

Are the Homeless Mentally Ill?*

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A paper presented at the Australian Social Policy Conference,
University of New South Wales,
8-10 July, 2009

* This paper is under review with *Urban Policy and Research*

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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 4,291 homeless people in Melbourne to investigate these propositions. The research found that neither proposition was plausible. Fifteen per cent of the sample had mental health issues prior to becoming homeless, and 16 per cent developed mental health issues after becoming homeless. For those that had mental health issues prior to becoming homeless, it was the breakdown of family relationships that usually precipitated homelessness. For those who developed mental health issues after becoming homeless, it was often their experiences in the homeless population that brought on mental illness. Regardless of whether mental illness preceded or followed homelessness, most people with mental health issues experienced long-term homelessness. The paper concludes with two policy recommendations.

Key words: Homelessness, mental illness, prevalence, policy.

Introduction

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 problem (Snow, Baker, Anderson and Martin 1986; Wright 1988). In Australia, the prevailing view is 'that the vast majority of homeless people experience at least one psychological disorder' (Martijn and Sharpe 2006, p. 1).

Three Australian studies have been influential in creating the impression that the mentally ill are the most common face among the homeless. The first study was undertaken in Melbourne by Herrman, McGorry, Bennett, van Reil and Singh (1989). The researchers used a broad definition of mental illness which included people with alcohol and substance abuse disorders as 'mentally ill'. Hermann et al. (1989) reported findings from a sample of 382 homeless people gathered at shelters for homeless people and boarding houses. They found that 72 per cent of their sample had a 'severe mental disorder' at some point during their lifetime, and that 50 per cent had a current disorder (Herrman et al. 1989, p. 1181). Of the 275 people who had experienced mental illness during their lifetime, 69 per cent had a substance related disorder (mainly alcohol dependence), 35 per cent had a mood disorder

(bi-polar, major depression) and 30 per cent had a psychotic disorder, such as schizophrenia. The inclusion of people with alcohol and substance abuse disorders as 'mentally ill' significantly inflated the figures.

In a study of 34 homeless young people in Melbourne, Reilly, Herrman, Clarke, Neil and McNamara (1994) also included people with substance dependence as mentally ill. Reilly et al. found that 82 per cent of their sample had a mental disorder. Alcohol dependence, depressive disorders and cannabis dependence were the most common forms of 'mental illness'.

Four years later, researchers in Sydney gathered a sample of 210 homeless people drawn from people using inner city hostels, as well as people seeking support whilst sleeping rough or living in cheap accommodation (Hodder, Teesson and Buhrich 1998). The researchers used a broad definition of mental illness which included people with alcohol and substance use disorders as mentally ill, although it was not specified in the report what constituted 'problematic drinking'. Overall, they concluded that 75 per cent of their sample had mental health problems, and that many people had more than one mental health issue, commonly referred to as co-morbidity (Hodder et al. 1998, p. 10).

The high rates of mental illness recorded in these clinical studies was partly a consequence of the broad definition of mental illness that was used. Clinical researchers often rely on definitions that have 'been standardized on more domiciled populations' (Snow et al. 1986, p. 421). Asking a person if they have felt 'down', 'depressed' or 'anxious' in the last four weeks (Hodder et al. 1998, p.p. 99-100) could not, in any meaningful way, be taken as an indication of mental illness. Most homeless people would answer 'yes', not because of mental health problems, but because of the material conditions of their existence. As Cohen and Thompson (1992, p. 819) state, it is:

. . . axiomatic that homelessness is accompanied by feelings of disconnectedness, self-blame, demoralization and powerlessness, regardless of the presence or absence of a severe and persistent mental illness.

The conflation of mental illness and substance abuse can make a significant difference, particularly when problematic drinking is defined narrowly. Teesson, Hodder and Buhrich (2003, p. 467) subsequently revealed that they defined 'alcohol dependence' as the

consumption of 'more than 12 standard drinks in any one year'. 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.

Despite our reservations, the findings from these studies have been widely cited by advocacy groups (Council to Homeless Persons 2005, p.p. 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, p. 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, p. 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 public domain. 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 6th March, 2008). A survey of nearly 1000 people found that 81 per cent identified mental illness as a primary cause of homelessness (Hanover Welfare Services 2006).

Clearly, disproportionately high rates of mental illness do exist among the homeless, but as American researchers Piliavin, Sosin, Westerfelt and Matsueda (1993, p. 578) point out 'research has not systematically investigated' whether mental illness is 'causally related to the onset of homelessness' or occurs afterwards.

In this paper we use a sample of 4,291 homeless people to investigate four issues. First, we discuss the prevalence of mental illness in the homeless population. We found that 31 per cent of the sample had mental health problems.

Second, we investigate whether mental illness preceded or followed homelessness. We found that 15 per cent of the sample had mental health problems before becoming homeless, and 16 per cent developed mental health issues after becoming homeless.

Third, we explain what happened to people in both groups. Fourth, we point out that regardless of whether people's mental health issues preceded or followed homelessness, most people in our sample had been homeless for one year or longer, and 81 per cent had been homeless a number of times. The paper concludes with two policy recommendations.

Methodology

The information for this paper was collected at two high volume services in inner Melbourne which work with homeless and 'at risk' people. The methodology for the research has been explained elsewhere (Johnson and Chamberlain 2008a), and here we summarise only the main points.

At both agencies, a case file was kept on every client and we obtained permission to read these case files from both agencies and our university ethics committee. 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 by staff at both agencies, but clients' names were not recorded and each record was allocated a number for identification purposes. Many files contained a great deal of retrospective information about people's housing histories and we could follow people's experiences of homelessness over many months or years.

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 definition includes the following people as homeless: people without conventional accommodation (streets, squats etc); people staying temporarily with other households (because they have no usual address); people in emergency accommodation (refuges, shelters etc); and people in boarding houses. We examined a total of 5,526 case histories and we had information on 4,291 homeless households.

The number of people identified with mental health issues depends upon how this concept is operationalised. Our database consisted of agency case files, so we could not

interview clients or use 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.

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 (Baldwin 1998; Piliavin, Westerfelt and Elliott 1989; Snow et al. 1986; Sosin, Piliavan and Westerfelt 1990). Like other researchers, we have concerns about the reliability of self report measures (Culhane, Parker, Poppe, Gross and Sykes 2007; Padgett, Gulcur and Tsemberis 2006), and it is possible that some people did not report their mental health issues.

At both agencies, staff endeavoured to make a broad assessment of the various factors that resulted in the person becoming homeless. We used information from the initial assessment, combined with information from other parts of the case history, to assess whether mental illness preceded or followed homelessness.

Our findings provide an indicator of the extent of mental illness among the inner city homeless, although there may be underestimation because some people did not disclose their mental health issues. 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 supplement our analysis with information from 65 in-depth interviews with a cross-section of homeless people using both agencies. The respondents matched the main sample on basic social characteristics such as age, gender and household type. Sixteen of the respondents had mental health issues and the interviews elicited a great deal about people's experiences.

On average the interviews lasted an hour and they were tape recorded and transcribed for qualitative analysis. We used narrative analysis to organise information

(Labov 1997), paying particular to whether mental health issues preceded or followed homelessness. We use qualitative data from the interviews and case notes to illustrate what happens when mental health issues precede homelessness and what happens when mental health issues follow homelessness. People's names and various personal details have been changed to ensure confidentiality.

Prevalence and temporal order

The first task was to establish the prevalence of mental illness in our sample. Then we investigated whether mental illness preceded or followed homelessness

The lifetime prevalence of mental illness in our sample was 31 per cent (N=1,337). Three other Australian studies have found the prevalence of mental illness to be between 12 per cent and 44 per cent (Flatau 2007; Harvey, Evert, Herrman, Pinzone and Gurele 2002; Rossiter, Mallett, Myers and Rosenthal 2003), and our finding of 31 per cent is roughly in the middle of this range. Our finding is also consistent with findings from a number of American studies which show that one-quarter to one-third of homeless persons have a severe mental illness (Cohen and Thompson 1992; Sullivan, Burnam and Koegel 2000; Wright 1988).

We recognise 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, than the estimates of 72 to 82 per cent referred to earlier in this paper.

Next, we examine whether mental illness usually precedes or follows homelessness. We found that 15 per cent of the sample (634 people) had mental health issues prior to becoming homeless. This finding challenges the community and media perception that mental illness is a primary 'cause' of homelessness (Hanover Welfare Services 2006; Zufferey and Chung 2006).

Sixteen per cent of the sample (703 people) experienced mental health problems after they became homeless. Of the 1,337 people in the sample who had experienced mental illness, just under half (47 per cent) had a mental health problem prior to becoming homeless, and just over half (53 per cent) developed a mental health issue following homelessness.

A number of studies confirm that homeless people often develop mental health issues after becoming homeless. A large American study (N=1,531) found that 35 per cent of homeless adults with mental health issues developed them after becoming homeless (Sullivan, Burnam and Koegel 2000, p. 447). In a study of 160 homeless youth in Britain, Craig and Hodson (1998) found that 30 per cent of those reporting mental health problems developed them after becoming homeless; and an Australian study found that two-thirds of those with mental health issues developed them following homelessness (Johnson, Gronda and Coutts 2008). These studies indicate that homelessness causes mental health issues for some people, particularly anxiety and depression.

In the following section, we examine what happens when mental health issues precede homelessness. Then we examine what happens when mental health issues follow homelessness. After that, we identify various experiences that both groups have in common.

Mental illness as a precursor to homelessness

There were 634 people who had mental health issues before their first experience of homelessness. Table 1 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 significant 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 out of the blue' (Joey).

Table 1: Age first homeless for persons whose mental health issue preceded homelessness

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

*Information on age in 89 per cent of cases.

As their mental health problems emerged at a relatively young age, most had no experience of maintaining their own housing and most were still living with their families when their mental health problems first emerged.

When mental health problems emerge, young people are often disturbed and frightened by their illness and they can experience mood swings, frustration and anger. In these circumstances maintaining friendships with other young people is often difficult and friends start to 'disappear'. Terry found that:

The friends that I did have couldn't handle me because I wasn't the person they used to know.

As their social networks diminish, young people with mental health issues rely increasingly on their families. Families provide a foundation for survival by 'providing material necessities like a place to live, food, transportation to and from activities' (Hawkins and Abrams 2007, p. 2033). Families also provide emotional support for young people and can encourage them to pursue hobbies and other activities. Parents are the 'single most important' source of support that enables young people with mental illnesses to remain housed (Hawkins and Abrams 2007, p. 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). 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, p. 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 1 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. There was variation in the experiences of this group, but there were two typical patterns.

The first pattern was where people had had maintained independent housing and worked full-time, some in middle class occupations. For this group, it was the onset of mental illness later in life that led to them losing their job, followed by the loss of their accommodation. Jenny was a 26 year old teacher when her mental health problems emerged. The case notes show that she:

... suffered a nervous breakdown and lost her job. Her mental health got worse. Diagnosed with schizophrenia. Lost her home and now moving around.

Jenny's parents were dead and she had no relatives who would take her in.

Many people are wary about being diagnosed as 'mentally ill', because the label 'mental patient' is a stigmatised identity in contemporary society (Gaebel, Zasko and Baumann 2006; Goffman 1961; Perese 2007). Jenny told her worker that she:

... wasn't prepared to tell anybody about my situation or my mental health (case notes).

When people deny they have a mental health problem, they are often unwilling to take medication and to accept other forms of assistance. If they are unable to undertake tasks such as paying the rent and other household bills, and there is no support from other family members, this often leads to a financial crisis, followed by eviction.

The second pattern was where people became homeless when they were 25 or older. This group first developed mental health issues in their late teens or early twenties, but had

received ongoing family support throughout their twenties and thirties. This was the larger group.

People with mental health problems are often supported by other family members for quite long periods of time, but sometimes these arrangements breakdown. For example, Henry had been living with his brother, Steve, but problems had emerged. A worker tried to contact Henry's brother:

Steve called back and asked that we do not ring him again. Steve and his wife do not want Henry to stay with them any longer ... It's too stressful ... (case notes).

Parents are often the major providers of assistance for adult sons and daughters who have mental health issues. We came across cases where people with mental illnesses became homeless in their thirties or forties, 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. This is what happened to Amelia. After her 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 we think that a range of environmental factors precipitated a decline in their mental health.

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

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

*Information on age in 97 per cent of cases.

Seventy-eight per cent of those who developed mental health issues after they became homeless were aged 24 or younger when homelessness first occurred (Table 2). Teenagers who become homeless have to deal with the trauma of family relationships breaking down. There are often bitter conflicts between children and parents preceding homelessness. Most homeless teenagers leave home on their own and they are often confused and angry. Many teenagers have no idea where they will stay or how they will acquire income, and this leaves them feeling isolated and demoralised (Johnson et al. 2008). After a few months out of home, Esther found 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.

Although some homeless teenagers become isolated, studies have found that homeless teenagers often become involved with other homeless people (Chamberlain and Mackenzie 1998; Fitzpatrick 2000; Johnson and Chamberlain 2008a). These friendships are often opportunistic in nature, but they provide 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.

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). We found that two-thirds (63 per cent) of the young people who developed mental health issues after becoming homeless also had substance abuse issues.

Drug use is 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, p. 137). Sam told us the medication made him:

... feel worse. I put on a massive amount of weight and I wanted to sleep all the time. I was zombie-like. The only way to feel normal was to take amphetamines.

This cycle is difficult to break and drug use increases the likelihood of experiencing psychotic problems such as delusions and hallucinations (Hides et al. 2006).

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 2). When older people first become homeless they experience considerable anxiety because they are uncertain about what will happen to them (Wong and Piliavin 2001). 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.

Newly homeless adults often double up with family or friends but this creates additional tensions and new anxieties. James was doubling up with some friends in a bed sit.

He found it:

... very frustrating. You're in each other's face. There's no privacy. You're in the same room as the kitchen, your lounge room, your bedroom. It's pretty hard to do anything.

These arrangements usually fall apart and people are forced to find other temporary accommodation. Many people ended up in boarding houses because they could not afford alternative accommodation. This was often a profoundly depressing experience. 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 everyday and every night. I didn't have any friends.

Adults were often embarrassed by their homelessness and withdrew from social contact with other people. This increased their sense of isolation, often resulting in more profound problems. 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.

In these cases, homelessness itself 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 homeless people with mental health issues had two important experiences in common. First, 92 per cent had been accommodated in a boarding house (Table 3), 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 significantly if mental illness preceded or followed homelessness (Table 3).

Table 3: Been in a boarding house by experience of mental illness and age first homeless

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

* Information on 93 per cent of cases

Boarding houses provide poor quality accommodation where personal safety is often at risk, substance use is widespread, and people are exposed to overcrowded and stressful living conditions (Perese 2007, p. 290). Tom told us that his rooming house experience:

... was crushing me .. I wasn't standing up for what I believed in. It caused me a real form of depression and self-loathing.

It was common for people with mental health issues to report that they were 'picked on' 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 et al. (2004, p. 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, p.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, Galanter, Dermatis and Westreich 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 (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 4: Duration of homelessness by experience of mental illness and age first homeless

	Mental illness before homelessness		Mental illness after homelessness		All (N=1,247*)
	Age 12 to 24 (N=228)	Age 25 or older (N=336)	Age 12 to 24 (N=529)	Age 25 or older (N=154)	
	%	%	%	%	%
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 4 shows that amongst those who first became homeless when they were 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. As others have pointed out, 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).

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

	Mental illness before homelessness		Mental illness after homelessness		All* (N=1,112)
	Age 12 to 24 (N=204)	Age 25 or older (N=274)	Age 12 to 24 (N=505)	Age 25 or older (N=129)	
	%	%	%	%	%
Two or more episodes	80	73	90	65	81

* Information on 83 per cent of cases

When people experience long-term homelessness, it has been suggested they accept homelessness as a way of life (Wallace 1965; Grigsby, Baumann, Gregorich, and Roberts-Grey 1990). In our view, this proposition is implausible. Table 5 shows 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.

Discussion

This paper set out to investigate the prevalence of mental illness in the homeless population and to ascertain whether mental illness is a primary cause of homelessness. The information was drawn from 4,291 homeless households using two high volume agencies in inner Melbourne. We pointed to various limitations of our data set, and these limitations should be borne in mind.

The research found that 15 per cent of the sample had mental health problems prior to becoming homeless, and 16 per cent developed mental health issues following homelessness. We also found that 79 per cent of people with mental health issues had experienced long-term homelessness, and many had been homeless on multiple occasions.

These empirical findings highlight two key challenges facing policy makers in Australia. The first is how to reduce the number of people with mental health issues who become homeless ('early intervention'). The second challenge is how to reduce the number of people with mental health issues who experience long-term homelessness ('breaking the cycle'). Next we examine the policy context in Australia. Then we make two policy recommendations.

The Australian Prime Minister, Kevin Rudd, has stated that it is unacceptable that there are 105,000 homeless Australians on a typical night (Rudd 2008). In December 2008, the Rudd Government released a white paper on homelessness, outlining a policy framework designed to halve homelessness by 2020 (Homelessness Taskforce 2008). The Government allocated \$1.2 billion in additional funding over five years. The white paper identified three strategies to reduce homelessness: 'early intervention', 'improving existing services' and

'breaking the cycle' (Homelessness Taskforce 2008, Ch. 3-5). Our policy recommendations focus on early intervention and breaking the cycle.

Early intervention

Our first policy recommendation is that there should be increased support for families that are caring for young people who have mental health issues. We found that 15 per cent of our sample had mental health problems prior to becoming homeless, and for those who were aged 24 or younger it was usually a breakdown of family support that led to homelessness. According to medical practitioners, early intervention involves early access to treatment. This is one aspect of early intervention, but early intervention also involves the provision of support to families who are caring for teenagers who have mental health issues.

The Mental Health Council of Australia argues that 'families may be the only reason these people are not in the homeless population' (Mental Health Council of Australia 2009, p. 17) and proposes an immediate investment in programs that focus on providing home based care. Families need a range of support including information, financial assistance, counselling or access to respite care in order to support young people who have mental health issues. Currently, mental illness accounts for 13 per cent of Australia's health costs yet only 6.8 per cent of health spending is targeted towards mental illness (Mental Health Council of Australia 2009, p. 26). Early intervention means resourcing families so that young people with mental health issues do not become homeless.

Breaking the cycle

A second priority of the Rudd Government is to reduce the length of time that people remain homeless and to stop recurring homelessness. We found that 80 per cent of homeless people with mental health issues had been homeless for one year or longer and that most people (81 per cent) with mental health issues had experienced two or more episodes of homelessness.

In Australia, the Supported Accommodation Assistance program (SAAP) is the Government's flagship program for providing services to homeless people. SAAP provides

short-term (crisis) or medium-term (transitional) accommodation, but access to this accommodation is contingent upon clients accepting support delivered through a case management program. The assumption underpinning this approach is that people's mental health issues must be addressed before that can be considered for permanent accommodation (Padgett 2007, p.1933).

It is difficult, however, to address mental health issues when people are in crisis or transitional accommodation if they continue to feel insecure. Some homeless people with mental illness do not engage with case managers and they are commonly excluded from services (New South Wales Ombudsman 2004). Other people with mental illness cannot get into SAAP accommodation because they try to resist the stigma of being labelled 'mentally ill', and assert that they do not need 'treatment' or 'support'.

The alternative approach is to give priority to people's housing needs, before addressing their mental health issues. This is known as the 'housing first' or 'supportive housing' approach and it is an increasingly popular in the United States (Tsemberis 1999). In this approach, access to housing is not conditional on people accepting support. The housing first approach offers people permanent accommodation and then allows them to engage with a support worker at their own pace. This is a more effective way of building long-term relationships with clients, because support relationships are entered into voluntarily and do not entail coercion (Gronda 2009).

The housing first approach draws on a long history of housing research interested in the psycho-social benefits of housing. Researchers often use the concept of 'ontological security' to draw attention to the importance of a home as a place of constancy in the social and material environment (Dupuis and Thorns 1998), a place in which people feel free from surveillance and free to be themselves (Saunders 1990). Padgett's (2007) study of 39 chronically homeless people focused directly on the psycho-social benefits of home. Padgett argues that the housing first approach offers participants a greater sense of continuity, freedom, privacy, choice and control. Having a home provides people with a 'stable platform for re-creating a less stigmatized, normalized life' (Padgett 2007, p.1934). As one of our informants told us:

I think having a stable house and a home has really helped. . . when you know your housing is Ok it's just one less thing to worry about. It makes having a normal life more realistic.

Homeless people with mental health issues have housing aspirations similar to most people. They want a safe, comfortable home.

There is also 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 of two groups of chronically homeless people with a mental illness: 139 people went into supportive housing and 2,864 went into a residential treatment program that uses a series of steps to gradually move people to independent living. Tsemberis (1999) found that the housing-retention rate was 84 per cent for those in the supportive housing program over a three year period, whereas the housing-retention rate was only 59 per cent for those who received traditional services over a shorter, two year period.

Tsemberis, Gulcur and Nakae (2004) compared two matched groups of homeless people with mental health issues. After 24 months, Tsemberis et al. (2004, p.p. 654-655) found that four-fifths of those allocated to supportive housing had retained their accommodation (N=99), but only about one-third of those who went into traditional services (N=126) retained their accommodation over the same period.

It is a policy priority of the Rudd Government to reduce the length of time that people remain homeless and to break the cycle of recurring homelessness. Our second policy recommendation is that homeless people with mental health issues need permanent accommodation before they address their mental health issues.

The housing first approach has three strengths. First, it offers people accommodation and then allows them to engage with a support worker at their own pace. This is a good way of building long-term relationships with clients, because the relationships are entered into voluntarily (Gronda 2009).

Second, the housing first approach recognises that supporting people with a mental illness to retain their housing can be time consuming. Currently, the median length of support for people in the Supported Accommodation Assistance Program is 7 days (Australian

Institute of Health and Welfare 2008:ix). This is insufficient time for service providers to address the complex needs of people with mental illnesses, and to support them developing positive relationships with friends and neighbours which are often essential if they are to avoid becoming homeless again (Perese 2007; Padgett 2007).

Third, the housing first approach also recognises that it is common for people who have schizophrenia or a bipolar disorder to need long-term support if they experience further episodes of ill-health, although these episodes may be years apart. 'Breaking the cycle' means providing long-term support to formerly homeless people who have mental health issues. Given the right material and emotional support, even the most chronically homeless people can 'get out' and 'stay out' of homelessness.

Acknowledgments

We thank the homeless people we interviewed. We also thank the staff at the HomeGround Services and The Salvation Army Crisis Services (St Kilda) for their assistance. Financial support for the research came from an Australian Research Council grant (LP0560760).

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