ORIGINAL PAPER

S. M. Odell · M. J. Commander

Risk factors for homelessness among people with psychotic disorders

Accepted: 23 May 2000

Abstract Background: Although it is widely accepted that rates of severe mental illness amongst single homeless people are high, little is known about the reasons these individuals become homeless. This study aimed to identify risk factors for homelessness among people with psychotic disorders. Methods: A matched case-control study of homeless and never homeless people with psychotic disorders was carried out, with respondents recruited from mental health services (N = 39 pairs). Data were collected by semi-structured interviews and from medical records. Results: A number of social and behavioural risk factors were identified; key factors being loss of contact with childhood carers, and substance use. Clinical and service use factors appeared less important as predictors of homelessness. Conclusions: Mental health services have a limited role in circumventing homelessness among people with psychotic disorders. An integrated approach involving other key agencies is required.

Introduction

High rates of severe mental illness amongst single homeless populations have been consistently reported in the literature (Scott 1993). The reasons for this disturbing finding arise, at least in part, from structural features in our society: high unemployment, restricted social security benefits, family disruption and reduced availability of affordable housing. However, the excess of severely mentally ill homeless people has fuelled anxieties about the adequacy of implementation of community care in an era that has seen a dramatic decrease in psychiatric hospital beds. In particular, it is the view of some commentators that people with severe mental illness have been rendered especially vulnerable to these adverse societal conditions as a result of their clinical status and a lack of appropriate psychiatric services (Lamb and Lamb 1990). Others have argued that the separation of this group from the remainder of the homeless population is ill-founded (Mossman and Perlin 1992). They point to non-clinical factors that the homeless severely mentally ill share with their non-mentally ill counterparts and, rather than seeking solutions in improved mental health service delivery, stress the need for generic measures to tackle the problem of homelessness.

Research into the antecedents of homelessness amongst people with severe mental illness has been limited. Most work has been carried out in the distinctly different environment that prevails in the USA, and this typically has failed to establish the chronological relationship between hypothesised risk factors and the onset of homelessness (Susser et al. 1993). The only risk factors identified as pre-dating homelessness are childhood adversity, problem behaviours and substance use disorders (Susser et al. 1991; Caton et al. 1994), although the pathways by which these might contribute to homelessness remain unclear. This paper describes a case-control study that aimed to identify risk factors for homelessness amongst people with psychotic disorders in the UK. Individuals who had been homeless were compared with others who had never been homeless. It was hypothesised that social, behavioural and clinical factors could be identified that predisposed people with psychoses to homelessness.

Subjects and methods

Sampling

Cases and controls were sampled from those in contact with psychiatric services. Cases were identified through a dedicated mental health service for homeless people (Commander et al. 1997a) and controls were sampled from an inner city community mental health
Data collected

Information was collected using a semi-structured interview. This included demographic data and historical information regarding childhood care, employment, relationships, family contact, forensic history and psychiatric service use. The Conduct Disorder section of the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (American Psychiatric Association 1994; SCID-II, First et al. 1994) was incorporated to enable a retrospective diagnosis of childhood conduct disorder to be made. The Structured Clinical Interview for DSM-IV (First et al. 1996) was used to establish lifetime diagnoses of substance (alcohol and drugs) abuse or dependence. A detailed accommodation history was taken and the first period of homelessness was identified. This was defined as: having ‘slept rough’ (without shelter, in a vehicle or derelict building) or stayed in a direct access hostel for homeless people for a period of 1 month or more. Throughout the interview attention was paid to temporal relationships and, for cases, whether or not hypothesised risk factors pre-dated the onset of homelessness. Interviews were carried out (by S.M.O.) between February 1996 and June 1997.

Clinical ratings were made from medical records (by M.J.C.). Data collected included lifetime diagnosis of psychotic disorder (DSM-IV, American Psychiatric Association 1994), and details of the course of illness (using the Life Chart Schedule, World Health Organisation 1992). Given the advantages of using multiple sources and methods to determine the presence of substance use disorders (Goldfinger et al. 1996), the presence of any lifetime substance use disorder was also assessed in this way (DSM-IV, American Psychiatric Association 1994). Onset of disorders and mental health service use were also recorded. After the interviews and clinical ratings had been completed, the independent ratings for onset of homelessness, presence and age of onset of any lifetime substance use disorders and age of first mental health service contact were compared. In the few instances of disagreement, a consensus rating was made.

Analysis

Analyses for hypothesised risk factors for homelessness were matched. Odds ratios (with 95% confidence intervals) were calculated to provide consistency between univariate and multivariate analyses. Data were analysed using SPSS (1992) and Confidence Interval Analysis (Gardner et al. 1992). Significant differences between cases and controls may have arisen due to experiences subsequent to the onset of homelessness. Consequently, lifetime comparisons were repeated considering only the time before the onset of homelessness for cases and a similar time period in the controls (determined using the age of onset of homelessness of the matched pair).

Results

Response

Forty-nine eligible homeless patients were identified. One spoke limited English and was excluded and nine refused or were too unwell to take part; 39 agreed to participate. Non-responders did not differ significantly from those interviewed in terms of age, sex, or ethnicity. Sampling for controls continued until all 39 cases were matched. This required a total of 69 people to be sampled. Again, one speaking limited English was excluded. A further 22 refused or were too unwell to participate, and, of those interviewed, seven were discounted due to past experience of homelessness.

Sample characteristics

The majority of participants were male (N = 36). The mean age of each group was 38 years (SD 9, range 22–56) and the greatest difference between matched pairs was 2 years. Most participants were white (N = 34 cases and N = 30 controls) and only two cases and three controls had been born outside the UK. For cases, the duration of homelessness ranged from 3 months to over 10 years (median 2–3 years). Controls were significantly more likely to have been born in Birmingham (N = 32 vs N = 19 cases; OR = 4.0, 95% CI 1.3–16.4). Thirty-three had been resident at the same place for over a year, 33 occupied private accommodation (as opposed to some form of communal establishment such as a hostel or residential care setting) and 15 were living with family (usually parents).

Risk factors for homelessness

Social factors (see Table 1)

Childhood environment: The social class of parents was similar for cases and controls. Cases more commonly reported discontinuity of childhood care, and were significantly more likely to have been placed in care, particularly in a juvenile detention facility or children’s home.

Education and employment: There was no difference between cases and controls in the duration of schooling, although cases were significantly less likely to have gained any qualifications. Prolonged periods of unemployment were common in both groups.

Relationships: Cases were significantly more likely to have lost contact with all childhood carers for 6 months or more, and this remained true for the pre-homeless period. Cases were more likely to have ended a marriage or a co-habiting relationship, although the difference was no longer significant when considering only the time before homelessness.