WPA POSITION STATEMENT ON HOMELESSNESS & MENTAL HEALTH

Homelessness is a global problem. The number of homeless individuals cannot be truly estimated as definitions of homelessness vary across countries. The numbers of individuals who can be classified as being homeless are affected by a number of factors which include economic factors, rapid urbanisation, migration from rural to urban areas, unemployment, poverty and scarcity of secure accommodation. Some groups are more vulnerable to homelessness than others. There is considerable research evidence indicating that rates of psychiatric disorders are higher in homeless individuals although in some cases psychiatric illnesses may lead to homelessness. Homelessness and psychiatric disorders are both strongly affected by social factors and the stigma related to both further complicates matters.

Definitions: A number of components of homelessness have been identified. These include both the absence of housing and the quality of accommodation, such as living in marginal housing, sleeping rough on the streets or in hostels, bed and breakfast hotels or squats. Another element which has been recognised in the literature is the duration contributing to homelessness. This is often said to be more than a month. These definitions also include facing the loss of shelter; having an insecure and uncertain tenure and living in derelict buildings, boarding houses or reception centres. It is obvious that a lack of security of tenure and physical quality of the actual residential setting play a role in influencing mental state of individuals, thereby contributing to mental illness and this may set up a circle of illness and homelessness.

Homelessness is not a new phenomenon though the nature of homelessness continues to change according to altering social factors. In the UK, for example first laws related to homelessness were passed

in 1349, 1351 and 1388. At this time, monasteries and houses of religion flourished and offered shelter to those who were in the need of shelter and food. Destruction of monasteries and changes in Henry VIII period led to wandering homeless individuals in 16th century when houses of correction were created and workhouses were set up to deal with vagrancy. However, these failed because they offered no treatment/intervention for vagrants with mental illness. Definitions changed in the Victorian times and in the 20th century when homeless individuals were differentiated into itinerant workers, itinerant non-workers and non-itinerant non-workers and were respectively called hobos, tramps and bums.

Psychiatric Morbidity: Studies have shown that high rates of alcohol problems, schizophrenia, personality disorders, neurocognitive impairment, substance abuse, depression and other psychiatric conditions co-exist especially in vulnerable individuals. Vulnerable groups include children, women, ethnic minority groups, migrants and refugees, veterans, elderly, LGBT, single, widowed or divorced individuals.

Homelessness and criminality have a bi-directional relationship further complicated by co-morbidity with alcohol and substance abuse.

The WPA calls upon all countries to ensure:

- Adequate affordable housing facilities are available for people being discharged from psychiatric hospitals.
- Community mental health care must include provision of a range of accommodation and supported housing. A range of residential and psychiatric facilities must be developed from sheltered accommodation to long-term residential housing and clear intermediate and sustainable housing with support. Workers in these

settings need appropriate training to help identify signs of mental illness and be aware of potential sources of help locally.

- Facilities are available for rapid assessment and treatment for people with mental illness who are homeless or in precarious residential settings.
- For homeless individuals who have committed a crime where appropriate, serious attention should be given to consider diversion from custody. It is imperative that such vulnerable individuals have ready access to primary care and treatment in community as required.
- Policymakers must focus on strategies to decrease poverty along with flexibility in providing jobs and shelters; flexible educational provisions as well as specially targeted programmes in particular dealing with domestic violence and programmes across sectors working with shelters, safe houses and other NGOs.
- Clinicians must focus on easy accessibility and availability of range of group, family and individual work including parenting skills; managing substance use; developing early intervention programmes.
- In addition primary care services must be accessible and non-stigmatising providing integrated care between physical and mental health care and social care.
- Researchers must focus on evaluating services with clear outcomes and economic outputs.

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