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Homelessness Among Individuals with A Psychotic Disorder

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ABSTRACT

Background: Homelessness has been a cause of concern in the United States and many other developing countries. There is a high prevalence of psychotic disorders, most commonly, schizophrenia among the homeless population. With economic and societal fluctuation comes a notable change in the composition of the homeless population. **Purpose:** This literature review aims to scrutinize the relationship between health maintenance of psychotic disorders and finding stability in housing. **Method:** This was a literature review. Research question: What effect do homeless individuals have on the health status of psychotic disorders? **Findings:** Results included societal stigma, causative agents, risk factors, and standardized screening tools for psychosis, and how this affects the homeless population. **Conclusion:** Those with psychosis may need help with identifying behaviors that keep them homeless. Therapy provides social interaction and a temporary warm and safe environment for those who are homeless. Community integration is how individuals are acclimated to living as highly functioning members of society and is the desired goal. Housing first provides a way for those who are homeless to have their shelter needs to be met. This is so the person can then focus on higher tasks such as employment, cessation of substances, and development of interpersonal relationships.

INTRODUCTION

Those within the homeless community are often overlooked by the rest of society. They may be seen on the side of the road or street corners trying to survive a harsh lifestyle, unfortunately, for many individuals that is all the attention they receive. Individuals with psychotic disorders are typically outcasts, in the same manner, therefore combining homelessness with a psychotic disorder amplifies the issue of societal neglect. The necessity of finding housing for someone who is diagnosed with a mental health condition can be the most powerful barrier in recovery [1]. The aforementioned factors indicate dysfunction in an individual's vocational, physiological, and socio-economic status. Topics of interest within this review include societal stigma, causative agents, risk factors, standardized screening tools, and health promotion within the homeless population affected by psychosis. Three clinical case studies will be reviewed to further elucidate a clinical understanding of psychotic disorders within the homeless population. Following the case studies, multiple research studies were comprehensively examined on the topic of the influence of psychosis and homelessness and its negative implication on the daily life of individuals. This literature review aimed to scrutinize the relationship between health maintenance of psychotic disorders and finding stability in housing. Research question: What effect do homeless individuals have on the health status of psychotic disorders?

BACKGROUND

For this study, homelessness is defined based on The Stewart B. McKinney Homeless Assistance Act established in 1987. This definition states that an individual is classified as homeless if they lack a fixed, regular, and adequate nighttime residence. This is also applicable to individuals whose primary nighttime residence is a publicly operated shelter designed to provide temporary living accommodations [2]. Anyone who is sleeping in a place where they have no legal right to be and has no other appropriate accommodation to resort to is 'homeless' [3].

There is a high prevalence of psychotic disorders, most commonly, schizophrenia among the homeless population. Although there is concurrency between the two topics, little is known about the underlying mechanism that precipitates findings of psychosis, disorganized thinking, and an altered ability to perceive reality. The following study will provide a literature review and case studies of psychosis within the homeless population. People living in precarious housing or

homelessness have higher than expected rates of psychotic disorders, persistent psychotic symptoms, and premature mortality [4].

Before addressing the case studies and literature review, an outline of both psychotic disorders and homelessness must be established. There are a variety of psychotic disorders that need to be defined as well as factors influencing homelessness. The following paragraphs highlight a brief description of psychotic disorders and the statistics regarding homelessness within the United States.

Psychosis Disorders

Psychotic disorders are subdivided into separate diagnoses that are slightly different in symptoms and onset. This includes schizophrenia, schizotypal personality disorder, delusional disorder, brief psychotic disorder, schizoaffective disorder, and substance-induced psychotic disorder. As shown in Figure 1, each psychotic disorder affects thinking, behavior, emotions, and the ability to perceive reality [5]. Schizophrenia symptoms are manifested in the late teens and early 20s [5]. To be diagnosed with schizophrenia, the person must have psychotic behavior or thinking present for at least six months and demonstrate an impairment in school, work, and self-care. Positive symptoms for psychotic disorders are hallucinations, delusions, alterations in speech, and bizarre behavior. Negative symptoms for psychotic disorders are anergia, alogia, blunt affect, anhedonia, and avolition [5]. Hallucinations, alterations in speech, anergia, and avolition impair one's ability to function productively and contribute to them becoming or remaining homeless.

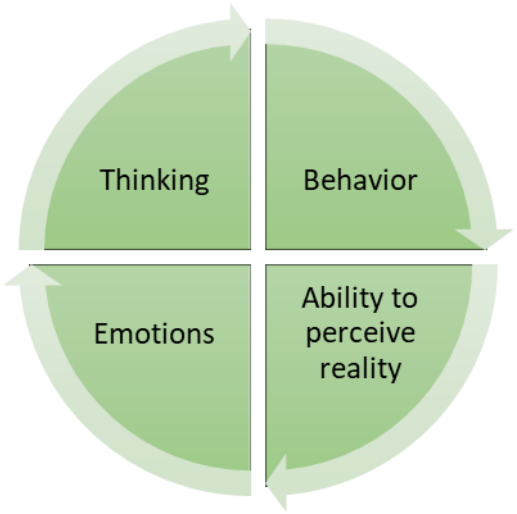

Figure No. 1: The psychotic disorder affects the person in four ways

Mentally ill patients experience a barrier to safe, adequate housing, making it harder for them to obtain a stable living environment. In Maslow's Hierarchy, the physiological portion of the basic needs of having safe shelter is not met [6]. If an individual is struggling to obtain shelter from the elements and away from possible crime, they are likely not thinking about obtaining a job and the quality of their relationships. Working through their mental illness in the therapy setting is also not a high priority when compared to the immediate physical needs. Psychotic disorders in the homeless community go untreated because the individual cannot recognize that their illness is contributing to their homelessness, or they lack the resources to effectively deal with their mental illness.

Homelessness Community

Homelessness affects a great population in the United States and depends on multiple factors that impact secure housing. In January 2020, 580,466 individuals experienced homelessness in the United States, with 70% being single individuals and 30% being families [7]. Michigan has a total of 8,638 people experiencing homelessness, which is on the lower side compared to other states. There has been a 6% increase in the cost of housing in Michigan [7]. The data does not represent homeless people with a mental disorder, yet society associates homelessness with poor mental health and may exacerbate symptoms of mental health disorders. Homeless individuals have an increased chance of having or developing a mental health disorder.

CASE STUDIES

Three homeless patients exhibited psychotic symptoms at the hospital. The hospital contains a specialized department for psychiatric illness. The following three scenarios feature various patient scenarios dealing with psychosis and homelessness for an extended period, along with an assessment of the affect and behavior of the patient.

Patient A

Patient A is a 20-year-old male diagnosed with new-onset schizophrenia experiencing his first psychotic episode. He is from another state and went missing for three months wandering the roads without a roof. He jumped into a stopped strangers' car stating, "They are coming!" He was holding a stick and had minimal clothing. The car owners called the police and they incarcerated him for a month, then transferred him to the hospital for evaluation. When assessing, he appeared well-groomed with brushed hair carrying a book around. During the conversation, he would look up and make statements to voices. He appeared to be responding to voices constantly. When asked about how homelessness affected his behavior, he stated that he was on a mission with the government to stop a foreign government from attacking the country, so he did not worry about housing that much. While on the street, he maintained his sleep hygiene by sleeping on park benches. He moved around through hitchhiking and begged for food.

Patient B

Patient B is a 28-year-old male who was diagnosed with a brief psychotic disorder. He was brought in by the police because he was found to be under the influence of multiple illegal substances such as cocaine. He was harassing people by talking about his grand plans to "unite all people" and to "build a better society for my brothers and sisters without technology" while also believing he was sent by God to do so. It is not known how long he has been homeless, but he said that he had been traveling from place to place for a while. His tattered clothing reflected that this was likely true and without intervention, he would still be out on the street. Additionally, he got into a conflict with another patient in his original unit due to his incessant talking about his cause and was moved to another unit for his safety.

Patient C

Patient C is a 30-year-old male who was diagnosed with schizophrenia and antisocial personality. He too was brought in by the police because he was found displaying inappropriate sexual behavior; therefore, he claims, “I deserve to die for what I did!” and “wish someone would just shoot me.” He was observed to have a calm affect and asked questions that were an attempt to help him gain information on the other patients and staff. He was frequently admitted to the hospital, and it was noted that his personality and recurring troubles with the law could be a relating factor in his homelessness. He believed that his trouble with finding a place to live, and a stable job is due to others not agreeing with him and his beliefs impair his ability to correlate his illness with his situation.

LITERATURE REVIEW AND FINDINGS

Each patient with indicative findings of a psychotic disorder has likely experienced homelessness at one point in their life. To look further into each of their personal experiences, it is important to look at journal articles discussing other factors that may contribute to each of the patients' lives. Multiple studies articulate homeless individuals and psychotic disorders. This section examines hospitalizations, risk factors for homelessness, substance abuse, stigma, physiological abnormalities, and health promotion activities. The university’s online library resources were used to collect information for this review on homelessness.

Stigma

Stigma, an unwanted indifference, generates fear of the unknown and false beliefs which can inevitably lead to discrimination, prejudice, stereotyping and social withdrawal [8]. Individuals challenged with mental, social, and structural inequities are faced with stigma from clinicians and the public respectively. People who suffer from mental illness or experience homelessness are notably labeled as social outcasts. Their actions are seen as hazardous and erratic, bringing rise to fear and aversion towards this group. These negative emotions provoke exclusion from their community. The lack of support brings about further deterioration of their health and a lack of pertinent resources that they can fall back on when in need. The stigma associated with both homelessness and psychotic disorders prevents an individual from seeking help and finding a

way to better their situation [1,8]. Their psychotic behavior could likely get them kicked out or impair their ability to allocate their resources correctly and efficiently.

Schizophrenia within the homeless

The homeless demographic experience numerous mental health disorders. Several studies show that schizophrenia amongst other psychotic disorders is the most common psychiatric disorder within the homeless population [9]. The studies were conducted throughout 13 countries representing 51,925 participants. The results indicated that there is a considerable number of homeless people who have a form of psychotic disorder. The most prevalent psychotic disorder was schizophrenia, yet other common diagnoses were schizophrenia form disorder and schizoaffective disorder [9]. This study represented the number of homeless individuals affected by a psychotic disorder, most commonly schizophrenia throughout various countries.

Another study [10] reported high prevalence rates of depressive and anxiety disorders, schizophrenia spectrum and psychotic disorders, substance use disorders, suicidal behavior, bipolar and mood disorders, neurocognitive disorders, and other mental disorders among homeless people (see Figure 2). Moreover, studies also reported a high burden of co-occurring mental and physical health problems among the homeless experiencing mental disorders [10].

PREVALENCE OF PSYCHOSIS AND OTHER DISORDERS AMONG THE HOMELESS PEOPLE	Schizophrenia
	Schizophreniform disorder
	Schizoaffective disorder
	Depression
	Anxiety disorders
	Substance use disorders
	Bipolar disorder
	Neurocognitive disorder
	Suicidal behavior
	Co-occurring mental and physical health problems

Figure No. 2: Prevalence of psychosis and other disorders among homeless people.

Risk factors

Risk factors for homelessness among people with psychosis include male gender, little social support, childhood trauma, and substance use (see Figure 3). Homeless individuals with psychosis have triple or quadruple the mortality rate than the public [11]. In addition, younger age groups are especially at risk of death. This is concerning since young adulthood is a critical age where a lot of growth and change is occurring. Impaired functioning and an interrupted transition to adulthood could contribute to those with psychosis becoming homeless [11]. Some older studies suggested that in the US, black homeless men have higher rates of drug abuse than white homeless men [12]. Findings highlight the point that black-white disparities in lifetime homeless risk are associated with socio-structural factors such as income and incarceration; individual adverse events such as traumatic events; and not associated with psychiatric or substance use disorders [12].

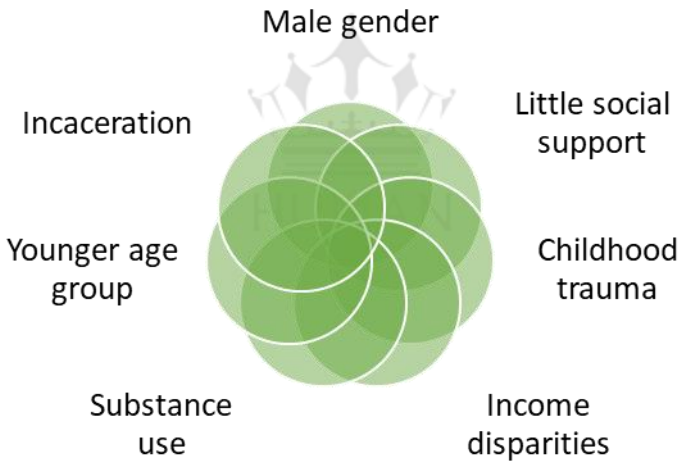

Figure No. 3: Psychiatric and non-psychiatric risk factors among homeless people.

Hospitalization Visits

Healthcare is essential for everyone, regardless of economic status. Many homeless individuals require a greater degree of care, so the care must be just as adequate in quality. A national survey was conducted to determine the number of homeless and non-homeless individuals who visit the emergency room [13]. The study examined the ethnicity and psychiatric history of each admitted patient. The data used was from the National Hospital Ambulatory Medical Care Survey from

2005 to 2015. The results conveyed that the homeless population made up less than 1/100 emergency room visits in the United States [13]. Despite the low emergency hospitalization rate among the homeless community, the likelihood of readmission within three days and the subsequent year is higher than non-homeless people. Non-Hispanic, African American males were seen the most compared to non-homeless persons in the urban areas. The homeless were in the emergency room for alcohol-related, substance abuse-related, and mental health-related problems. Findings were indicative of schizophrenia in greater numbers than that of other psychotic disorders [13].

One study [14] examined a nationwide cohort study for people above the age of 18 discharging from psychiatric wards and their risk of becoming homeless by using a survival analysis technique (see Figure 4). The survival analysis included a logarithm using Poisson regression. The results showed that patients who are discharged from a psychiatric ward are at the highest risk of becoming homeless in the first year, especially if having a substance use history [14].

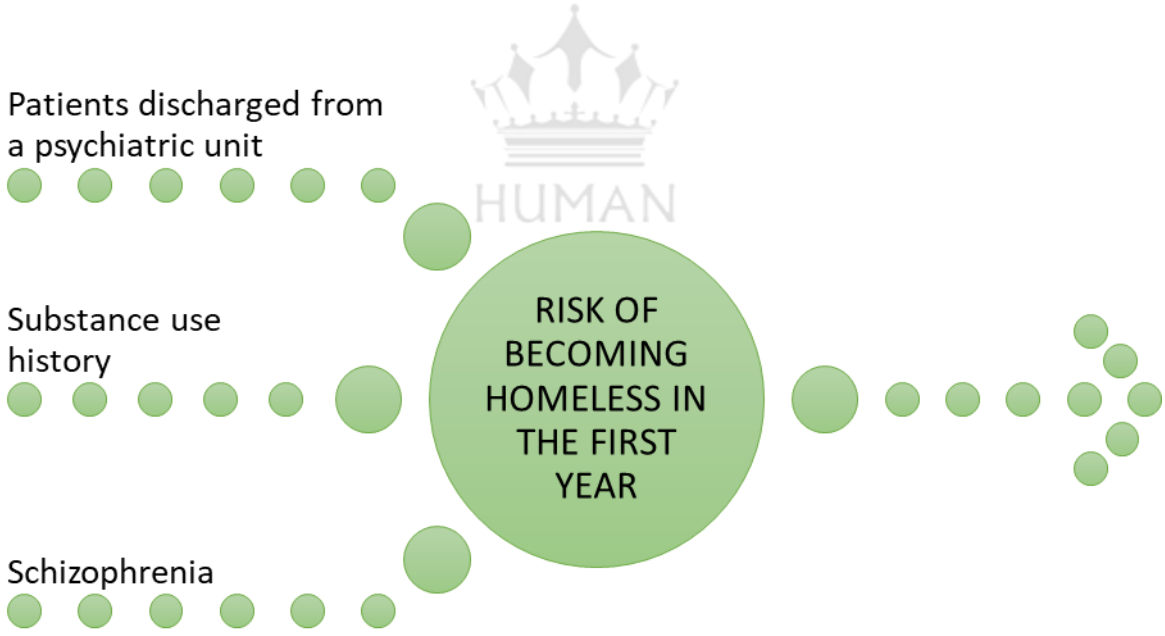

Figure No. 4: Risk of becoming homeless in the first year of discharge from a psychiatric unit.

Substance Use

Tri-morbidity is a term coined for individuals conjunctively experiencing substance abuse, physical illness, and mental illness leading to an increased mortality rate [15]. It primarily affects homeless communities or people living in precarious housing conditions. Psychosis, defined as a mental state with grossly impaired reality testing, operationally manifests as hallucinations and delusions is a debilitating disorder that is frequently recognized within the homeless community [15]. Epidemiological studies favor the idea that persistent occurrence of substance abuse psychosis can over time precipitate chronic psychotic disorders such as schizophrenia, schizoaffective, and schizotypal psychotic disorders. A longitudinal study of six years was conducted in Vancouver, Canada in the effort of correlating substance abuse and psychosis within the homeless community. The study included a monthly examination of 437 participants highlighting their use of nonprescribed substances, a psychosis screening, and a urinary drug test. As shown in Figure 5, the study found that the use of methamphetamine, alcohol, and cannabis poses a high risk for the development of substance-induced psychosis within the homeless demographic [15]. One can further denote from this study that prompt treatment of substance abuse disorder will yield a decrease in psychotic incidences within socioeconomically deprived populations.

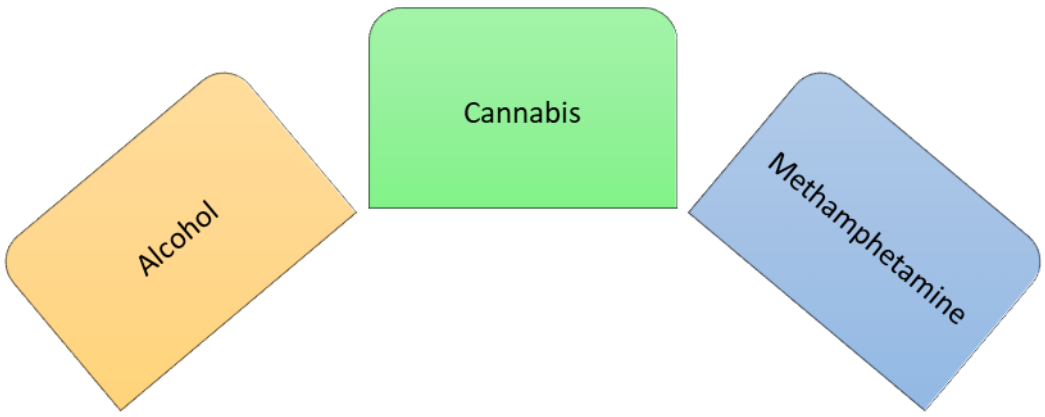

Figure No. 5: Three substances pose a high risk for substance-induced psychosis in the homeless population.

As mentioned above, those with psychosis often have comorbid conditions such as substance use and alcoholism which are strong predictors of homelessness. When one has little to no income,

coping with complications of substance abuse or chronic drinking depletes funds rapidly and perpetually keeps them in a homeless state. Psychotic disorders and substance use are associated with intermittent homelessness [16]. Escaping a situation with drugs or alcohol is often the easiest means of coping with life's stressors but leads to a positive feedback loop. A “housing first” program that emphasizes establishing stable housing for those who are homeless regardless of their drug use status is something to consider, as opposed to previous programs where sobriety was a prerequisite [16].

Physiological Status

Physical inactivity, inadequate sleep, a diet low in nutritional value or high in convenience food, smoking, and excessive alcohol or substance abuse are poor lifestyle decisions observed in individuals diagnosed with a psychotic disorder [17]. The following choices perpetuate negative physiological outcomes centered around cardiovascular dysfunction. Some possibilities include impaired glucose tolerance, increased waist circumference, hypertension, and hyperlipidemia. Patients who fit this description are categorized as ultra-high risk for psychosis (UHR). The COM-B model suggests that to live a fruitful and healthy life, an individual must have the capability, opportunity, and motivation to take on a behavior. Motivation, particularly autonomous motivation, is severely lacking in UHR psychosis patients. This is an intrinsically controlled characteristic that highlights the need to engage in behavior due to its alignment with personal views rather than the input of others. Long-term goals are not prioritized and are often uncompleted in this group of people. This is where social support is crucial and if correctly implemented, patients will display higher confidence and self-esteem levels. Studies show that when social support is used to increase motivation for engagement in physical activity the participants experience an even higher degree of confidence and self-esteem. Therefore, we can conclude that there might be a continuous cycle whereby motivating social support for the engagement in physical activity can lead to greater confidence levels which in turn stimulates their motivation even more [17].

Homeless individuals have a higher prevalence of cognitive dysfunction than the general population which is related to unstable shelter. Sheltered homelessness is where an individual has a place such as an emergency shelter, housing programs, or a safe-haven. In contrast, unsheltered homeless individuals sleep and live on streets, vehicles, parks, and empty buildings.

Unsheltered homeless people have a higher risk of mental illness, substance use, and medical illnesses than those who are sheltered [18]. In conclusion, the prevalence of adequate shelter proves to be pertinent in an individual's mental status, independent living skills, interpersonal relationship skills, and cognitive function. People that cannot call on others for help and struggle with living on their own are likely to be homeless. Unity among the community and a sense of compassion can go a long way when treating the homeless epidemic.

Health Promotion

Community integration (CI) is an important concept regarding homeless people with psychosis and involves the process by which a person can interact with other people, physically live-in proximity to others, and psychologically have a sense of belonging. The goal of CI is allowing a person to sustain their independence while staying out of homelessness [19]. Marshall *et al*. stated, interventions such as assertive case management, housing first, peer support groups, cognitive behavioral therapy, and social enterprise intervention as means that are implemented to facilitate growth (see Figure 6). The goal of social enterprise intervention is to reinstate homeless individuals back into the workforce. This provides an opportunity for the homeless to make their own money and empowers them to use available tools to better their way of living.

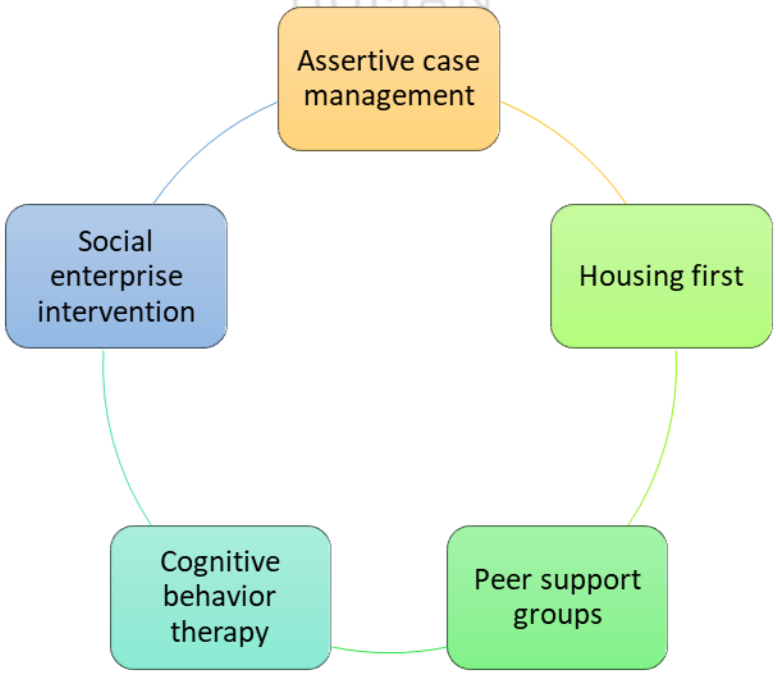

Figure No. 6: Means that are needed to facilitate growth for homeless people.

Health promotion activities are imperative for patients with any mental health disorder. A big disease affecting schizophrenic patients is cardiovascular disorders. Westman *et al.* [20] analyzed if psychosocial interventions helped improve health and reduce alcohol effects. The method used to promote such interventions was a part of the impact method that is based on cognitive behavioral therapy and motivational speaking. However, after the trial finished, there was little to no difference between the controlled group and the interventional group. More cases need to be examined and another method needs to be implemented to help the physiological response of schizophrenic patients.

In contrast, another study examined diet and lifestyle interventions on patients in an inpatient and outpatient setting diagnosed with schizophrenia with their first episode of psychosis [21]. The randomized controlled study consisted of interventions such as yoga, tai chi, anaerobic and aerobic exercise. The results signified a beneficial response to moderate aerobic exercise. Implementation of physical activity displayed greater efficacy than psychosocial therapy. Based on the study's results, psychosocial therapy did not show a dramatic effect on lifestyle interventions. Their ability to measure the outcomes of physical activity such as body mass index, waist circumference, blood pressure, and glucose was significantly easier than those of psychological factors [21]. When comparing the two studies, diet and exercise produced the best results but further examination is warranted.

DISCUSSION

The stigma of homelessness and psychotic disorders will always be prevalent because of societal standards. After reviewing the negative experiences that homeless people endure, people can learn and try to destigmatize homelessness by recognizing their feelings through self-examination [8]. Individuals can also educate themselves about psychotic disorders and how to help homeless people.

Housing first is an essential intervention for people who are homeless regardless of whether they have psychosis. As mentioned above, it involves the idea that establishing an individual with a house regardless of their history or current use of substances is beneficial. According to Maslow's hierarchy of needs, shelter is the most basic of needs along with food and water [6]. As shown in Figure 7, providing homeless people with housing allows them to focus their energy on

factors that contribute to their psychosis and acquiring help. This may allow people to shift their focus from a day-to-day mindset to one that is more long-term and that of a high functioning member of society.

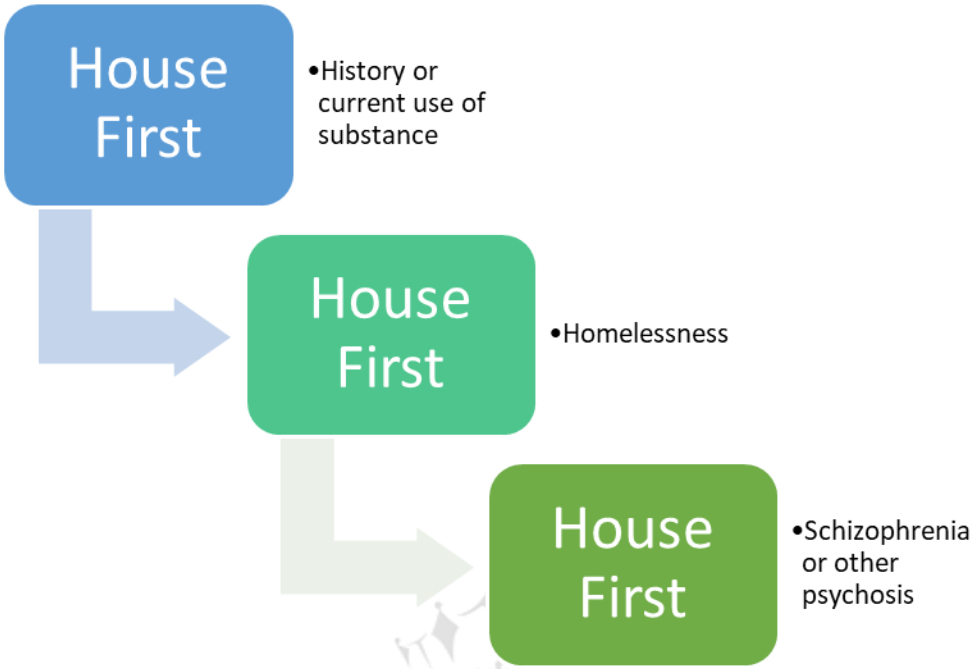

Figure No. 7: House first should be the focus of priority intervention for the homeless.

It is important to use interventions to promote health and decrease disability. Social support, exercise, and psychosocial therapy are beneficial in living a balanced lifestyle. Another intervention homeless individuals can use is cognitive-behavioral therapy [19]. Cognitive-behavioral therapy involves the use of techniques and therapy sessions to retrain the brain to adopt behaviors that are more adapted than what was previously used. For those with psychosis, this means providing individuals with methods to minimize or stop hallucinations and delusions, control impulsive behavior, and develop patterns of positive self-talk [15]. The behavioral part of this therapy uses reinforcement and consequences to change behavior. Those with psychosis may need help with identifying behaviors that keep them homeless. The therapy also provides social interaction and a temporary warm and safe environment for those who are homeless. Interrupting the self-perpetuating severity of psychotic symptoms in a vulnerable group of people could contribute to reducing premature mortality [4].

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CONCLUSION

The systemic review of homelessness and psychotic disorders enlightens on important concepts. Topics of interest included societal stigma, causative agents, risk factors, and standardized screening tools for psychosis, and how this affects the homeless population. Three clinical case studies were reviewed to further elucidate a clinical understanding of homelessness and psychotic disorders. It is worth noting that the individuals discussed in the case studies would benefit from the interventions mentioned above. Community integration is how individuals are acclimated to living as highly functioning members of society and is the desired goal. Housing first provides a way for those who are homeless to have their shelter needs to be met. This is so the person can then focus on higher tasks such as employment, cessation of substances, and development of interpersonal relationships. Will they stay in the house and work towards their goals? This will be a topic for further research.

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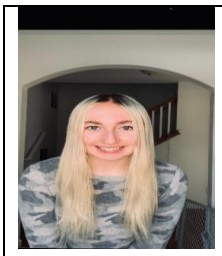
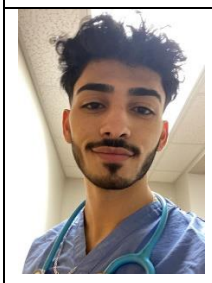
	**Riley M. Alvord** *Bronson School of Nursing, Western Michigan University, Kalamazoo, Michigan, USA*
	**Ali M. Elkhachin** *Bronson School of Nursing, Western Michigan University, Kalamazoo, Michigan, USA*
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