

## **Medicalising Mental Health and Homelessness**

The best mental health care service in my community is my local park. During our recent summer holidays, people of all ages were out in the park kicking and hitting balls, laughing, reading books, cuddling, doing tai chi, picnicking, pushing prams and walking dogs.

Many of us may not regard local parks as a mental health service. Instead, we associate mental health services with services that provide treatment for people who have a mental illness or a 'mental health issue'. The primary focus of these services is on providing 'sick care' not 'health care'.

The distinction between 'sick care' and 'health care' is an important one. It determines the way health resources are allocated. Historically, our health care budget has been spent mostly on sick care. Yet the decline in mortality over the past century has been due to improvements in diet, employment, education, living conditions, sanitation and medical treatments. Medical treatments are only one part of the equation in improving our mortality.

Similarly, medical treatments are only one part of the equation in improving our mental health. Although people with a mental illness often benefit from medical treatments, social, economic, cultural, environmental and personal factors play an important role in mental health. A home, family, friends, and meaningful employment are just some of the things that help to keep us all sane.

Here lies a contemporary quandary: both 'mental illness' and 'mental health' are now treated as medical issues. Although evidence supports mental illness being treated medically, mental health is often a social, not medical, issue. For example many of us experience mental health issues due to relationship difficulties, grief, loneliness, sadness, unemployment, bullying, poverty, domestic violence, and traumatic childhoods. When these problems are treated medically, people are treated with medication, counselling or perhaps cognitive behavioural therapy. Although these treatments may be helpful for some individuals, they do not change the underlying social conditions that cause the distress.

Take homelessness as an example. It is often claimed that mental illness is a primary cause of homelessness, and that most people who are homeless have a mental illness. Some mental health agencies claim that up to 85 per cent of people who are homeless has a mental illness (Sane Australia 2014; MHCA 2014). If we accept this claim, we risk medicalising homelessness in the same way that we now medicalise mental health.

We need accurate statistics on the prevalence of mental illness among people who are homeless. Accurate statistics help to determine the type of support services that may be required. However, there are currently no reliable estimates of the prevalence of mental illness among people who are homeless. The lack of reliability has serious implications for policy and support services.

A systematic review of the prevalence of mental illness among people who are homeless in Western Countries including Australia found widely divergent prevalence rates (Fazel et al. 2008). The prevalence of psychotic illnesses ranged from 3 to 42 per cent; the prevalence of major depression ranges from zero to 41 percent. Australian clinical studies in the 1980s and 1990s found the prevalence of mental illness among people who were homeless as ranged somewhere between 39 and 75 per cent (Herrman et al. 1989; Reilly et al. 1994; Hodder et al. 1998).

A more recent study by Johnson and Chamberlain (2011) found the incidence of a mental illness was much lower. They found that 15 per cent had a mental illness prior to becoming homeless. Interestingly, they found 16 per cent developed a mental illnesses following homelessness.

This lack of consistency in the statistics may be due to the definition of a "mental illness". Many studies use a broad definition of mental illness, which includes people with a dependency on alcohol and other drugs. Johnson and Chamberlain (2011) argue that categorising people with a dependency on alcohol and other drugs as 'mentally ill' inflates the prevalence statistics.

Another explanation for the discrepancy in the statistics concerns the level of rigour in the research design. For example, one study asked people who were homeless if they have felt 'down', 'depressed' or 'anxious' in the last four weeks (Hodder et al. 1998). Is it surprising that many people who were homeless answered 'yes'? Another problem is due to 'convenience sampling' —recruiting participants through specific agencies. This results in a biased sample.

Medicalising homelessness risks overlooking the complex range of social and economic factors that may also cause homelessness. These social determinants of homelessness include poverty, gaps in the social security safety net, high levels of unemployment, problem gambling, family breakdown, domestic violence and a poor supply of affordable housing for people on low incomes.

Support services that focus primarily on treating mental illness may not meet the needs of those people who are homeless due to poverty, unemployment, substance abuse or domestic violence. Clearly a range of services is required to address these complex issues. In our study, young people with both a mental illness and substance abuse issues (a 'dual diagnosis') described important differences between Mental Health and Alcohol and Drug services (Russell and Evans 2009). These differences reflected the medical and social models of health.

While we all want to see better support for people with a mental illness who are homeless, policy needs to address the range of socio-economic, political, environmental, cultural and health factors that may contribute to homelessness. Medicalising homelessness is utter madness.

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Sane Australia Facts and figures about mental illness

<http://www.sane.org/information/factsheets-podcasts/204-facts-and-figures>