The Use and abuse of statistics on homeless people.

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In the Victorian period homelessness in Britain were viewed as a policing problem. The Vagrancy Act of 1824 and 1935 were used as criminalising instruments by which to control vagrancy (Steedman, 1984). In 1912 Thomas Holmes, the secretary of the Howard Association and a retired police court officer, wrote a book under the title 'London underworld', (Johnes,1974).

In this book Mr Holmes showed his concern for the homeless mentally ill people. He used the 'epidemiological data' available at the time to prove that homeless people were mentally ill. He used the statistics of the Royal Commission on the Care and Control of the Feeble- minded. He concluded that as only a third of these people identified by the commission were in workhouses, asylums, prisons etc then the remaining two thirds must constitute the homeless. He went on to suggest 'a national plan for the detention, segregation and control of all persons who are indisputably feeble-minded'.

It is surprising to notice the similarity of Mr Holmes argument with those of some contemporary writers on the subject of homelessness. In the 1930s George Orwell lived as a homeless person and wrote his memoirs in 'Down and Out in London and Paris'. He

gave a clever explanation why some think that homeless people are mentally ill. He wrote 'The Paris slums are a gathering place for eccentric people - people who have fallen into solitary, half-mad grooves of life and given up trying to be normal or decent. Poverty frees them from ordinary standards of behaviour, just as money frees people from work', (Orwell, 1986).

More and more studies are showing that the majority of the mental health problems of the homeless might be a result of the process of adaption to homeless difficult living and life style. The main causes of homelessness lie in housing shortage, unemployment, and under spending on health and community service. Politicians favour linking homelessness to de- institutionalisation and community care because this diverts attention from the socio-economic problems that contribute to homelessness. Some psychiatrists also favour this hypothesis because they are attached to old mental institutions and feel threatened by the principle of community care. In addition, the chronic mentally ill are vulnerable and disadvantaged group that will be influenced by cuts in housing and other welfare benefits which are the main causes of homelessness.

Homelessness is only one manifestation of the most acute and visible form of class poverty and powerlessness (Brandon, 1974). The main reason for homelessness is the lack of affordable housing for those on low incomes. The British Association of Social Workers in a report in 1985 showed the depth of the problem. 53% of all repossession orders were where the owner had a local authority mortgage. In between 1978 and 1985 there was a shortfall of 750,000

new homes due to inadequate government spending on housing programmes (Clode, 1985). The government's policy in the cut-back of housing programmes, high unemployment and the cuts in housing and other benefits are the direct cause of increasing homelessness (Randall et al, 1986).

In the book 'Homelessness and Mental Health Services in Britain' Berry and Orwin (1966) examined the trend of No Fixed Abode (NFA) patients admitted to Hollymoor Mental Hospital in the Birmingham area. In a retrospective survey of the records of 105 males and 40 females admitted between 1961-1964 they correlated the increase of the proportion of NFAs admitted to this hospital with the implementation of the Mental Health Act 1959 and community care policies (Berry & Orwin, 1966). The authors played down the significance of the continuing redevelopment of Birmingham City which resulted in the reduction of lodging houses available for the homeless. This could provide an alternative explanation for the increase in psychiatric patients with no fixed abode.

Lodge Patch (1971) in a study of the Salvation Army hostel in London stated that very few (11% of the residents) could be considered psychiatrically as normal (Lodge Patch, 1970). Crossly and Denmark, a social worker and a psychiatrist, (1966) studied the psychiatric morbidity of the residents of a Salvation Army hostel. They reported that out of the 51 residents 33 were 'considered' to be suffering from 'personality disorders'. 10 of these 33 had been in a mental hospital (Crossly & Denmark, 1966). They suggested that these findings indicated that people being discharged into the

community who were still in need of 'Asylum'.

The only psychiatric study that has asked a different question - how best to help the homeless people - was Leach and Wing's study 'Helping the destitute men' in 1980. What followed were more studies that continue trying to prove that there is 'a large' number of people with mental illnesses among the homeless claiming that this has happened because of the community care policies and the closure of mental hospitals.

Studies on the homeless are often received, quoted and used without taking into consideration the limitations and biases of these studies (Hamid et al, 1993). Many of these studies have used brief psychiatric interviews as an instrument to detect the pressure of mental illnesses in this population. Recent reports (particularly in USA) have begun to question the suitability of the psychiatric interview for this purpose as it may measure homeless people's adaption to their difficult circumstances rather than mental disorders.

Nigel Shanks, a GP who has done a lot of work with homeless people in Manchester, found that the validity of the homeless peoples self reporting to the professional interviewers whom they met for the first time had been found to be questionable because of the homeless peoples' mistrust of these professionals (Shanks, 1981). This is extremely important in reaching a 'psychiatric diagnosis'. Other methodological problems include the sampling difficulties which include the lack of an operational definition of who are the homeless and using unrepresentative samples in addition to the high refusal

rate (Hamid et al, 1993).

In addition to these methodological problems, it is also difficult to establish the relationship between homelessness and mental illnesses which caused which. Epidemiology teaches us that the only sound way to prove such an association is by using follow up studies. Psychiatric studies on the homeless have used cross- sectional designs to generate psychiatric diagnoses without allowing for the different social and environmental conditions in which these people live.

The 1977 Homeless Persons Act has made it difficult to help single homeless people if they are not 'vulnerable'. Sometimes, I have been told by a GP, to help these people who are in desperate need of accommodation, doctors are prepared to give them one of the vulnerability criteria stated in the act. The easiest of these is to diagnose mental illnesses which temporarily may aid the individual but such a label may effect their whole life.

The International perspective.

In the USA homelessness is viewed by many politicians as a result of de-institutionalisation (Hartman, 1984). George Bush said that mental illness was 'principle cause of homelessness' while Ronald Reagan claimed that a 'large' percentage of the homeless were former mental patients. In attending a workshop on homelessness in New York in 1989, I noticed that the decision makers were talking about the homeless as if they are all chronic mentally ill and victims of

de-institutionalisation (Hamid, 1989). The then Mayor of New York, in a meeting with the workshop, suggested solving the problem by putting homeless people in shelters in islands around New York. His argument was that the homeless are mentally ill; they cannot care for themselves; and nobody would accept them in the community.

In a survey that I conducted in one of the New York shelters, I found that the majority of these people are young healthy people whose only problem was their inability to afford the costly accommodation. They all were treated as if they were all mentally ill. The set-up of these shelters were much worse institutions than the old Victorian mental hospitals. These institutions are creating a new population of dependent and probably more mentally disabled people than they help.

Jones et al (1984) tried to establish a psychodynamic profile of homeless people in New York. They interviewed 158 individuals using psychological tests and a psychosocial survey. The most frequent psychological problems mentioned were sadness and depression, and aggression and frustration. The authors argued that any interpretation of these results should take in consideration the extraordinary environment in which these people were living (Jones et al, 1984).

Snow et al (1986) used a different methodology to study the mental health problems of 911 homeless street dwellers in Austen, USA. The assessment of their mental state was reached by using criteria which depended mainly on observation judgment of the

subject's behaviour by researchers and other homeless individuals. The authors suggested that previous psychiatric studies had found a higher prevalence of mental disorders because psychiatrists had tended to 'medicalize' these problems (Snow et al, 1986). This study shows that the use of mental health assessment other than the psychiatric diagnosis may give different results and impressions about homeless peoples' problems and needs.

A study in Verona, Italy, investigated the effect of community care on the mobility of people with psychotic illnesses using the area psychiatric registry. The study found that the mobility of psychotic patients is not significantly different from that of the general population and it is even lower than the mobility of the neurotic patients (Lesage & Tansella, 1989).

Recent Literature on Homelessness and Mental Health.

The major follow-up study of long-stay psychiatric patients discharged to the community found that very few of the sample became homeless, the majority were homeless before admission to hospital (Leff, 1993). Furthermore a recent survey of the health status of single homeless people in Sheffield suggested that psychiatric symptoms in these people were the result rather than the cause of their homelessness (Westlake & George, 1994).

In a research project, which was undertaken in the Bloomsbury Health District, the mental health problems and needs of the homeless people were investigated. An analysis of a recording system

kept by the Community Psychiatric Nursing Services (CPNS) in Bloomsbury for the years 1985 and 1986 showed that about a third of the CPN clients were homeless. The pattern of psychiatric problems, as assessed by the CPNS, was surprisingly similar in both the homeless and the home-based clients. The only significantly different problem in the two groups was those related to housing, employment, and financial difficulties which for the homeless clients were more severe. An alarming difference in the care provided to the homeless clients compared with that provided to the home-based clients was detected. This difference remained after controlling for presenting problems.

In the same project a survey of the mental health problems and needs of a random sample from the long-stay hostels for homeless men in Bloomsbury was also undertaken. The results of this survey showed that though the problems and needs of these men differ significantly from that of the patients in psychiatric institutions, the unmet needs are similar in the two populations (Hamid, 1991).

Comparing the Bloomsbury sample with a sample from New York shelter for homeless people have shown that the two samples were similar in their problems (Hamid, 1989). The needs of the two samples showed astonishing differences in that though New York shelters had much more mental health services and resources these apparently had increased the needs and the unmet needs of the residents rather than alleviating them. There were higher needs and unmet needs because the institutional nature of these shelters may have made the resident more dependent on the services.

Michael Satchel in a detailed investigation of the residents of St Mungo Housing Hostels suggested that the residents with chronic mental illnesses refuse to utilise the traditional psychiatric services (Satchell, 1988). The solution of this problem is surely not to force these people into psychiatric institution but to use a more acceptable form of community oriented services. The high utilisation rate of the CPN service in Bloomsbury by homeless people showed that this is possible (Hamid & McCarthy, 1989). More resources are needed for specialised mental services that would assess the needs of the homeless people for community mental health care and co-ordinate the care provided in the community.

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