviewed three studies that reported a low to moderate level of mental illness among homeless people and three studies that reported a much higher level. We also drew attention to the argument that mental illness is the principle cause of homelessness. In this section we use quantitative data to estimate the prevalence of mental illness among our sample and quantify the number of people who had mental health issues before becoming homeless.

The overall lifetime prevalence of mental illness in our sample was 31 per cent. We have pointed out the limitations of our database, but we believe that 31 per cent is a more realistic estimate of the prevalence of mental illness among homeless Australians for two reasons. First, our findings are consistent with an emerging consensus in the US that suggests that between one-quarter and one-third of homeless people have a severe mental illness (Cohen and Thompson 1992; Sullivan, Burnam and Koegel 2000; Wright 1988). Second, our estimate

is closer to those Australian studies that do not include substance use in their definition of mental illness (AIHW 2007; Rossiter et al. 2003; Flatau 2007). They also found that most homeless people were not mentally ill. Thus, if only around one-third of the homeless are mentally ill, then it cannot be the case that mental illness is the primary cause of homelessness. Table 1 shows that only 15 per cent of our sample had mental health issues prior to becoming homeless. This means that the majority of our sample became homeless for reasons other than mental illness.

In fact, we identified five ideal typical pathways into homelessness and found that nearly half (46 per cent) of the adults had become homeless because family relationships had failed (comprising two distinct pathways - youth and family breakdown). One-fifth (19 per cent) had become homeless because of a housing crisis, and another 17 per cent became homeless because of substance abuse.

Table 1 also shows that as many people developed mental health issues after becoming homeless (16 per cent of the sample), as developed a mental illness beforehand (15 per cent). A number of studies using a clinical definition also report that between one-third and two-thirds of homeless people develop mental health issues after homelessness (Craig and Hodson 1998; Sullivan et al. 2000; Martijn and Sharpe 2006). As we discuss below, for some people homelessness seems to cause mental health issues, particularly anxiety and depression.

**Table 1: Mental health problems before or after homelessness**

	N	Per cent
Mental health problems before	634	15
Mental health problems after	703	16
No mental health problems	2954	69
<b>Total</b>	<b>4291</b>	<b>100</b>

These findings challenge the community perception that mental illness is the primary 'cause' of homelessness (Hanover Welfare Services 2006; Zufferey and Chung 2006). Framing mental illness as the primary cause of homelessness renders homeless people as 'a series of unfortunate cases who need charitable support' (Hodgetts and Chamberlain 2006: 322). This not only individualises the problem of homelessness but it also depoliticises it (Cohen and Thompson 1992; Snow et al. 1986; Wright 1988).

Overall, we argue that clinical researchers exaggerate the number of homeless people who have mental health issues. At the same time, they pay insufficient attention to the well-established body of local and international research which indicates that family breakdown, insufficient income, a lack of affordable housing and poverty all have a powerful influence on the size and composition of the homeless population in western countries (Elliott and Krivo 1991; Neil and Fopp 1993; Main 1998; Wolch, Dear and Akita 1998).

## Mental illness before homelessness

Next we examine what happens when mental health issues precede homelessness and what happens when these problems follow homelessness. We show that there is considerable variation in the experience of people in both situations, before outlining two important experiences that people with mental health issues have in common.

There were 634 people in our sample who had mental health issues before their first experience of homelessness. Table 2 shows that 40 per cent were under 25 years old when they first became homeless and 60 per cent were aged 25 years or older. There were important differences in the experiences of the two age groups.

Mental illness was always implicated in the reasons why those under 25 became homeless, but there were often other factors that contributed to young people's mental health problems. In some cases, poor mental health was linked to adverse childhood experiences such as abuse or neglect, sometimes their parents had mental health or drug problems, but for others their mental health issues emerged with little warning.

**Table 2: Age first homeless for persons whose mental health issue preceded homelessness**

	N	%
Age 12 to 24	227	40
Age 25 or older	338	60
<b>Total</b>	<b>565*</b>	<b>100</b>

\*Information on age in 89 per cent of cases.

When mental health problems emerge, young people often find it difficult to maintain friendships and they rely increasingly on their families. Previous research has found that families offer a foundation for survival by 'providing material necessities like a place to live, food, transportation to and from activities' (Hawkins and Abrams 2007: 2033). Families also provide emotional support for young people and can encourage them to pursue recreational activities. Parents are the 'single most important' source of support that enables young people with mental illnesses to remain housed (Hawkins and Abrams 2007: 2033).

However, some families find it increasingly difficult to deal with their children's behaviour, especially if the young person experiences excessive mood swings or other inappropriate forms of behaviour (Thompson, Pollio, Eyrich, Bradbury and North 2004). One of our interviewees, Tamara, told us that her mother:

...couldn't cope with me, my brother couldn't handle it...mum would come home and just see me getting worse. It was really tense and there were heaps of problems.

As tensions between family members increase, maintaining supportive relationships becomes increasingly difficult and some families attempt to 'minimize conflict by withdrawing' their support (Hawkins and Abrams 2007: 2034). Tamara said that after 12 months the situation at home:

got so bad that my whole family wanted nothing to do with me...like they even changed the locks.

Young people who develop mental health issues before the age of 25 need ongoing family support if they are to avoid homelessness. In some cases, the family cannot cope with the young person and they are evicted from home. In other cases, there is acute family conflict and the young person refuses to stay. Either way, when family support is no longer available, homelessness follows fairly soon after.

Table 2 showed that 60 per cent of those who had mental health problems prior to becoming homeless were aged 25 or older when they first experienced homelessness. Many had developed mental health issues in their late teens or early twenties, but had received ongoing family support throughout their twenties and thirties. We came across cases where people with mental illness first became homeless in their forties or fifties, following the death or incapacity of an elderly parent. In these cases, there were no other family members who would take on the carer's role. After Amelia's parents died, her married brother:

...didn't want me to stay with them. They had their reasons, I suppose. You could tell they were worried about having me there ... they thought I might do something crazy, I suppose.

When people with mental health issues have no family members who will support them, then homelessness often follows.

For those aged 24 or younger, the breakdown of family support usually occurred because the family could not cope with the young person's mental illness. Amongst those aged 25 or older, the breakdown of family support usually occurred following the death or incapacity of an elderly parent.

### **Mental illness following homelessness**

Sixteen per cent of our sample developed mental health issues after they became homeless. It is possible that these people would have developed mental health issues even if they had remained housed, but the evidence from their case notes suggests that a range of environmental factors precipitated a decline in their mental health.

Seventy-eight per cent of those who developed mental health issues after becoming homeless were aged 24 or younger when homelessness first occurred (Table 3). Previous research has found that teenagers who become homeless have to deal with the trauma of family relationships breaking down, and that many have no idea where they will stay or how they will acquire income (Johnson et al. 2008). This can leave them feeling isolated and demoralised. For example, Esther reported that:

...things sort of snowballed. You feel quite alienated from the rest of society. About Christmas time things got real bad. I was really beaten and broken and I spent the whole of January locked up in my room. I became very isolated, very reclusive. It sort of pushed me over the edge.

**Table 3: Age first homeless for persons whose mental health issue followed homelessness**

	N	%
Age 12 to 24	530	78
Age 25 or older	152	22
<b>Total</b>	<b>682*</b>	<b>100</b>

\*Information on age in 97 per cent of cases.

Previous research has found that although some homeless teenagers become isolated, others form friendships with homeless people (Chamberlain and Mackenzie 1998; Fitzpatrick 2000; Johnson and Chamberlain 2008a). These friendships are often opportunistic in nature, but they provided young people with a sense of belonging and interpersonal validation (Snow and Anderson 1993). Friends also provide crucial information that help young people get by on a day-to-day basis.

Studies have shown that many young people engage in recreational substance use before they become homeless, but it is in the homeless subculture that substance use often turns into substance abuse (Johnson and Chamberlain 2008b). Our study found that two-thirds (63 per cent) of the young people who developed mental health issues after becoming homeless also had substance abuse issues. Further, drug use has often been identified as a common trigger for mental illness among young people, but substance use is often a preferred alternative to anti-psychotic medication which can have adverse ‘side effects’ (Hides, Dawe, Kavanagh and Young 2006: 137). The case histories indicated that when young people have both a mental health and substance use problem they often cycle in and out of hospital. During periods of ill-health, they withdraw from social contact. When their health is stable, they engage with other homeless people and this often involves taking drugs.

We cannot establish direct causal linkages between environmental factors and mental illness. Nonetheless, it seems probable that the trauma of family breakdown had a deleterious impact on the mental health of some teenagers, and that substance abuse precipitated mental health issues for others.

Twenty-two per cent of those who developed mental health issues following homelessness were adults aged 25 or older (Table 3). Wong and Piliavin (2001) report that when older people first become homeless they experience considerable anxiety because they are uncertain about what will happen to them. In our study, Terry was worried:

... about how long I was going to be homeless. Living with friends, living insecurely . . . anything can happen. It's really hard. It's something that is always on your mind. You are always worried.

Many people ended up in boarding houses because they could not afford alternative accommodation. John recalled that his mental health problems:

...started when I started living in single rooms...It's a horrible feeling knowing you haven't got anywhere to go...just sitting in a room every day and every night. I didn't have any friends.

Adults were often embarrassed by their homelessness and withdrew from social contact, increasing their sense of isolation. Louise recounted her experience in a boarding house:

There was just emptiness. I can't describe it except that it was a very lonely, dark, empty place...I'm still on antidepressants...I was depressed all the time.

For these participants, homelessness itself seems to have caused anxiety and depression.

Overall, we found that mental illness followed homelessness for 16 per cent of our sample. The trauma of family breakdown impacted on the mental health of some teenagers. For other teenagers, substance abuse precipitated mental health issues. For many adults, homelessness itself caused anxiety and depression.

### Common experiences

Most people with mental health issues in our sample had two important experiences in common. First, 92 per cent had been accommodated in a boarding house (Table 4), and some had been in and out of boarding houses over many years. The proportion in boarding houses was similar for people in different age groups and the proportion did not change if mental illness preceded or followed homelessness (Table 4).

**Table 4: Been in a boarding house by experience of mental illness and age first homeless**

	Mental illness before homelessness		Mental illness after homelessness		
	Age 12 to 24 (N=228)	Age 25 or older (N=336)	Age 12 to 24 (N=529)	Age 25 or older (N=154)	All* (N=1,247)
Been in a boarding house	91	90	94	86	92

\* Information on 93 per cent of cases

It was common for people with mental health issues to report that they were harassed by other boarding houses residents. Over time, people developed strategies to help them get by, including routines to minimise their exposure

to other homeless people, such as avoiding communal kitchens at meal times. Other strategies included sleeping rough, if violence in the boarding house got out of hand. According to Thompson and colleagues (2004: 289), the development of these survival strategies can further ‘alienate the individual from society and their social networks’. Not only does this reduce the quality of their life, but it can also ‘exacerbate existing disorders’ (Perese 2007: 289).

The second thing that homeless people with mental health problems have in common is that they usually experience long-term homelessness. The distinction between ‘short-term’ and ‘long-term’ homelessness is often made in the international literature, but there is disagreement about how these categories should be operationalised (Piliavin, Sosin, Westerfelt and Matsueda 1993; Culhane and Hornburg 1997; Leal et al. 1998). While any typology is ultimately a matter of judgment, for the purposes of this research short-term homelessness was classified as less than three months. With regard to long-term homelessness, there is an emerging convention in Australia that 12 months is an appropriate threshold and we followed this convention (Human Rights and Equal Opportunity Commission 1989; Chamberlain and Johnson 2002; Johnson et al. 2008: Ch. 2). This left a middle category – those who were homeless between three and 11 months – and we refer to this as medium-term homelessness.

**Table 5: Duration of homelessness by experience of mental illness and age first homeless**

	Mental illness before homelessness		Mental illness after homelessness		
	Age 12 to 24 (N=228)	Age 25 or older (N=336)	Age 12 to 24 (N=529)	Age 25 or older (N=154)	All (N=1,247*)
	%	%	%	%	%
Long-term (12 months or longer)	80	71	89	62	79
Medium-term (3-11 months)	8	13	7	18	10
Short-term (less than 3 months)	12	16	4	20	11
	100	100	100	100	100

\* Information on 93 per cent of cases

Table 5 shows that amongst those who first became homeless when they were aged 24 or younger, between 80 and 89 per cent had been homeless for more than a year, as had 62 to 71 per cent of those who became homeless as adults. Overall, 79 per cent of those with a mental health problem had been homeless for one year or longer, and 50 per cent had been homeless for two years or more. Certainly, previous research has indicated that people with mental health issues often become trapped in the homeless population for sustained periods of time (Leal et al. 1998; Piliavin et al. 1993; Johnson et al. 2008).

When people experience long-term homelessness, it has been suggested they accept homelessness as a way of life (Wallace 1965; Grigsby et al 1990). In our view, this proposition is implausible. We found that 81 per cent of people with mental health issues had attempted to return to conventional accommodation but, unfortunately, these tenancies had failed.

People with mental health issues do not normatively accept homelessness as way of life. Rather, they pragmatically accept their situation because they have few housing options, insufficient income, and little family support. This pragmatic acceptance can change quickly once people perceive that alternatives are available and then they want conventional accommodation (Tsemberis et al. 2004).

## **Discussion**

This article set out to investigate the prevalence of mental illness in the homeless population and to ascertain whether mental illness is the primary cause of homelessness. Now we focus on two issues of practice and policy. First, we argue that researchers interested in the link between mental illness and homelessness need to be more realistic and contextually sensitive in the way they frame mental illness. Then we discuss why the provision of permanent housing and long-term support for people with mental health issues should be considered as an integral part of their treatment program.

### **Framing the issue**

There has been a long debate in the social sciences about what constitutes mental illness (Scheff 1966; Szasz 1962, 1971; Mangan 1982) with some writers preferring broader definitions and others preferring narrower ones. In this paper we have reviewed two approaches to estimating the prevalence of mental illness among the homeless. The three clinical studies used the same diagnostic tool and reported higher rates of mental illness. These studies have been influential among advocates and policy makers. In contrast, the three studies that reported lower rates of mental illness have had little impact on the policy process. This could be because the studies are more recent, but their lack of influence may also be because they offer no cogent critique of the clinical approach.

Our view is that the higher rates found in the three clinical studies are misleading because they include people who are regular alcohol and drug users as mentally ill. This way of framing mental illness is not well suited to populations such as the homeless where drinking and drug use are widespread recreational activities, and where some people use alcohol and drugs as a way of coping with a harsh, oppressive environment. It is crucial that researchers take into account the social, cultural and material context when formulating operational definitions of mental illness. We think that mental illness and drug and alcohol dependence are better framed as separate issues, given that they require different service responses.

As it stands, the conflation of mental illness and drug and alcohol dependence has the unfortunate consequence of framing homelessness as a medical issue. The medicalisation of homelessness reinforces the public perception that homelessness is best understood as an individual problem. At the same time, the medicalisation thesis creates the impression that the best way to prevent homelessness is through early medical treatment. This deflects attention away from both the structural causes of homelessness and also the damaging impact of long-term homelessness.

### **Policy implications**

We found that 80 per cent of our sample had been homeless for one year or longer, and 50 per cent had been homeless for two years or more. We also found that most people (81 per cent) had experienced two or more episodes of homelessness. While the nexus between homelessness and mental illness may not be as strong as some suggest, it is clear that new policy approaches are required to assist homeless people who are mentally ill.

For the most part, responses to the homeless mentally ill have been tied to a treatment model. This approach assumes that if mental health problems are resolved first, then homelessness will be resolved later. Underpinning the ‘treatment’ approach is the ‘entrenched view among mental health providers that most persons with schizophrenia or bipolar are too unstable to live on their own’ (Padgett, 2007:1933). It is difficult, however, to address people’s mental health issues when they are living in substandard accommodation such as boarding houses, where they are vulnerable to violence and have no control over their environment.

More recently, some health professionals and policy makers have adopted a social model of health and well being. This approach suggests that medical interventions are more effective when they are delivered in conjunction with non-medical services such as housing. In the United States, this is known as the ‘housing first’ or ‘supportive housing’ approach. It offers people permanent accommodation as part of an integrated package that includes long-term support. Access to housing is not conditional on people accepting support and support relationships are entered into voluntarily. Padgett’s (2007) study of 39 chronically homeless people who were given permanent housing focused directly on the psycho-social benefits of home. Padgett argued that the housing first approach offers participants a greater sense of freedom, privacy and control. Having a ‘place to call home’ had both a positive impact on people’s mental health, as well as providing a stable base through which medical interventions could be more effectively delivered.

There is quantitative data to indicate that it is more effective to provide housing to homeless people before they receive treatment for mental health issues. Tsemberis (1999) compared the housing retention rates of two groups of chronically homeless people with a mental illness. One group went into supportive housing (N=139) and the other group (N=2864) went into a transitional program that gradually moves people into independent living. The

housing-retention rate was 84 per cent for those in the supportive housing program after three years (Tsemberis 1999), whereas the retention rate was only 59 per cent for those who received traditional services after two years. In another study, Tsemberis, Gulcur and Nakae (2004) found that four-fifths of those allocated to supportive housing (N=99) had retained their accommodation after two years, compared with one-third of those who went into traditional services (N=126).

The housing first approach has four strengths. First, it provides people with permanent accommodation for 're-creating a less stigmatized, normalized life' (Padgett 2007:1934). Second, when support programs are entered into voluntarily, there is a greater likelihood of developing trusting relationships which underpin success in supportive interventions (Gronda 2009). Third, housing first provides long-term support. This gives service providers the time they need to build positive relationships which are necessary to address the complex needs of people with a mental illness. Fourth, the stability that permanent housing provides enables clients to re-engage with support workers if their mental health issues reoccur and they need support to maintain their housing.

There is little doubt that rates of mental illness among the homeless population are higher than in the general community, and it is clear that a significant minority of homeless people have mental health problems. However, it is inaccurate to claim that most of the homeless are mentally ill, or that mental illness is the primary cause of homelessness. This deflects attention away from the more pervasive structural causes of homelessness, such as family breakdown, insufficient income and a lack of affordable housing. For homeless people directly affected by these structural factors, the solution to their problems lies outside the medical arena.

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