CORRESPONDENCE

The Prevalence of Mental Illness in Homeless People in Germany

A Systematic Review and Meta-analysis

by Dr. med. Stefanie Schreiter, Prof. Dr. med. Felix Birmphol, Prof. Dr. med. Michael Krausz, Prof. Dr. med. Stefan Leucht, Prof. Dr. med. Wulf Rössler, PD Dr. med. Meryam Schouler-Ocak, and Dr. med. Stefan Gutwinski in issue 40/2017

Better Care Possible

The meta-analysis by Schreiter et al. (2017) shows the significant supply deficit for homeless people who have severe mental illnesses with overall multimorbidity. Against the background of my experience as a psychiatrist in the health department and in working with homeless people in Berlin, I believe that better care of these people would be possible in the context of integration support. Homeless people suffer from the same mental illnesses yet do not live like people who receive integration support, who are largely well provided for in their own homes, in shared apartments, or in care homes. In contrast, homeless people find themselves in this distressing situation because they could not sufficiently adapt to the rules of institutions and administrations. In general, they live in shelters or emergency shelters, or sleep rough on the streets, in house entrances, or in makeshift camps. Integration support can also offer these affected people a dignified existence.

If we are to implement inclusion according to the UN Convention on Rights of Persons with Disabilities, and participation according to the German Federal Participation Act (*Bundesteilhabegesetz*), this group of homeless persons with mental health multimorbidity must also be reached. Therefore, I propose the following measures:

- Provide single rooms with bathrooms for homeless people;
- Avoid „either ... or“ in social housing assistance and integration support, providing instead a case management for social services;
- Equip homeless facilities with outreach social work according to the criteria of integration support;
- Equip the social psychiatric services and infectious disease protection in health departments with sufficient and especially specialist medical staff to provide the appropriate outreach assistance appropriate.

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References

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Conflict of interest statement

The author declares that no conflict of interest exists.

In Reply:

In his correspondence, Dr. Podschus discusses important results of our meta-analysis (1). In the first point, Dr. Podschus states the basic requirements for care, with which we can only agree.

We would like to add the following to his other points. Despite the nationwide social security systems installed in Germany, the number of homeless people is increasing. In other Western countries with less well-developed security systems, such as North America, targeted assistance—and especially outreach concepts, such as Assertive Community Treatment (ACT) and Intensive Case Management (ICM)—and Housing First concepts (for which homeless people do not need to qualify by abstinence, for instance from alcohol) have been developed and scientifically evaluated in recent years (2, 3). These have been shown to have a good effectiveness in terms of rehousing and improving mental and physical health.

Many aspects of these concepts that have been specially developed for care are already part of German support systems, for example the psychiatric integration support (*Eingliederungshilfe*). It would be conceivable to:

- Compare the internationally proven concepts, such as those mentioned, with the existing support structures in Germany, and to modify the latter if necessary;
- Reduce any interface problems and unify structures;
- Focus on outreach support.

Moreover, with a pooled 1-month prevalence rate of 77.4% (95% confidence interval: [71.3; 82.9]) for Axis I disorders among homeless people in Germany (1), the question is indeed whether having separate care providers for psychiatric integration support and social housing assistance—as currently is the case—is necessary. As this often leads to questions about responsibility and results in interface problems, it ultimately provides suboptimal care for homeless people in many cases.

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CLINICAL SNAPSHOT

Heterotopic Ossification in a Dialysis Patient

A 59-year-old man on dialysis complained of pain in the hips, mainly on the left side. He was known to have peripheral arterial obstructive disease. Physical examination revealed swelling and impaired mobility of the left hip. A pelvic x-ray showed marked soft-tissue calcification bilaterally, which was diagnosed as heterotopic ossification (*Figure*). There was no antecedent trauma. The potential role of tertiary hyperparathyroidism in this patient as the sole causative factor of heterotopic ossification must remain speculative. His pertinent laboratory findings were: serum calcium 2.63 mmol/L (reference range 2.09–2.54 mmol/L), serum phosphate 2.36 mmol/L (0.81–1.45 mmol/L),

parathyroid hormone 66.4 pmol/L (1.6–6.9 pmol/L). Tertiary hyperparathyroidism is typically found in patients undergoing long-term dialysis. This patient had been under dialysis for only one year, after long hesitation. Parathyroidectomy is recommended in the KDIGO (Kidney Disease: Improving Global Outcomes) guideline for patients in stages 3–5D of chronic renal disease who have severe, drug-resistant hyperparathyroidism. This patient's ossifications were not seen on a prior pelvic x-ray obtained in 2015. The old and new x-rays were shown to him and he agreed to undergo the procedure.

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