

Josef Bäuml, Monika Brönnner, Barbara Baur,
Gabriele Pitschel-Walz and Thomas Jahn (2017)

Die SEEWOLF-Studie. – Seelische und körperliche Erkrankungen bei wohnungslosen Menschen [The SEEWOLF-Study – Mental and Physical Illness among Homeless People]

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There is a joke among medical doctors: “Whoever regards him- or herself as being in good health has just not yet received sufficiently thorough medical examination“. The 232 homeless people studied for the book under review have indeed received thorough medical examination, with an average duration of between seven hours and 14 hours. They had to participate in three separate examinations: a psychiatric assessment, an intelligence test and a physical examination (in exchange for a meagre incentive of 30 Euros for their participation). The results of these examinations were supplemented with additional information from their medical records and separate external ratings by medical experts and social workers.

First results of the study, which was conducted between 2010 and 2012, were published in a summary of 14 pages in 2014 and widely distributed in German media. Spiegel online reported in 2014 under the heading “Many roofless people suffer from mental dysfunctions” (Spiegel online, 2014; all translations by the author of this review). A medical journal (aerzteblatt.de, 2014) reported that rising rents on urban housing markets, often quoted as a reason for rising numbers of homeless people in Germany, were “only one side of the coin. The other one is a gap of psychiatric care.” Almost all press publications also referred to the estimated number of homeless people in Germany (at that time 335,000 people as an annual prevalence estimate) and presented the study as based on a “representative sample” of this group in Munich. The authors of the study confirmed later that the study conducted in Munich “can be regarded as representative for the general situation of homeless people, especially in metropolitan areas with a diversified support system” (Bäuml *et al.*, 2017, p.34).

But in late 2017, the whole study was published as a book and it is now possible to check sample design and details of the research. Indeed the book starts again in the preface with the question of “why a certain part of the population fails to

procure their housing autonomously and with success. Is it solely due to the economically caused scarcity of housing in areas of high population density like Munich or is it not even more likely that individual reasons are responsible for it?" (Bäumli *et al.*, 2017, p.13).

For those who are not familiar with the housing market in Munich: Munich is the city with the highest housing prices in Germany. Some facts from the most recent report of Deutsche Bank Research (2018, p.2) about the housing market in Germany: "In Munich, apartment prices more than doubled between 2009 and 2017. During this period, the population rose from 1.36 million to 1.53 million. There is a shortage of several tens of thousands of residential units. The vacancy rate is near zero, and current and planned future building activities will not suffice. The supply shortages should drive house prices and rents upwards in the coming years." So you don't have to be particularly weak or ill to struggle seriously when looking for affordable housing in Munich. But if you are ill and have additional problems on top of being poor you are highly probable to struggle even more and to remain excluded from permanent housing.

SEEWOLF is an acronym derived from the long original title of the study but is also intended to remind us of Jack London's *The Sea-Wolf*, because, as the main author lets us know in a separate preface, many of the homeless people examined showed "an unbelievable toughness and preparedness to suffer privations" but also the willingness "to fight and not give up" (p.11).

For the authors of the SEEWOLF study, the main results are as follows: 93 per cent of their sample had a diagnosis of mental illness (including addiction) at some point in their entire life (life-time prevalence), 74 per cent of the sample had an acute mental illness in need of treatment during the last month (1-month prevalence), 55 per cent had at least one personality disorder and a large part of the group suffered considerable cognitive impairment.

Even if we learn from the same authors that quite a considerable proportion of the general population, namely 50 per cent, has a life-time prevalence of mental illness when examined properly, and that the 1-month prevalence in the general population of Germany is at 27.7 per cent (see Bäumli *et al.*, p.225), mental illness was obviously much more widespread in the Munich sample of homeless people than in the general population.

The authors have undoubtedly used a number of internationally acknowledged diagnosis instruments like the Mini-Mental Status Examination (MMSE), the Wechsler Adult Intelligence Scale (WAIS), Clinical Global Impression Scale (CGI) or the Structured Clinical Interview (SCID I and II). However, medical experts have criticised that such clinically tested instruments might be met with doubts when

applied to homeless persons: Interview questions regarding problems falling asleep or having undisturbed sleep at night, feeling depressed or having feelings of anxiety or being threatened might have very different meanings for people who lack the protection of a home than for those having one or living in a protected environment. And behaviour that might otherwise be seen as an indicator of unrealistic judgement of their life situation might also be interpreted as a necessary adaptation to a life on the streets (Kunstmann, 2017).

Some of the ratings of “participation behaviour” gathered from external experts (social workers, psychologists, directors of the institutions) for a subsample of examined homeless individuals (or inmates) are highly questionable. Questions about “adjustment to rules and routines”, “assertiveness” or “group skills” will probably rather reflect the survival skills in enforced communities than tell us anything about the individual’s potential to live in regular housing. And the particularly negative judgement about inmates’ “capacity for family and intimate relationships” have to be seen in light of the fact that many of those examined persons lived in single-sex shared accommodation – surely not the most favourable external conditions to build an intimate relationship.

But the main reasons why the results of this extensive and elaborated study are neither providing us with useful information about “the general situation of homeless people” in Germany nor about the necessary measures to change this deplorable situation are twofold:

1. The sample: By no means do we have here a sample, in which the 232 examined homeless people could be defined as “representative” for several hundred thousand homeless people in Germany. They cannot even represent the homeless people in Munich. The authors themselves quote (on p.20) the Munich social department that at the end of 2013 about 5,800 homeless people (single people and families) were living in Munich. The authors ignore the 2,300 homeless families with children and even from the remaining 3,500 single homeless people they have exclusively focused their study on a subgroup of 1,635 people in specific NGO institutions from which they have drawn their sample. Sofa surfers, people sleeping rough and those provided by the municipality with temporary accommodation in hostels etc. were ignored by the study. From the remaining 1,635 people, a further 15 per cent was excluded because they didn’t speak German well enough (see p.96 of the study). And finally, of the originally envisaged 25 per cent sample (N=413), only 232 persons participated in the study; no information is provided about the reasons for the high non-response rate of more than 40 per cent.

If we take a closer look at the institutions from which the sample (184 men and 48 women) was selected we learn (at p.50) that almost 50 per cent of the people included in the study were living in institutions which were financed under section

53 of the Social Code XII (52 people) or in so-called “long-term institutions” (61 people). In order to get a hostel place financed under section 53, it is a necessary pre-condition to have a psychiatric diagnosis, because access to these hostels is exclusively restricted to people seriously disabled by mental health problems. Equally, long-term institutions for homeless people are by definition reserved for people who are diagnosed as permanently unable to live on their own, because they are too old and/or have serious health conditions like Korsakoff’s syndrome and the like. Given that for 50 per cent of the whole sample it is a prerequisite to have a serious mental health problem in order to get access to the institutions where they were selected from, and given that 27.7% of the general population is diagnosed with a 1-month prevalence of mental illness, it is almost surprising that the rest of the sample (drawn from low threshold shelters, emergency accommodation, supported communities and “reintegration” hostels) seemed to have fared pretty well in terms of this type of diagnosis. Unfortunately there is no further information available about the diagnosis results per type of accommodation, obviously because numbers would have been too small for this type of analysis.

That the sample is highly selective can also be seen from some of the profile information provided. Only 14.5 per cent of the people in the sample had a migration background (according to the National Alliance of Services for Homeless People, BAG W, the share of users with a migration background of NGO services for homeless people was higher than 28 per cent in 2013). The median age in the sample was 49.5 years. The average duration of homelessness was as high as 61.3 months, i.e. more than 5 years. Even if we know that cross sectional studies like this one tend to over-emphasise long-term homelessness, this high average duration is a clear indicator for the selectivity of the sample.

2. The conclusions drawn from the examination: The authors make extensive reference to the national and international psychiatric literature about homelessness and mental health problems when they present the methodology and results of their examinations. But despite the large amount of studies quoted as underpinning their approach and results, they tend to ignore studies that would likely speak against them. One of their statements quoted several times in the press is that in Germany, like in the US, psychiatric deinstitutionalisation has led to a massive “displacement to the pavement” of chronically mentally ill people, thereby increasing the share of mentally ill people among homeless people. Both claims, the allegedly extremely high proportion of mental illness among homeless people and the deinstitutionalisation as the main causal factor for it, have been seriously criticized by prominent authors like Montgomery *et al.* (2013) or Snow *et al.* (1986) who haven’t made their way into the reference list of Bäuml *et al.*

To avoid any misunderstanding: of course nobody should ignore that mentally ill and addicted people have a high risk of becoming homeless and that it is a scandal that all too often they do not receive the necessary support and care they need. But what is the right type of support for this subgroup of homeless people, no matter how large or small it may ever be? Bäuml *et al.* seem to regret that there are no measures to force them into psychiatric care. They state (on p.238) that the NGO institutions for homeless people would have more time and capacity to care for those homeless people without acute mental illness, if one could successfully “transfer” the others (and they explicitly refer to 74% of all homeless people) to psychiatric and psychotherapeutic treatment, “in case of need also against their will, accompanied by the necessary legal requirements” (p.236). And they mean and state explicitly that the transfer should lead into “institutionalised psychiatry” (p.238), i.e. into mental health hospitals. For the remaining homeless people, the only conceivable consequence according to the authors seems to be small improvements of their conditions in institutional accommodation. So the only conclusions of Bäuml *et al.* from answers to questions about satisfaction with living conditions are that single rooms in institutions and enough qualified staff should be the rule (p.118). The idea that access to individual self-contained housing and floating support might be an option does not occur to them.

What – in this context – is even more ignorant, in light of the many references quoted from other European countries and elsewhere, is that the massive evidence about the convincing results of the Housing First approach is not mentioned at all. Housing First has turned out to be a much more adequate response to the issues of particularly the group of people who are the focus of the SEEWOLF study – that is, people with complex problems, mental health issues and addiction. A large number of studies have proven during the last 20 years that people with serious mental illness can be stabilised in their own apartments with appropriate financial and social support and with respect for their personal choices, even after long histories of homelessness and even if they have a double diagnosis. A lot of this supporting evidence has been published in psychiatric literature in the US, Canada and elsewhere. A literature review published in 2015 listed 184 publications (Raitakari and Juhila, 2015) and many more have been made available after that.

“Housing first” is mentioned only once on the 324 pages of the SEEWOLF-publication, on page 233, in a short review about “The Situation of Homeless People in International Context” and the reference mentioned is followed immediately by another one referring to Summergrad (2015), who according to the authors demands that for the “often severely mentally ill” homeless people “standards for the treatment of patients against their will have to be revised and adapted”.

In an “important introductory remark” and in the conclusions, the authors of the SEEWOLF study emphasise that the study “in no way wants to contribute to the partially already existing stigmatisation of roofless or homeless people” (p.12) and that the result “is not at all meant to contribute to a global psychiatrisation of all people who are affected by homelessness” (p.239), but that is exactly what it does.

Interestingly enough, the authors do not consider the question why, given that more than a quarter of the general population of Germany has been diagnosed with a mental health problem in need of treatment during the preceding month, only a tiny minority of them is homeless. Obviously, it is possible for the majority of mentally ill people to live in regular permanent housing. All efforts should be directed to support the rest of them, and the large number of homeless people who do not suffer from mental illness to do so as well.

Strategies to end homelessness without forcing homeless people into psychiatric hospitals exist and should be implemented in Germany and elsewhere. That such strategies should also include adequate psychological and psychiatric support for those homeless people in need of it, but on a purely voluntary basis, is an important requirement and one of the substantial elements of the Housing First approach. The authors of the SEEWOLF study and those who have commissioned the study are urgently requested to start reading about it.

› References

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Volker Busch-Geertsema
GISS, Bremen, Germany