

Homelessness: a study of the perceptions of people working with the homeless, on the mental illnesses depression and schizophrenia.

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Table of contents:

<u>Contents</u>	<u>i</u>
<u>Acknowledgements</u>	<u>ii</u>
<u>Title</u>	<u>iii</u>
<u>Abstract</u>	<u>iv</u>
<u>Introduction</u>	<u>v-xvii</u>
<u>Aims of study</u>	<u>xviii</u>
<u>Methods:</u>	<u>xix</u>
Materials	xix-xx
Participants	xx-xxi
Design	xxi
Procedure	xxi-xxii
Ethical guidelines	xxii
Analysis	xxii
<u>Results</u>	<u>xxiii</u>
Hypothesis 1,2,3	xxiii
Descriptive Statistics	xxiv
<u>Discussion</u>	<u>xxv</u>
Homeless Descriptive Statistics	xxix-xxx
Depression Descriptive Statistics	xxx-xxxii
Schizophrenia Descriptive Statistics	xxxii-xxxiii
<u>Conclusion</u>	<u>xxxiii</u>
<u>Limitations</u>	<u>xxxiv</u>
<u>Further Suggestions</u>	<u>xxxvi</u>
<u>References list:</u>	<u>xxxvii - xxxix</u>

<u>Appendix 1</u>	<u>xl</u>
<u>Appendix 2</u>	<u>xli - xlii</u>
<u>Appendix 3</u>	<u>xliii – xliv</u>
<u>Appendix 4</u>	<u>xlv</u>
<u>Appendix 5</u>	<u>xlvi</u>
<u>Appendix 6</u>	<u>xlvii</u>

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Title:

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Abstract:

It is the aim of this research project to explore homelessness depression and schizophrenia measures by the perceptions of people working with the homeless. The issue of homelessness in our society is one of huge concern, the number of people who have fallen into the trap of homelessness over the years is hugely increasing. Homeless people lack social, cultural and health needs, and homelessness with mental illness is on the increase. A quantitative survey design was used, self administered questionnaires were given to 93 employees of homeless agencies around Dublin, they measured the participant's perceptions on homelessness, depression and schizophrenia. Results indicated that all three variables had a positive significant correlation with each other, showing that there was a link between homelessness, depression and schizophrenia. In conclusion homelessness and mental illness is seen as a significant and real problem among those who work with the homeless, that indeed they have links to each other and therefore make it harder for the homeless person to cope with their illness as they lack adequate support

Introduction:

This dissertation will look at the links between homelessness and the mental health disorders, depression and schizophrenia. Homelessness is very real within today's society and is causing growing concerns as more and more people and families find themselves falling into the trap of homelessness, especially with the current economic era. Homelessness in Ireland is defined as 'A person shall be regarded by a housing authority as being homeless for the purposes of this Act if:

a) there is no accommodation available which, in the opinion of the authority, s/he, together with any other person who normally resides with him/her or who might reasonably be expected to reside with him/her, can reasonably occupy or remain in occupation of, or
b) s/he is living in a hospital, county home, night shelter or other such institution, and is so living because s/he has no accommodation of the kind referred to in paragraph a. And s/ he are, in the opinion of the authority, unable to provide accommodation from his/her own resources.' (The housing act 1988).

Mental health is described as the psychological state of the mind. Mental health is something everybody has but it's put into two categories, mentally ill or mentally healthy. Mental illness is when someone experiences severe and upsetting psychological symptoms, and it can get to the point where normal everyday functioning is impaired.

Depression has different forms it can be short lived or severe. Short lived depression can be where someone experiences sad feelings or emotions, most people will encounter this at some stage of their life. Severe depression is one which may be so bad it requires treatment. At any one time over 400,000 people in Ireland experience some sort of depression. A depressive emotion is an overpowering feeling which effects thinking,

distracts the person's concentration and drains energy. It may decrease interest in food, sex, work and everyday activities, and can also disrupt sleep. (UCC online).

Schizophrenia is a severe brain disorder. People who are diagnosed with schizophrenia have many different thoughts, such as feeling that people are reading their minds, controlling their thoughts, or scheming to harm them. The person may hear voices within their head that no one else can hear, and when they are talking they may make no sense to others. The illness can be extremely terrifying for the person and therefore make them exceptionally agitated. (NIMH online).

The health care and needs of homeless people are directly connected to the chaotic and unhealthy lifestyle of homelessness. When a person is homeless they face many difficulties, and are at a much higher risk of diseases and infections such as chronic respiratory and cardiac ailments. The living conditions of homeless people can increase the incidence of such things as skin infections that may be infectious or non infectious. They generally have less adequate sanitation, safe drinking water, food and can have very poor hygiene. Many of the severe physical ailments linked with homelessness also have a psychological factor that cannot be neglected. The pressure of living with conditions that need constant support is extremely nerve-racking for the person and can affect them in many ways. The different lifestyle and social exclusion a homeless person has, compared to those who are not homeless is very stressful and this stress is without a doubt one of the main factors that cause depression, schizophrenia, personality disorders and anxiety that are very common among the homeless population. Among homeless people, mental health can be both a cause and an effect. People with a history of previous mental illness may find themselves homeless and by this their illness may remain or get worse. (Feantsa policy statement online). for people who become homeless and have no previous mental illness homelessness, may be the cause of someone to be diagnosed with one.

"Housing is a major cause of stress for people with a mental illness, and it has been well documented that a significant percentage of the homeless in Ireland have a mental illness. Current reports suggest that up to 30% of the homeless population have some form of mental illness." (SIRL online).

Schizophrenia and homelessness have been strongly linked for over 150 years, but has only been really recognised for the past 25 years. This may be the result of more research into the area, and also changes within society's attitudes towards the homeless with a mental illness . With the acknowledgement of the link between the two, there has been a development of mental health services for homeless people. The development has mainly been private and non government funded in such countries of Europe, United Kingdom, and United States. (M.E Sharpe website).

Few groups present a greater challenge to services than the homeless, because of their need for help within areas such as social needs, and health issues, including mental. Homeless people are more likely to experience higher death rates, due to things such as, a shortage of food and water, inadequate sanitation, inadequate shelter, physical and mental issues and overdoses and are therefore expected to have lower life expectancies. They are also more likely to die due to suicide than non homeless people.

A homeless agency count in Ireland In 2005 showed that there was 2015 homeless people, 954 men, 550 women, 463 children, and 40 had no response. Around 41,000 people in Ireland are directly affected by schizophrenia, it also affects their family, friends and careers.

When thinking about homelessness, many different reasons why someone becomes homeless comes to mind, not only mental illnesses. The following studies look at different pathways into homelessness.

The first study is that by Sullivan,G., Burnam,A., Koegel,P. (2000). 'Pathways into homelessness among the mentally ill'. People with a mental illness are becoming a huge part of today's homeless society, mental illness is also one of the huge risk factors for people finding themselves homeless. The aim of this study was to look at the differences between mentally ill homeless people and homeless without a mental health issues. This was done by comparing and contrasting 334 mentally ill homeless people who had a mean age of 37.5 years, 1,197 homeless people with no mental illness who had a mean age of 36.6 years and a 183 housed mentally ill people who were taken from a study done by Rand's Course of Homelessness and the Epidemiological Catchment Area survey. The results indicated that a lot of people who are homeless share economic and social disadvantages from their childhood. Those who became homeless becoming mentally ill, reported to have the highest level of disadvantage throughout their lives and those who found themselves homeless after becoming ill, reported to have a higher dependency on alcohol. So in conclusion mental illness can indeed play a role in a person becoming homeless, but it is unlikely to be the main factor. To help those who are homeless and who are homeless with a mental illness, outreach programmes and mental health services should be easily accessible.

Another study was done by Laere I,R,V., Wit,M.A.D., Klazinga,N.S. (2000). 'Pathways into homelessness; Recently homeless Adult's problems and service use before and after becoming homeless in Amsterdam'. This study was conducted to improve and look at ways to prevent people becoming homeless. 120 People who had recently become homeless were surveyed, their last period of housing was up to two years ago, and they also had to be legally living within the Netherlands at the time, they were examined to look at their different pathways into homelessness, their problems and their service use before and after becoming homeless. The samples were taken from the streets, day centres and overnight shelters within the Amsterdam area, during April and May 2004. Some of the statistics that

resulted from the studies were, 88% of the participants were male, the mean age was 38 years, and the mean duration of homelessness was 23 weeks. The following statistics were the main reported ways into homelessness, Evictions from participants housing accounted for 38%, relationship problems which was 35%, release from prison was 6% and other reasons 22%. There were only 38% of participants that had any form of contact with social services, and a total of 27% had contact with medical service before they became homeless. During the periods of homelessness, only the contacts with social work and benefit agencies increased, the rest remained low or nonexistent. In conclusion, contacts with different services to help the homeless were unstable and therefore did not help prevent homelessness. Many of the homeless participants fit the profile of the homeless population thought to be in Amsterdam, which was single Dutch men in their early 40 with an array of different problems, such as financial debts, addiction, physical and mental problems.

While mental illness is defiantly a part of today's homeless society, the parts being studied are depression and schizophrenia. The following studies were previously investigated to see if these two mental illnesses have a relationship with each other and with those who are homeless.

O'Brien J., Waldron A.M., Tobin G., McQuaid, P., Perot, S., & Pigott-Glynn, L. (2008). 'The Mental and Physical Health and Well-being of Homeless Families in Dublin'. Focus Ireland was founded in 1985 and is part of the national voluntary agencies in Ireland working with homeless people. It offers a range of services including transitional housing. They aim to help homeless families and their children, but for this to happen both issues of social and personal factors had to be addressed so families could settle into new housing and crack the cycle of homelessness. Focus Ireland are the only homeless agency with transitional housing. Its objective is to try and provide, help, support, education and time, to allow families to experience what it is like to live in their own house and to help them re-enter the

community by moving to new accommodation once they seem capable. This study was conducted with the help of three organisations, Focus Ireland, the Mater Hospital, and the Northern Area Health Board. It was done to test the effects of homelessness on families and their children, how the lack of adequate support services and the mental health of parents impacts on children. They surveyed fourteen different families within the focus Ireland transitional housing, with thirty one children between them, twelve of the families had single mothers as the head of the family. This study was influenced by a study carried out by Vostanis (1996 and 1997) in Birmingham. Vostanis and colleagues initially undertook a sample study of 19 homeless families with 50 children aged 2-15 years to examine the psychological situation of homeless children and their families. His design was modified and adapted to fit the Irish study. The Irish study was a small one and each team studied their own area within it, For example Focus Ireland drew on the social aspect, the Northern Area Health Board drew on the health of the families, and the Department of Child and Family Psychiatry at the Mater Hospital drew on the mental health of the families and children.

The aim of the first study done by Justin O'Brien was to examine the social and accommodation status of homeless families, living in the transitional housing unit. To do this they had to complete a questionnaire on their previous accommodation, the reported reasons for being homeless, income, education, and previous service use before and while they were homeless. In conclusion twelve of the families were lone-parent families and the fathers were not helpful to the mothers with their children, the other two had both mother and father. The bulk of the families had been homeless for an average of 8.5 months before entering the units. The parents reported relationship difficulties with family and friends, drug addiction and domestic violence as reasons for becoming homeless in the first place. It was reported that all the families had disadvantages in education. While they were situated in the transitional houses all the families usage of specialist services increased.

The conclusion for the second Waldron, A., Tobin, G., Mc Quaid, P., Dept of Child & Family Psychiatry, Mater Hospital Dublin, who researched the mental health status of homeless children and their families in Dublin were as follows: Once the General health questionnaires were completed by all the parents, it proved that 28 % of the mothers indicated psychiatric caseness. Child behaviours checklists were completed by each mother on the 31 children. They proved that more than a third of the children had a Total Problem Score above the clinical threshold, indicating the existence of mental health problems and the recommendation to go for treatment. 45% of the children proved to have externalising problems such as aggressive behaviour in the deviant range, while 29% of the children manifested internalising problems such as depression, anxiety and becoming increasingly withdrawn in the clinical range. 78% of the families had at least one child with child behaviour checklist elements. Each mother completed a stress index, 70 % reported feeling they lacked ability in their parenting role, that they were being overpowered by their children's needs, and were feeling social isolation from relatives and peers. Their scores also indicated poor self-esteem and significant depressive symptoms. The highest score was for the lack of emotional and active support from the opposite parent. A very high level of stress was recorded in this study among the group of homeless mothers and their children, indicating the need to provide appropriate mental health supports and services for this vulnerable group is a must.

The conclusion to the third part of this report researched by Perot, S., and Pigott-Glynn, L. Northern Area Health Board who were dealing with the health status of homeless families and their use of medical services was as follows. There was a high percentage of smoking during pregnancy by the mothers. More than half the children who took part in the study could be at risk of contracting infectious diseases as a result of unfinished or no immunisations. In the six months prior to the survey more than half the children had attended

the doctor or accident and emergency with reported problems such as respiratory or gastrointestinal tract infections. There was an under use of some health-care services and questionable use of others. Proving that the health status of these homeless families were not generally too great as an overall with so many visiting the a & e or their doctors, a need for more accessible, cheap and reliable medical care would be of benefit.

Another study was conducted by Votta E., & Farrell, S. (2009), 'Predictors of Psychological Adjustment among Homeless and Housed Female youth'. Its aim was to explore the impact of coping styles, self esteem and apparent support on the psychological adjustment of housed and homeless female youth. Data was gathered from an emergency hostel and from local high schools in Canada. The homeless females in the shelter numbered to 72 and had a mean age of 17.5 years. In contrast data was gathered from 102 housed females from local high schools and who had never been homeless, they had a mean age of 17.2 years. When the data was gathered the results to this study proved that the homeless females had increased levels of suicidal behaviour, had less support from their parents, they reported lower levels of self worth, and higher levels of symptoms associated with depression, they also had higher levels of internalising problems such as, anxiety and depression, and externalising problems such as, aggression and delinquent behaviour. In conclusion homeless youth reported having much less support than housed youth and this effected them psychologically. The results brought the idea that you have to consider coping styles, parental support in the presentation of depression and behavioural problems and self worth in both housed and homeless youth.

Another study done by Baggerly, J. (2004), 'The Effects of Child-Centred Group Play Therapy on Self-Concept, Depression, and Anxiety of Children Who Are Homeless'. Homelessness for children is rising fast, as a child is growing everyday their youth plays a huge part and influences the person they become. Homeless children face a number of

different challenges including decreased self-esteem and increased depression and anxiety. The aim of this research was to find out if the group therapy would decrease depression and anxiety and whether it increased self esteem. In conclusion the study proved that child centred play therapy can considerably improved the children's self esteem, anxiety and depression levels.

The following was a study done on homelessness and schizophrenia conducted by, McHugo, G., Bebout, R., Harris, M., Cleghorn, S., Herring, Q., Becker, D., Haiy,X., & Drake, R. (2004). 'A Randomised Controlled Trial of Integrated Versus Parallel Housing Services for Homeless Adults With Severe Mental Illness'. The following research consisted of a group of adult residents of Washington DC, with severe mental illness. They were currently homeless or at high risk of becoming homeless. Participants had to meet the following to participate, to be between ages 21 to 60, to be enrolled in the DC Commission on Mental Health service, to have a severe mental illness as certified by DC Commission on Mental Health for at least the last 2 years, to be in housing at least part of the past year but at risk of homelessness, and to be willing and have the ability to give informed consent to participate. It compared two modern approaches to linking housing and mental health services. In the integrated housing program, case management and housing services were provided by teams within a single group and were closely coordinated. In the parallel housing, case management services were provided by mobile assertive community treatment teams and housing by community based landlords. There were 121 adults with severe mental illness who were also at a high risk of homelessness and 72.7% had some form of schizophrenia, they were picked at random and placed into either integrated or parallel housing services and followed for a period eighteen months. In conclusion after the 18 months integrated housing services proved to lead to more days of stable accommodation. They reported a decrease in psychiatric symptoms, and an increase in interaction between

clinical and housing services and higher levels of life satisfaction than participants of the parallel housing. This may be due to the fact that residents in the integrated housing were linked in with on site supports, this gave those people more independence with the backup of support if they needed it, this proved to be especially so for males.

Another study was that of Harriet, B., Navneet, K., Hunt, I., Robinson, J., Meehan, J., Parsons, R., McCann, K., Flynn, S., Burns, J., Amos, T., Shaw, J., Appleby, L. (2005). 'Suicide in the homeless within 12 months of contact with mental health services'. Suicide prevention is a big priority for the health services in many countries. As most people know people who work within the services to help homeless people face a lot of challenges because with homelessness comes an array of health and social needs. The aim of this study was to find out the numbers of homeless patients in contact with services who die by suicide. Harriet, B., et al, wanted to look further into suicide methods and social and clinical characteristics of the homeless population. A 4year (1996-2000) was conducted on a clinical sample of people in England and Wales who died by suicide. Detailed information was collected on people who had committed suicide but who had been in contact with mental health services within the years before their death. In conclusion the results of the survey showed that a total of 131 people who died by suicide had reported being homeless at the time of death. This reported being 3% of every psychiatric patient over a 30 year period. The most reported reason for suicide was schizophrenia and the most common method was hanging. Around half of the people were actually in patients at the time of suicide. Therefore the following actions need to take place to reduce the number of suicidal deaths by the mentally ill homeless, an increase in in-patient safety is needed, an engagement in the community may also prove helpful. This can be done by assertive community treatment programmes, dual diagnosis service, and a dedicated community mental health team.

The next was a study done by Caton, C., Shrout, P., Eagle, P., Opler, L., Felix A., & Dominguez, B. (1994) 'Risk factors for homelessness among schizophrenic men'. The aim of this study was to identify the risk factors faced by the severely mentally ill homeless people, a case study was conducted in Manhattan using 100 schizophrenic men who met the criteria for being classed as homeless and also 100 men with no homeless history. The homeless men were gathered from shelters, clinics, and inpatient psychiatric programs in Manhattan. Clinical interviewers were administered to look at the three domains of risk factors. Firstly how severe the mental illness was, the second was the participants family background, and thirdly their prior mental health service use. This research resulted in the conclusion that Homeless people showed much higher rates of a concurrent diagnosis of drug abuse, and antisocial personality disorder. Homeless participants had experienced a more disorganised family life and setting from birth to the age of 18 than the non homeless participants, and they also at the time of the study had less current family support. The men who had never been homeless reported higher rates of attending therapy, this study therefore proved that the Homeless schizophrenic men differed from the non homeless men in all three areas investigated, family background, nature of illness, and service use history, proving that the non homeless scored lower and therefore not being homeless and having more supports could be a benefit for them.

The next study was done by Olfson, M., Mechanic, D., Hansell, S., Boyer, C.A., & Walkup, J.(1999). 'Prediction of Homelessness within Three Months of Discharge among Inpatients with Schizophrenia'. The aim of this study was to try identify factors that place patients with mental illnesses, such as schizophrenia, at risk of becoming homeless after they were discharged from hospital. 263 Patients with schizophrenia were assessed at discharge from general hospitals in New York City and reassessed three months later. This follow up was done to see if any of the inpatients had reported becoming homeless within the three

month. The results of the study after the three month follow up were as follows: twenty patients (which was about 7.6 %) had encountered at least one episode of homelessness. Those who had a drug addiction at release from hospital had increased chances and were more likely to report becoming homeless at some stage of the follow up, compared to those who had no addiction. When being assessed on leaving the hospital the patient's mental illness was scored on the brief psychiatric scale, reading that those who scored over 40 reported to having more of a chance of becoming homeless than those with a score below 40. When both the drug disorder and the brief psychiatric scale was looked at 12 out of the 30 patients who had a drug addiction and who also had a score of over 40 reported actually becoming homeless when released. In conclusion the effects of both drug misuse and psychiatric symptoms at the time of discharge from hospital, has an increase risk of the person becoming homeless, even if only for a short time. These tests resulted in the idea that the patients who are schizophrenic, and also fit the profile may very well be good candidates for such things like community based programmes, which were introduced and specifically aimed at preventing homelessness for those with severe mental illnesses.

The next study looks at depression and schizophrenia together it was done by Wolfram., A.D, Konnecke., R, Kurt., M, Ropeter., D, Heinz., H. (2005), Depression in the long-term course of schizophrenia. This study was concerned with looking at depression in patients with schizophrenia. Depression is one of the most important characteristics of schizophrenia. The following study looked at the occurrence of depression in a total of 107 patients of the ABC schizophrenia study, over a twelve year period of first admittance to hospital, it looks into the occurrence of depression at different stages throughout the illness and the predictive outcome of depressive symptoms. The results indicated that 106 patients out of 107 experienced one or more of the 10 episodes of depressed moods between the first assessment and the follow up. In any month of the follow up at least 30 to 35 % of patients

reported feeling one of the following, depressed moods, loss of pleasure, loss of interest, feeling guilty, loss of their self confidence and suicidal thoughts. In conclusion during a psychotic episode a depressive mood is often frequent at around 50 %. There proved to be a significant correlation between the amount of depressive symptoms during a psychotic episode and the frequency of relapses as well as the length of time an inpatient receive treatment. The occurrence of depressive symptoms didn't make a patients need more treatment in the long run.

The next study was done by Sands, J, R. Harrow, M, (1999), and looked at Depression during the longitudinal course of schizophrenia. This was a study done to test patients for depression during a course of schizophrenia. The researchers wanted to compare depression in schizophrenia, they wanted to see if some schizophrenia patients were vulnerable to depression and they wanted to test the relationship of depression to post hospital adjustment in schizophrenia. There was a total of 187 participants, 70 with schizophrenia, 31 who were schizoaffective depressed, 17 who were psychotic uni-polar major depressed, and 69 who were non-psychotic uni-polar major depressed. The participants were assessed during their period in hospital and reassessed within 4.5 years and 7.5 year intervals. In conclusion when reassessed between 30 and 40 % of the patients with schizophrenia experienced depressive symptoms at both follow ups, and a group within that experienced repeated depression throughout. The two symptoms of depression and schizophrenia together were associated with and resulted in a poor overall outcome of the persons life, resulting in lower activity, disorganisation, dissatisfaction, work impairment and suicidal thoughts. During the most severe phase there was no change in the rates or severity of the depressive symptoms.

Aims of the present study:

The aims of the present study is to further the research on these topics and also to replicate and extend to existing research on homelessness, and on the mental illnesses, depression and schizophrenia. It was also done to look at the existing studies and see if they are supported or not, and to see if things have changed from when these were first researched.

A total of three hypotheses will be proposed, such as:

1. It is predicted there will be a positive correlation between homeless and depression measured by the perceptions of people working with the homeless.
2. It is predicted there will be a positive correlation between homeless and schizophrenia measured by the perceptions of people working with the homeless.
3. It is predicted there will be a positive correlation between depression and schizophrenia measured by the perceptions of people working with the homeless.

Descriptive statistics were run on questions from all three questionnaires, from the first questionnaire on attitudes of homeless people question one and eight were tested, from the second questionnaire on homelessness and depression questions four and nine were tested and from the third questionnaire on homelessness and schizophrenia questions one and eight were also tested.

Method section:

To carry out this study self administered questionnaire were given out to people working in agencies that deal with homeless people and mental health issues. Participants were asked to complete a short pamphlet of questionnaires, which contained parts of the following three questionnaires, Attitudes towards the Homeless Inventory, (Davis Buck et al 2005), Are you depressed? (Mary Shannon, 2005) and the Schizophrenia Screening Quiz, (John M. Grohol, 2007).

Materials:

These three questionnaires were put together into a booklet and were given out to the participants from a variety of different organisations dealing with homelessness and mental health. On the front of the questionnaires there was a cover note (see appendix 1), this was attached to firstly inform the participants what the study was looking to find out, thanked them in advance for completing, asked them for their own privacy not to sign their name anywhere and asked whether they were male or female and their age. Each questionnaire was a 12 item measure and each one was scored on a 5 point scale ranging from (1) strongly agree, (2) agree, (3) neither agree nor disagree, (4) disagree, (5) strongly disagree, scores ranged from 12 to 60 with higher scores indicating a more positive view of homelessness depression and schizophrenia.

The first questionnaire dealt with attitudes of people towards the homeless population (see appendices2), 'Design and validation of the Health Professionals Attitudes towards the Homeless Inventory', (Davis s Buck et al 2005)'. This questionnaire was concerned with looking at medical students attitudes of homeless people. The questionnaire gave general assumptions and they had to answer if they felt it was true or false. Such questions like, 'homeless people are victim of circumstance, homelessness is a major problem within or

society', and 'doctors have a duty to care for homeless people'. There was also more specific questions such as 'I resent the amount of time it takes to see a homeless patient', and 'I feel overwhelmed by the number of problems homeless people have'.

The second was on homelessness and depression (see apidencies3), Are you depressed? Mary Shannon, (about.com Guide 2005) am I depressed? Times online Dr Jim Bolton and Dr Martin Briscoe, 2008. This was developed and was concerned with asking general question on a person's mood, the way they answered would indicate whether the person may have symptoms of depression. Such questions like 'do you feel unhappy most of the time?', and 'do you lack self confidence in areas that you used to feel competent in?' were asked.

The third focused on homelessness and schizophrenia (see apedencies4), Schizophrenia Screening Quiz, (By John M. Grohol, Psy.D, 2007), self test for schizophrenia, SLS treatment services. This questionnaire was developed to ask questions to see if the person them self or a family member would answer indicating that the person was having schizophrenic thoughts. Such questions like 'do you or a loved one hear voices that seem to come from somewhere outside of you?' And 'do you or a loved one believe that other people can read your thoughts?' were asked.

The questionnaires that were administered were based on these three questionnaires but some questions were deleted or altered and some were included to base the research more around the specific things that this study was looking at.

Participants:

The questionnaires were administered by a full time student in Dublin Business School, to employees and volunteers of different homeless agencies and mental health

institutions around the Dublin area. The questionnaires were all voluntarily completed and generally took between 2-4 minutes. While trying to contact people to take part many organisations didn't have the time, so the ones who did were chosen at random. There were a total of 93 participants, 30 males and 63 female.

Design:

A quantitative survey design was used. The 93 participants were chosen by various different agencies by the managers that chose to take part. It was a non experimental research design, using correlations to test the relationship between the different variables. Frequencies were run to find the different percentages of people's general attitudes to homelessness, and their attitudes to homeless people with depression and schizophrenia. All the participants received the same questionnaire and guidelines on answering it.

Procedure:

This research project was conducted within different homeless agencies in the general Dublin area. On conducting this research, permission had to be granted from managers of every organisation first. The chosen organisations were contacted by phone or email, and asked if they would be interested in allowing their employees to participate in the research, the managers were sent a cover letter from Dublin Business School to obtain their approval before they agreed(see appendix 6). This was sent to the managers including a copy of the questionnaires, Once they had agreed they requested for a certain amount to be either, emailed, posted or hand delivered. The questionnaires were then administered within the organisations. On the front section of the questionnaire the participants were given information on the nature of the research and because they were all over 18 they gave their own consent to participate. The cover note on the front stated what the research was trying to investigate, ensuring participants that all information was strictly confidential, asking them

to make sure to answer them all exactly how they felt, and thanking them in advance for taking part(See appendix 1) .At the end of the questionnaire there was another note attached(see appendix 5) which thanked the participants again, and gave them information on how to contact someone if they wanted to know further information on the research.

All negative answers were recorded, and the total scores were computed, frequencies were run, and data was then analysed using SPSS version 15.

Ethical guidelines:

It was important to note the relevant ethical guidelines that would be needed to be followed with the sensitive nature of this project, so Ethical guidelines were a huge priority in this research. In recent years ethical considerations across the research district have come to the forefront. This is partly an outcome of governmental change in human rights and data protection. Participants were informed about the research and were personally allowed choose whether they wanted to take part. Participants were also informed that the questionnaires would remain strictly confidential throughout the study. This was stated on the front cover note, and it was also asked that they do not sign their name for further confidentiality. The researcher of the study has been the only one to see the answers and has kept them in a secure place, and all the data used in the analysis of the data is kept on a password protected memory key. These were all proper ethical guidelines to follow.

Analysis:

The present study was an analysis for a non experimental, correlational study.

Results section:

A total of three hypotheses will be tested:

1. It is predicted there will be a positive correlation between homelessness and depression measured by the perceptions of people working with the homeless.
2. It is predicted there will be a positive correlation between homelessness and schizophrenia measured by the perceptions of people working with the homeless.
3. It is predicted there will be a positive correlation between depression and schizophrenia measured by the perceptions of people working with the homeless.

To test the relationship between the three variables a correlation test was used. Frequencies were then ran. This was done to look at percentages of perceptions of the people working with the homeless.

A correlations test was conducted for homeless and depression. Results indicated that there was a moderate positive significant correlation between participants perceptions of homelessness and depression, $r=.326$, $n=93$, $p<.05$. Therefore the hypothesis for homelessness and depression was supported.

A correlation test was conducted for homeless and schizophrenia. Results indicated that there was a small positive significant correlation between the participants perceptions of homelessness and schizophrenia, $r=.432$, $n=93$, $p<.05$ Therefore the hypothesis for homelessness and schizophrenia was supported.

A correlation was conducted for depression and schizophrenia. Results indicated that there was a moderate positive significant correlation between the participations perceptions of depression and schizophrenia, $r=1$, $n=93$, $p<.05$. Therefore the hypothesis for depression and schizophrenia was supported.

A selection of questions from the questionnaire that were found to be interesting were picked and frequencies were run on them to find out peoples attitudes in percentages.

Do you think that homeless people are easily indentified/ recognised? 67% of people agreed, 20% neither agreed nor disagreed, and 13% disagreed.

Do you think that most homeless people with a mental illness are dangerous? 25% of people agreed, 33% neither agreed nor disagreed, and 42% disagreed.

In your experience do some homeless people have thoughts about death or suicide? 77% of people agreed, 22% neither agreed nor disagreed, and 1% disagreed.

In your experience do some homeless people feel hopeless about the future? 75 % of people agreed, 21% neither agreed nor disagreed, and 4% disagreed.

In your experience do some homeless people, hear voices that come from somewhere outside of them? 43% of people agreed, 44% neither agreed nor disagreed, and 13% disagreed.

In your experience do you think some homeless people cannot trust what they are thinking because they can't tell if it's real or not? 44% of people agreed, 38% neither agreed nor disagreed, and 18% disagreed.

Discussion section:

For the purpose of this study the data was analysed using correlations and descriptive statistics. The aim of the study was to find out the perceptions of people working with the homeless on such things like homelessness depression and schizophrenia.

When the data was being analysed the researchers had the chance of the direction of the relationship to either be positive or negative. It was hypothesised that they would all be positive which means if one variable goes up the other goes up, for example the more papers you deliver the longer it will take you, when the data was analysed all the hypothesis were supported and where proven to be positive, this meant that as one variable increased so did the other.

The purpose of the current study is to firstly examine the participant's perceived attitudes of homelessness, and the mental illnesses depression and schizophrenia and to see if they had a relationship. Secondly descriptive statistics were run on some questions to find the percentages of people attitudes on questions asked throughout the questionnaire.

The first hypothesis was testing the relationship between the participant's perceptions of homelessness and depression using a correlational analysis, this was found to support the hypothesis that there would be a positive relationship between homelessness and depression. This proves the point that people think that homelessness can be a cause of depression but is not the only cause. This ties into a comparative study done by Waldron, A., Tobin, G., McQuaid, P., Dept of Child & Family Psychiatry, Mater Dublin. This study looked at the mental health status of homeless children and their families, after being tested 28% of mothers indicated psychiatric problems, more than a third of the children had the existence of a mental

health problem, 29% reported internalising problems such as depression and anxiety. In studies it has proven that the main idea is being homeless indeed has an effect on the mental health status of a person. This also ties in with the study done by McHugo, G., Bebout, R., Harris, M., Cleghorn, S., Herring, Q., Becker, D., Haiy, X., & Drake, R. (2004), 'A randomised controlled trial of integrated versus parallel housing services for homeless adults with severe mental illness'. The findings of this study were that the participants who were in integrated housing, (which is housing that links the residents with onsite services and supports, and helps with independence for people with difficulties), reported after 18 months to have decreased psychiatric symptoms and a higher level of life satisfaction than those in the parallel housing units, the people in the parallel housing units had reported less days in the stable accommodation this therefore suggested the people who were in the integrated housing with support scored higher levels of satisfaction and lower levels of psychiatric symptoms due to more stable accommodation and interaction between the housing services. Therefore previous research in this field was also found to have a significant positive correlation between homelessness and depression.

Following this homelessness and depression was tested, Another correlational analysis was conducted on the participants perceptions of homelessness and schizophrenia, previous literature predicted there would be a positive relationship between the two, it was then hypothesised that there would be a positive relationship between both, and this tested to be true. A comparative study was done by Harriet, B., Avnet, K., Hunt, I., Robinson, J., Meehan, J., Parsons, R., McCann, K., Flynn, S., Burns, J., Amos, T., Shaw, J., Appleby, L. (2005), 'suicide in homeless within twelve months of contact with mental health services', they wanted to look into suicide methods and the social and clinical characteristics of being homeless. Their findings suggested that over a four year study data was collected on people who had passed away by suicide but who had been in contact with mental health services

before their death. The study reported that over the period of the study, 131 people who died by suicide had reported being homeless at the time of death, this was 3% of psychiatric patients over a 30 year period and that the most reported reason for suicide was schizophrenia. This proves that homeless people especially those living with a mental illness like schizophrenia need more engagement within the community and also a dedicated community mental health team may benefit them to prevent such things like suicide.

Another study that ties in with this was done by Caton, C., Shrout, P., Eagle, P., Opler, L., Felix A., & Dominguez, B. (1994), 'Risk factors for homelessness among schizophrenic men', this study compared homeless men to men who had never been homeless. Both groups were reported to have some form of schizophrenia. Interviews looked at how severe the mental illness was, the participant's family background, and their prior mental health service use. The homeless men reported higher rates of drug abuse and antisocial personality disorder. The men who had never been homeless had higher percentages of attending therapy for their illness. Therefore it can be said that in this study it's proved that homeless men differed for the non homeless in all three domains of risk factors, they reported less use of the services available to them which in turn lead to more negative attitudes of behaviour. They had less support from both their families and support services and had a more disorganised life as children.

A further comparative study was done by Olfson, M., Mechanic, D., Hansell, S., Boyer, A.C., & Walkup, J. (1999). 'Prediction of Homelessness within Three Months of Discharge among Inpatients with Schizophrenia', their study aimed to look at different factors that would place schizophrenia patients at the risk of becoming homeless after discharged from hospital. Participants were assessed on discharge from hospital and also reassessed three months later, 8% of the participants had experienced an episode of homelessness, those with drug addiction had increased chances of becoming homeless, 12 out

of 30 patients with a diagnoses of drug disorder and a score above 40 on the brief psychiatric scale reported becoming homeless when released, the conclusion to the study was that patients who had a psychiatric symptom at discharge had increased risk of homelessness and even more of a risk if they had more than one diagnoses.

The hypothesis for this correlational test on homelessness and schizophrenia was proved to support the previous literature conducted in this field

Another correlational analysis was conducted on depression and schizophrenia, there was a prediction that there would be a positive relationship between the both and this tested to be true. This is an interesting result but is lacking previous literature on these two topics relating to homelessness, the existing literature related to the two mental illnesses in the general public. The research conducted in the fields of depression and schizophrenia was found to have a positive significant relationship between the two. A comparison study was that of Wolfram., A.D, Konnecke., R, Kurt., M, Ropeter., D, Heinz., H. (2005), Depression in the long-term course of schizophrenia, this study looked at the occurrence of depression among schizophrenic patients. There results indicated that only one out of the 107 schizophrenic patients did not experience one of the 10 depressive mood symptoms, in any of the months over the twelve year follow up period around a third of the patients felt a depressive mood, such as loss of confidence, loss of interest and suicidal thoughts. This concluded in proving that when a psychotic episode occurs a depressive mood is often frequently following it with around 50% of the patients reporting this.

Another study by Sands, J, R. Harrow, M, (1999), looked at Depression during the longitudinal course of schizophrenia, this was done to test schizophrenic patients for depression and to see if they were vulnerable to have depressive moods. Their results proved that when patients were reassessed after their discharge between 30-40% had encountered

depressive symptoms, and within that group a number of people had reported experiencing repeated depression. This therefore proves that depression may indeed be an outcome of schizophrenia for many different reasons such as the person feeling isolated or different, the person's life may be affected and changed when they are diagnosed with schizophrenia and in the end sometimes may end up being too much for them with a number of schizophrenic patients actually reporting to committing suicide(this was reported in a study done by Harriet.,b, et al 'Suicide in the homeless within 12 months of contact with mental health services'). Depression and schizophrenia together resulted in the participants feeling disorganised, dissatisfied, engaging in less activity, experiencing impairments in everyday life and work, and often suicidal thoughts.

Some descriptive statistics were run on two questions from each part of the questionnaire, this was done to find out the perceptions of people working with the homeless attitudes towards the homeless in general, between homelessness and depression and homelessness and schizophrenia. Two questions were chosen from each questionnaire, the first was on attitudes, the second on depression and the third on schizophrenia.

Homelessness:

When the participants were asked a question on whether they thought a homeless person was easily recognised, over half the participants agreed that a homeless person is easily identified or recognised with 67% agreeing, 13% disagreed and the further 20% were neutral. Although a majority of the participants answered the question with either strongly agree or agree, the further participants who were neutral may not have felt that all homeless people are actually visible, because in the question it wasn't stated what a homeless person was. This statistic can link into a study done by Laere I,R,V., Wit,M.A.D., Klazinga,N.S. (2000). 'Pathways into homelessness; Recently homeless Adult's problems and service use

before and after becoming homeless in Amsterdam', in this study the finding suggested that the homeless participants fitted the profile of the population thought to be homeless in Amsterdam, which was single Dutch men in their early forties with a variety of different problems, this study is the proof that every society has their own views of what a majority of their homeless look like, although no one can be exactly right on what a homeless person looks like, in a growing society where more are becoming homeless everyday.

When the participants were then asked the question 'do you think most homeless people with a mental illness are dangerous'? Nearly half the participants disagreed with this, and the rest resulted in a higher amount being neutral 33% and 25% agreeing that they are. This was an interesting finding and I was surprised to find that no research had been done on this particular topic before because none had been aimed at certain aspects of the dangers of the mentally ill homeless towards those working with them, which would be interesting to find out more on.

Depression:

When asked the question in your experience do some homeless people have thoughts about death or suicide a huge number agreed 77%, 22% were neutral and 1% disagreed, the reason for a number of people being neutral may be the fact that some of the participants may not have dealt first hand with the mental problems of the homeless people and therefore didn't know. The majority of participants did feel that the homeless population have had thoughts about death and suicide and this links into the study done by Harriet, B., Navneet, K., Hunt, I., Robinson, J., Meehan, J., Parsons, R., McCann, K., Flynn, S., Burns, J., Amos, T., Shaw, J., Appleby, L. (2005). They researched 'Suicide in the homeless within 12 months of contact with mental health services'. Their results indicated that 131 of the

patients that died from suicide had reported being homeless at the time of death, and that the most reported reason for suicide was schizophrenia. This links in with the thought that many homeless people have had thought of suicide.

Another frequency was run on the question asking 'in your experience do some homeless people feel hopeless about the future?' 75 % agreed, 21% neither agreed nor disagreed, and 4% disagreed. This is the type of question that anyone could relate to and some people commentated on this but the people were asked to think from their experiencing of dealing with homeless people, a big percentage in the end did agree. This also ties into the study done by Harriet, B., Navneet, K., Hunt, I., Robinson, J., Meehan, J., Parsons, R., McCann, K., Flynn, S., Burns, J., Amos, T., Shaw, J., Appleby, L. (2005). The results of this study indicated that 131 people who committed suicide over the 4 years had reported being homeless at the time. This leads us to the idea that homeless people do have hopeless thoughts about the future which some even act on, it also proves that indeed they need more mental health support, to try prevent such things happening this can be done through such things like an assertive community treatment programme, and a dedicated community mental health team.

Schizophrenia:

When people were asked the question 'in your experience do some homeless people, hear voices that come from somewhere outside of them?' a frequency was run and the results indicated that 43% of all participants agreed, 44% neither agreed nor disagreed, and 13% disagreed. The reason that there was a big percentage of neither agreed or disagreed could be due to the fact that again some of the volunteers may not have dealt with people in this type of situation, as this would be a more specialised field that they may not have encountered. This proved to be an interesting finding, as there has not been much done on this type of topic

before it proved hard to find any existing literature on how people experience their schizophrenic thoughts.

Following that the participants were asked the following 'In your experience do you think some homeless people cannot trust what they are thinking because they can't tell if it's real or not?' 44% agreed, 38% neither agreed nor disagreed and 18% disagreed. Like mentioned above the volunteers may not have known the true answer to this question, and this could have resulted in the 38% neither agreeing nor disagreeing. Previous literature only talked about schizophrenia in general it did not go into detail in any of the studies about how the people feel or experience their thoughts, so this therefore didn't link to any studies but was an interesting statistic.

Conclusion:

Homelessness is major problem within our society along with that of mental illness, it may be said that homelessness does have a huge effect on a person's mental health, such things like schizophrenia can affect a person in many ways and if they don't have the right treatment for it they may be at higher risk of becoming homeless. Community based programmes were introduced and aimed at preventing homelessness among the severely mentally ill. It was hypothesised that all three variable would have a relationship with each other which was supported within this study , once one variable went up so did the other, this can lead us to think that maybe in some cases these variables are cause and effect of each other.

Homelessness is very real within our society and so is mental illness, for homeless people to live with a mental illness can be very distressing and cause in extreme cases such things as suicide if they do not get the appropriate medical treatment. Mental illness doesn't only cause homelessness many different things do but it can be a huge factor that contributes

to it. This study proved that people working with homeless people have perceptions that homelessness depression and schizophrenia are closely linked.

This study was conducted in the Dublin area, as previous literature either dealt with a broad topic, like that of Focus Ireland, that looked at families and children, other studies were in different countries. Some of the studies such as, O'Brein, J, et al (2008) and Canton, C, et al (1994) have pointed out the fact that homeless people have generally had a more disorganised lifestyle since birth, lower levels of education, and less support at that moment in time or throughout many years.

It may be agreed that being homeless has an effect on ones mental illness as much as having a mental illness can lead to one being homeless. In a report done by mental health Ireland the following was stated, 'In 2000 the ERHA and RCSI did a study on Irish hostel dwellers in Dublin. It revealed that 52% suffered from depression, 50% suffered from anxiety and 4% from other mental health problems. It also found that 72% of homeless men in hostels, who met criteria for serious mental health problems, were not in receipt of care' (mental health Ireland online).

In a report done by amnesty international on homelessness in Ireland it was recorded that "Professionals working with the homeless in irelands, will generally concede that 25% of this group do not admit to having psychological problems, while 75%. Of the latter, 42% are believed to have a history of mental health problems which are a consequence of their social deprivation and homelessness. The remaining 33% are believed to suffer from severe mental and/or behavioural disorders which contribute significantly to their homeless state and are exacerbated by it." (Fernandez J, 1996). This proves that within Ireland people who are homeless and who do have a mental health issue are not always so obvious to the eye and won't always admit or think that they have a problem, and therefore slip even further through

the gaps of homelessness within our society, making it harder for them to cope. Patients with schizophrenia frequently suffer from more than one psychiatric disorder. More than half will experience some form of depression during their lifetime.

The rate of suicide among individuals with schizophrenia is about 10 percent, highlighting the importance of recognizing and treating depression associated with schizophrenia. (Marder.,S.R, 2001).

This research project looked at the relationship between homelessness, depression and schizophrenia, and previous research had found that there would be a positive relationship between them all, which this research project supported. When correlations and descriptive statistics were run and the percentages were gathered, it was interesting to find that some of the ideas that arose had not been specifically looked at before, many dealt with a broad topic in general and didn't focus on more specific things like the feeling and emotions one is faced with schizophrenia. Like mentioned there was little research done on only depression and schizophrenia among the homeless, it looked at specific things like depression and homelessness and schizophrenia and homelessness or homelessness and mental illnesses in general, therefore although all these were interesting finds it would be good to have gather more in-dept analyses on them to compare with my results.

Limitations:

The study was limited a bit in regards to sample size. To get a reasonable enough sample of people to analysis approximately 100 or more questionnaires had to be handed out, after weeks of ringing, emailing, meeting people and posting questionnaires to many different organisations many failed to return them which made the sample size smaller and after extensively exhausting many of the resources available the study ended up only having 93 questionnaires filled out.

Furthermore another limitation was that the study focused on people working with or who have worked with people who have been or are homeless, quite a number of the participants were working within agencies but a few were volunteers from such organisations as the St Vincent DePaul soup run which was done on two different nights by Trinity and UCD students, during the input of the data it was generally very easy to pick out which participants had filled out which answers as many of the volunteers resulted in answering 'neither agree or disagree' for a majority of questions, this may have somewhat affected the true analysis of the results compared to if having been completed by only employees of homeless agencies. An example of this would be question eight on the attitudes questionnaire, 'do you think most homeless people with a mental illness are dangerous'? when the frequency was run nearly half the participants disagreed with this, and the rest resulted in a higher amount being neutral 33% and 25% agreeing that they are, generally volunteers would not have the chance of working in settings with people who have had severe cases of mental illness and therefore would result in either answering from what they think could be right, or opting for the neutral answer because they genuinely don't know. The reasons volunteers were used was because firstly it proved difficult to get many of the questionnaires back from agencies, or to get approval of managers, some reported that there currently were other studies going on and that they felt answering to many different things would confuse their staff and secondly the thought that volunteers might not actually know the answers was not even thought about until the questionnaires were returned.

A further limitation that could be considered was the use of quantitative analysis, although statistics were relevant to this study, the use of qualitative analysis could maybe have produced a more in depth analysis of a few people's perceptions of working with the homeless which would also eliminate the use of being neutral, which therefore may have given a more real in depth analysis.

Future suggestion:

In the questions throughout the booklet the person was generally 'asked in your experience of working with homeless people', or 'in your experience do some homeless people', there was comments left on some of the questionnaires that this could be relevant to everyone not just homeless people, so the person answering usually opted for the neutral answer, although it was stated in the questions it was only about homeless people, maybe on the front cover to the questionnaire a reminder could be added to ask the person to relate only to the homeless population they have worked or work with and not to any one else even if it was common among the non homeless. A suggestion that may have resulted in higher correlation or percentage for the data would be to just get people working with the homeless and mentally ill to answer and not any volunteers. While looking up previous literature there was relevant articles on homelessness and depression and homelessness and schizophrenia, but there was none on homelessness depression and schizophrenia together, there was only some on depression and schizophrenia in general. as it was hypothesises that there would be a positive correlation between the two, measured by the perceptions of people working with the homeless, this proved hard to access information and the studies that are used for comparison are on the general public and not specifically homeless, this is a gap in the literature that would benefit being researched.

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Appendix:

Appendix 1:

HOMELESSNESS AND MENTAL HEALTH

This study is concerned about looking to see the effects of homelessness on mental health issues, such as depression and schizophrenia. Please answer each section as honestly as you can, do not spend too long thinking about each question as there are no right or wrong answers. Any information that you give will remain strictly confidential, you are not required to write your name anywhere on this survey. I hope you find this interesting, and I would like to thank you in advance for your time and co-operation.

Please attempt all questions. Be as honest as possible. Your confidentiality is of utmost importance. Please do not sign your name.

Gender Male [] Female []

Age _____

INSTRUCTIONS: The completion of these questionnaires will be able to help indicate if homeless people experience mental health issues, and the effect it has on them. Please circle number the number beside the question that best describes how much you agree or disagree with each one:

1 = strongly agree

2 = agree

3 = neither agree nor disagree

4 = disagree

5 = strongly disagree

Appendix 2:

1. Do you think that homeless people are easily identified/ recognised?
..... 1 2 3 4 5
2. In your experience of working with homeless people do you think a lot of them have some form of mental illness? 1 2 3 4 5
3. Do you think homeless people are victim of circumstance? 1 2 3 4 5
4. Do you think homelessness is a major problem within our society?
.....1 2 3 4 5
5. In your experience of working with homeless people have you ever felt overwhelmed by the complexity of their problems? 1 2 3 4 5
6. Do you think that homeless people come from all walks of life?
..... 1 2 3 4 5
7. Do you think that a lot of homeless people are homeless due to some addiction, ie; drugs or alcohol?1 2 3 4 5
8. Do you think that most homeless people with a mental illness are dangerous?
.....1 2 3 4 5
9. Do you think helping a homeless person with their financial problem often improves their condition?1 2 3 4 5
10. From experience do you think there is little that can be done for people in homeless shelters except to see that they are comfortable and well fed?
.....1 2 3 4 5
11. Do you think that homeless people should have the right to basic health care?
.....1 2 3 4 5

12. Do you feel comfortable being a primary care provider for a homeless person
with a mental illness?1 2 3 4 5

Appendix 3:

1. In your experience do some homeless people feel low in energy, and not very interested in daily life?1 2 3 4 5
2. In your experience do you think some homeless people have increased periods where they feel, sad, hopeless, or anxious?.... 1 2 3 4 5
3. In your experience do you think some homeless people feel worthless? 1 2 3 4 5
4. In your experience do some homeless people have thoughts about death or suicide? 1 2 3 4 5
5. In your experience do some homeless people feel unhappy a majority of the time? 1 2 3 4 5
6. In your experience do some homeless people have increased lack of self confidence in areas that they used to feel confident in? 1 2 3 4 5
7. In your experience do you think some homeless people avoid other people of friends for some unknown reason? 1 2 3 4 5
8. Do you think that some homeless people start to blame themselves for things? 1 2 3 4 5
9. In your experience do some homeless people feel hopeless about the future?1 2 3 4 5
10. Do you think from experience that some homeless people have had increased difficulty in concentrating, are indecisive and have higher amounts of slow or fuzzy thinking than usual? 1 2 3 4 5

11. In your experience had there been some homeless people who feel
unhappy most of the time?1 2 3 4 5

12. In your experience of working with homeless people do you think that
some have reported feeling bothered by things that usually didn't bother
them?..... 1 2 3 4 5

Appendix 4:

1. In your experience do some homeless people, hear voices that come from somewhere outside of them?1 2 3 4 5
2. In your experience do some homeless people, believe they have special powers or connections over others?.....1 2 3 4 5
3. In your experience do some homeless people believe other people can read their thoughts?1 2 3 4 5
4. In your experience do some homeless people feel very confused and/or have dull thoughts?.....1 2 3 4 5
5. In your experience do some homeless people think that people around them or on the TV/radio are talking about them? 1 2 3 4 5
6. In your experience do some homeless people see things around them that no one else can?1 2 3 4 5
7. In your experience do some homeless people feel they have nothing in common with others, including family and friends? 1 2 3 4 5
8. In your experience do you think some homeless people cannot trust what they are thinking because they can't tell if it's real or not?1 2 3 4 5
9. In your experience do you think some homeless people think that others are plotting against them? 1 2 3 4 5
10. In your experience of working with homeless people do you think some talk to other people that no one can hear or see? 1 2 3 4 5
11. In your experience do you think that some homeless people feel others are controlling how they think and feel? 1 2 3 4 5
12. In your experience do you think that some homeless people are unable to concentrate and forget things? 1 2 3 4 5

Appendix 5:

I would once again like to thank you for taking part in this study and would remind you that all information given here will remain strictly confidential. If you would like to know more about this study, please do not hesitate in contacting my tutor at the address below.

Paul Halligan, Department of Social Science, Dublin Business School of Arts

34/35 South William Street

Dublin 2

Ireland

Appendix 6:

Dr. James Brunton and
Dr. Bernadette Quinn,
Research Coordinators,
Dublin Business School.
10th February 2010

Dear Sir/ Madam,

Re: Permission to conduct a research study with members of your organisation.

Corrine Doyle is enrolled as a final year social science student at Dublin Business School. DBS social science students are required to complete an independent research project during their final year of study. Corrine's final year research project aims to examine the attitudes of individuals working with the homeless, or those who would encounter the homeless in their work, in both urban and rural settings.

All research conducted by final year students is done for the purpose of meeting course requirements. All results obtained are strictly confidential, and to be used for assessment of the researching student's qualifications for receipt of a BA in Social Science. Corrine is requesting written permission, as soon as possible, to collect research data.

Please feel free to address any questions regarding this research to Dr. James Brunton or Dr. Bernadette Quinn, Research Coordinator, Social Science Programme, Dublin Business School. Corrine can also provide further details about how she will conduct her research study. Thank you for your time.

Yours Sincerely, Dr. James Brunton

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Email: James.Brunton@dbs.ie

Dr. Bernadette Quinn

Tel: 01 4178578

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