

Homelessness, housing instability and mental health: making the connections

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Research on the bi-directional relationship between mental health and homelessness is reviewed and extended to consider a broader global perspective, highlighting structural factors that contribute to housing instability and its mental ill health sequelae. Local, national and international initiatives to address housing and mental health include Housing First in Western countries and promising local programmes in India and Africa. Ways that psychiatrists and physicians can be agents of changes range from brief screening for housing stability to structural competence training. Narrow medico-scientific framing of these issues risks losing sight of the foundational importance of housing to mental health and well-being.

Keywords Homelessness; housing instability; mental health; human rights; structural competence.

Mental illness and homelessness

The bi-directional relationship between mental ill health and homelessness has been the subject of countless reports and a few misperceptions. Foremost among the latter is the popular notion that mental illness accounts for much of the homelessness visible in American cities. To be sure, the failure of deinstitutionalisation, where psychiatric hospitals were emptied, beginning in the 1960s, led to far too many psychiatric patients being consigned to group homes, shelters and the streets.¹ However, epidemiological studies have consistently found that only about 25–30% of homeless persons have a severe mental illness such as schizophrenia.²

At the same time, the deleterious effects of homelessness *on* mental health have been established by research going back decades. Early epidemiological studies, comparing homeless persons with their domiciled counterparts, found that depression and suicidal thoughts were far more prevalent, along with symptoms of trauma and substance misuse.^{2,3} A recent meta-analysis found that more than half of homeless and marginally housed individuals had traumatic brain injuries – a rate far exceeding that of the general population.⁴ Qualitative interviews with street homeless persons bring to life the daily struggles and emotional toll of exposure not only to the elements but to scorn and harassment from passers-by and the police.⁵

In the USA, healthcare professionals were among the first responders to the homelessness ‘epidemic’ of the 1980s. The Robert Wood Johnson Foundation Health Care for the Homeless initiative funded 19 health clinics around the nation, beginning in 1985. Individual physicians, including Jim Withers in Pittsburgh and Jim O’Connell in

Boston, made it their mission to go out on the streets rather than participating in the ‘institutional circuit’⁶ that led so many homeless men and women to cycle in and out of emergency departments, hospitals and jails. Health problems such as skin ulcerations, respiratory problems, and injuries were the visible indicia of what foretold a shortened lifespan.⁷ Less visible but no less dire are the emotional sequelae of being unhoused – children are especially susceptible to the psychological effects of homelessness and housing instability.⁸ The gap between mental health needs and service availability for the homeless population is vast.

The bigger picture: global housing instability and structural factors

Literal homelessness – sleeping rough in places unfit for human habitation – can be seen as the tip of an iceberg of housing insecurity affecting millions of people around the world.⁹ As with attempts to count the number of homeless people and the definitional difficulties attending such counts,¹⁰ providing an estimate of the number of housing-unstable persons globally is definitionally and logistically challenging. In terms of slum dwellers (a prevalent form of housing instability), Habitat for Humanity cites estimates ranging from 900 000 to 1.6 billion.¹¹ The Dharavi slum in Mumbai has one million residents squeezed into two square kilometres, one of the densest human settlements in the world.¹¹ Substandard housing affects the well-being of inhabitants – crowding, poor sanitation and

infestations bring their own risks to health and mental health.¹²

Severe housing shortages in low-income countries contrast with the greater availability of housing in higher-income countries. And yet the visibility and persistence of homelessness in wealthier nations attests to the effects of growing income inequities in the midst of plenty. In the USA, attempts to address homelessness must take several structural barriers into account. First, housing is fundamentally viewed as a commodity and is bound up with economic gains in the forms of tax benefits for homeowners and builders, equity or wealth accumulation from owning property, and developers' profits from housing market speculation.¹³ The worst 'slumlords' (landlords who own and rent decrepit properties to poor families) reap greater levels of profit than their counterparts who build for affluent buyers or renters.¹⁴ Second, exclusionary zoning ordinances ensure protection of single-family properties, thus reducing housing availability for renters and preventing multi-family dwellings.¹⁵ Finally, access to housing is not a purely economic proposition. The effects of centuries of *de facto* and *de jure* racial exclusion continue to uniquely harm African Americans in denying them access to housing and associated wealth accumulation, thus contributing to their disproportionate representation among homeless persons in the USA.¹⁵

The ultimate causes of homelessness are upstream, i.e. a profound lack of affordable housing due in large part to neo-liberal government austerity policies that prevent or limit public funding for housing, gentrification that displaces working and poor families, and growing income disparities that make paying the rent beyond the means of millions of households. Currently, more than half of US households must devote over 50% of their income to paying for housing, an unprecedented level of rent burden.¹⁴ Farmer refers to this phenomenon as 'structural violence': the combined and cumulative effects of entrenched socioeconomic inequities that give rise to varied forms of social suffering.¹⁶ Social suffering does not easily align with existing psychiatric nomenclatures and diagnostic algorithms, but its influence on health through chronic stress and allostatic overload weakens immune systems and erodes emotional well-being.¹⁷

International and national initiatives

Interestingly, since its 1948 declaration of a right to housing,¹⁸ the United Nations (UN) has generally steered clear of re-enunciating such a right until the Sustainable Development Goals (SDGs) were announced in 2015. Subsumed within SDG #11, labelled 'sustainable cities and communities', is Target 11.1 of 'safe and affordable housing for all by 2030'.¹⁹ The UN Special Rapporteur on the right to adequate housing, Leilani Farha, recently submitted a set of guidelines for achieving this goal.²⁰

In the global south, access to mental healthcare for the most vulnerable is extremely limited despite legislative initiatives to expand such care^{21,22} and reduce human rights abuses against psychiatric patients.²³ The Global Mental Health Movement (GMHM), which began with a series of

articles in the *Lancet* in 2007 asserting 'no health without mental health',²⁴ came together to address a crisis that results in a 'monumental loss in human capabilities and avoidable suffering'.²¹ The *Lancet* Commission on Global Mental Health and Sustainable Development, part of the GMHM, has strategically partnered with the UN's SDGs to ensure that mental health and substance misuse are integral to the SDGs moving forward.²¹ And there are signs of progress – most originating in the work of citizen advocates and patients working through non-profit rather than formal government channels. In Chennai, India, a visionary non-profit known as The Banyan has pioneered a culturally and socially innovative approach, 'Home Again', to help homeless persons with severe mental illness recover their lives and live independently or return to their family homes.²⁵ In West Africa, advocates for AIDS and leprosy patients have turned their talents and expertise to developing programmes for persons with mental illness that are inclusive, rehabilitative and rights based.²³ Zimbabwe's 'Friendship Bench' programme, which situates attention to mental health within ongoing community activities, has been replicated worldwide.²⁶ Although the African approaches are not targeted at homeless persons, they have been heralded as low-barrier and inclusive – and by their location are likely to assist persons with housing insecurity problems among others.²¹ The recent *Lancet* Commission report on global mental health²¹ included mention of homelessness as both a cause and consequence of poor mental health.

The advent of Housing First has been a rare success story at the programmatic and systems levels in the US, Canada and Western Europe.²⁷ Begun in New York City as a small but determined counterpoint to 'treatment first' approaches making access to housing contingent on adherence, Housing First has achieved an impressive evidence base and extensive adaptations to new populations such as homeless youth, families and opioid users.²⁷ By reversing the usual care continuum of first requiring medication adherence, abstinence and proof of 'housing worthiness', Housing First is the prime exemplar of an evidence-based, cost-saving enactment of the right to housing. Importantly, it is not 'housing only', i.e. support services including mental healthcare are essential to its success.²⁸ Early reliance on assertive community treatment in Housing First support services was eventually expanded to include less-intensive case management supports for clients whose mental health recovery had proceeded further.²⁷

Another evidence-based programme known as critical time intervention (CTI) has proven effective in preventing homelessness pending discharge from institutional care.²⁹ Using time-sensitive intensive supports before and after discharge, CTI connects the patient or client with housing and support services to ease return to the community and avert falling into homelessness.²⁹ Like Housing First, CTI has focused on persons with mental disorders but has since been adapted for other at-risk groups, such as clients leaving substance misuse treatment settings or prisons.

In the USA, there are a few signs that housing as a social determinant of health is receiving greater recognition. The Obama-era Affordable Care Act offered states the opportunity to expand Medicaid eligibility to millions of low-income households, including coverage for mental healthcare.³⁰

Although federal rules prohibit use of Medicaid funds to pay for housing (with the exception of nursing homes), some states have creatively used Medicaid funds for all housing-related services short of rent, including move-in costs and follow-up supports.³⁰ Unfortunately, capital funding for building and developing new housing units remains woefully inadequate, and it is too often left up to the private sector to act on a profit motive incentivised by government subsidies and tax incentives.¹⁵ Given the current national political situation in the US, positive change at the federal level is unlikely, but states and cities continue to independently seek ways to move from shelters to housing.³⁰

The healthcare landscape in the UK offers opportunities for service integration under coordinated national healthcare, and the link between housing and health is evident in recent cooperation between the National Housing Federation and the Mental Health Foundation in providing supported accommodation for persons with mental disorders.³¹ In Western Europe, the establishment of FEANTSA (European Federation of National Organizations Working with the Homeless; www.feantsa.org) in 1989 with support from the European Commission has brought together representatives from 30 nations for programmatic and research initiatives (many using Housing First). Consideration of mental problems as cause and consequence of homelessness is a key component of FEANTSA's work, with psychiatrists actively involved in research at several sites, e.g. France's multi-city randomised trial of Housing First.³²

Psychiatrists and physicians as agents of change

In what ways can healthcare providers help? For housing-related risk assessment, family or general care physicians may make use of brief screening items inquiring about recent moves, evictions and rent arrears³³ as a means of ascertaining a patient's housing instability. Regrettably, there are limited programmes available to which to refer patients with 'positive' screens, but raising awareness and knowing a patient's life challenges can only improve care. Calls for medical training to include 'structural competency'³⁴ point to the broader importance of practitioners becoming versed in patients' life circumstances linked to poverty to contextualise their health problems. According to Metz and Hansen,³⁴ structural competency is the practitioners' trained ability to recognise that patients' problems defined clinically as symptoms, attitudes or disease also represent the downstream implications of upstream decisions about housing affordability, healthcare availability, food delivery systems and other infrastructure supports.

Some physicians have called for the right to prescribe housing as a means of solving this underlying problem, with the added advantage of reducing medical costs.³⁵ Prescribing housing as a form of 'preventive neuroscience' has received support from the O'Neill Institute as a cost-saving humane investment in children's brain development.³⁶ Such attention to social and environmental determinants of health is hardly misplaced, as they account for 90% of health status, with only 10% attributable to medical care.³⁰

Homeless men and women have few encounters with physicians, much less psychiatrists and other formal mental

healthcare providers. Those with diagnoses of severe mental illnesses might have an assigned psychiatrist to prescribe anti-psychotic medications, but these are brief encounters at best. Even in wealthier nations, psychiatrists working in the public sector are relatively fewer in number, overworked, underpaid and rarely able to address the hidden crisis of mental ill health wrought by homelessness and housing instability. In low-income nations, the service gap is even wider.²²

A recent US report on the alarming lack of access to mental healthcare even for the well insured points to a broad-based crisis in mental health services.³⁷ Ignoring laws ensuring parity, insurers provide much lower coverage for mental health treatment than would be tolerated for cardiac or cancer care, and out-of-pocket costs can run as high as \$400 per private psychiatrist visit.³⁷ The prospects for a homeless man or woman who is feeling anxious, depressed or suicidal are indeed dismal. Although many homeless and other low-income individuals in the US are enrolled in Medicaid, an acute scarcity of psychiatrists who accept Medicaid patients renders such coverage virtually unattainable in many parts of the US.³⁷

A caveat about the medico-scientific approach moving forward

Attempts to incorporate social determinants thinking into public policy discourse on the mental health benefits of stable housing still have some way to go in jurisdictions where the medico-scientific approach holds sway. As a case in point, witness the recent report by the prestigious US National Academy of Science, Engineering and Medicine (NASEM) on the health benefits of permanent supportive housing (PSH), a major source of housing and supports for formerly homeless persons with severe mental illness.³⁸ Acknowledging that research on the topic was severely limited owing to the recency of PSH and its many poorly defined iterations, the NASEM report nevertheless concluded that the health benefits of such housing were minimal, with the possible exception of persons with HIV/AIDS having improved outcomes.³⁸ The report argued for the need to identify 'housing-sensitive' health conditions to point future researchers in the right direction.³⁸

Such delimiting of what is important to 'housing-sensitive' medical conditions exemplifies the narrowness of the medico-scientific model set against a social determinants model combined with human rights. In response to such reductionism, the British Psychological Society recently proposed the Power Threat Meaning Framework as an alternative to the medicalisation of mental illness,³⁹ proposing that greater attention be given to the implications of power and inequality.

Homelessness represents an existential crisis that threatens mind and body alike. The concept of ontological security, having its modern origins in the writings of sociologist Anthony Giddens, offers phenomenological insights into the benefits of stable housing that domiciled persons easily take for granted. As noted by this author,⁴⁰ going from the streets to a home enhances one's ontological security, as such a transition affords a sense of safety, constancy in

everyday life, privacy, and a secure platform for identity development.⁴⁰ As with Maslow's hierarchy,⁴¹ fundamental human needs must be met in order to satisfy higher-order needs such as belonging and self-actualisation.

Conclusion

Despite a plethora of research linking mental and physical health to housing stability, the salience of structural barriers is too often submerged in 'blaming the victim' for her or his plight. Physicians and healthcare providers receive little training in social determinants and often view them as off-limits or distracting from attention to signs and symptoms. Yet psychiatrists and other mental health professionals can become agents of change by paying greater attention to the social determinants of mental health and seeking structural competence in their practice. It is difficult to overestimate the benefits of having a stable, safe home as fundamental to mental health and well-being.

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Declaration of interest

None.

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