Homelessness and ADHD: A Hidden Factor?

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HOMELESSNESS AND ADHD: A HIDDEN FACTOR?

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by

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HOMELESSNESS AND ADHD: A HIDDEN FACTOR?

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DOCTOR OF PSYCHOLOGY

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ABSTRACT

HOMELESSNESS AND ADHD: A HIDDEN FACTOR?

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Attention Deficit/Hyperactivity Disorder, henceforth known as ADHD, is a common psychiatric problem recognized and diagnosed in children; however, it is not recognized or diagnosed as often in adults. There has been some research illustrating a relationship between ADHD and homelessness. The purpose of this study was to further explore if ADHD could be a hidden factor contributing to homelessness in adults. This descriptive study utilized archival data of patients at a health center in the United States to examine the relationship between homelessness and ADHD. Two analyses were completed using IBM SPSS version 25. Starting from a master dataset including all the patients at the Health Center (N=2980), two separate samples of 300 were randomly selected for inclusion in this study. Chi-square analyses were used to discover group differences for separate analyses of each sample after checking for differences in the samples in gender, race, and homeless status or ADHD. The first dataset examined the frequency of ADHD among a random sample of 150 homeless vs. 150 not homeless patients. The second dataset examined the frequency of homelessness among 150 patients with a diagnosis of ADHD vs. 150 patients without a diagnosis of ADHD. Both analyses revealed that there was not a significant difference in the frequency of ADHD diagnoses between patients who were homeless and those who were not homeless or in homelessness between patients diagnosed with ADHD vs. those not diagnosed with ADHD. However, this study highlights the importance of ADHD screenings for all patients. The study’s results, other findings, limitations, and implications for
future research are discussed. This dissertation is available in open access at AURA (https://aura.antioch.edu) and OhioLINK ETD Center (https://etd.ohiolink.edu).

*Keywords:* adult ADHD, homelessness, ADHD screening, archival data
Dedication

For my Godmother, Carolyn Ruggiero, who inspired me to become a psychologist.
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First and foremost, I would like to thank my family, who have been patient, understanding, and encouraged me throughout this process. I would especially like to acknowledge my mother, Dolores, whose faith, prayers, support, and sacrifice are most appreciated. A very special thanks goes out to my advisor and chair of my dissertation committee, Dr. Kathi Borden, who has given me countless hours, advice, and guidance throughout this journey. I would also like to thank my committee, Dr. Barbara Belcher-Timme and Dr. Susan Vonderheide, who have guided me, taught me, supervised, and enriched me. Also, a thank you to Dr. Alexander “Sandy” Blount, who inspired me to undertake this research. I would also like to acknowledge Janna O'Leary, who helped me with the data collection, and Cynthia Bianco, who helped me with the data analysis. Finally, thank you to my friends and colleagues who cheered me on and propelled me forward to reach this milestone.
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INTRODUCTION

This dissertation focused on the phenomena of homelessness and Attention Deficit Hyperactivity Disorder (ADHD) in adults. Adults experiencing homelessness face many challenges and adults who have ADHD face other challenges. Some research has indicated that the prevalence of ADHD in homeless adults is high (Hesse & Thiesen, 2013). However, the research regarding the connection between ADHD and homelessness is limited (Matteson, 2017).

LITERATURE REVIEW

This literature review begins with a discussion of homelessness, followed by an overview of general ADHD literature. Then, the prevalence, risk factors, and impact of each population are addressed followed by a review of the literature on ADHD in homeless populations. Next, a hypothesis is proposed that ADHD is under-recognized in homeless adults. Finally, a quantitative design using archival data to examine the prevalence of ADHD in homeless adults is described. The case is made that given there is limited but valid research suggesting an association between ADHD and homelessness, further exploration in this area is needed. This study is designed to add to existing research on the relationship between ADHD and homelessness in adults with the goal of increasing awareness regarding the importance of providing homeless people access to ADHD screening and treatment.

Homelessness

Definition

There are several ways to define homelessness. According to the National Health Care for the Homeless Council (2019), the U.S. Department of Health and Human Services defines homeless individuals as:
An individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations and an individual who is a resident in transitional housing. A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities; abandoned building or vehicle; or in any other unstable or non-permanent situation. (Public Health Service Act 42, 2018, Sec. 330, U.S. C., 254b)

Furthermore, the U.S. Department of Housing and Urban Development (HUD) includes the following in their definition of who is considered homeless:

People who are living in a place not meant for human habitation, in emergency shelter, in transitional housing, or are exiting an institution where they temporarily resided. People will be considered homeless if they are exiting an institution where they resided for up to 90 days and were in shelter or a place not meant for human habitation immediately prior to entering that institution. (HUD, 2012)

For the purposes of this study, homelessness is defined as occurring when a person does not live in a conventional dwelling or permanent residence such as an apartment or a house. People living in a shelter or a tent are still considered homeless because these are not permanent residences. Moreover, people who are forced to stay with friends, family, or in a hotel or motel are also considered homeless because they are unable to retain their own housing.

**Prevalence of Homelessness**

Homelessness is a prevalent problem in the United States. It is difficult to know the exact number of those who are homeless as many homeless people frequently move from place to place and are invisible to researchers (Cowan et al., 1988). However, it is estimated that in North America and Western Europe alone there are more than one million people without homes (Salavera et al., 2014).

According to one report, as of January 2017, there were approximately 553,742 homeless people in the United States (National Alliance to End Homelessness, 2017). When there is not sufficient affordable housing, the rate of homelessness rises (Garfield, 2018). The number of
people who are homeless increased by 7% between 2016 and 2017, equating to approximately 17 homeless persons per every 10,000 persons within the general public. (National Alliance to End Homelessness, 2017).

People in low-income brackets are at a particular risk for homelessness. The prevalence of poor people, including those with low incomes, is also important as they are at particular risk for homelessness. Although, there was a decrease of people living in poor households between 2015 and 2016, there has been a 30% overall increase since 2007 (National Alliance to End Homelessness, 2017).

**Risk Factors for Homelessness**

There are several risk factors associated with homelessness. The top causes of homelessness among families are lack of affordable housing, unemployment, poverty, and low wages. Single individuals experiencing homelessness share three risk factors including lack of affordable housing, unemployment, and poverty, with the addition of mental illness, substance abuse, and lack of access to services for mental illness and substance abuse treatment (National Law Center on Homelessness & Poverty, 2015). Additionally, the leading cause of homelessness for women is domestic violence (National Law Center on Homelessness & Poverty, 2015). Moreover, school expulsion, offending and antisocial behavior, prior imprisonment, and a small social network are also risk factors for homelessness (Shelton et al, 2015).

**Mental Illness and Substance Abuse**

Both mental illness and substance abuse can be consequences and causes of homelessness (Polcin, 2016). People with mental illness or substance abuse disorders are particularly susceptible to becoming homeless (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017). Additionally, homeless people are also prone to developing mental illness
due to the extreme misery and trauma of living on the streets (Peterson, 2019). Although one factor related to a person’s homelessness could be readily identified as substance abuse, there could be other hidden factors that have not been discovered or treated. One such possibility is the presence of ADHD. Research has indicated that children who receive a diagnosis of ADHD should be followed for extended periods, because if not properly treated, they could end up homeless (Jacobs, 2018).

Impact of Homelessness

Homelessness impacts taxpayers, leaving a person to be chronically homeless can create a taxpayer burden of $35,000–$40,000 per year (United States Interagency Council on Homelessness, 2016). Homeless people are also stigmatized; Americans often think of homeless people as mentally ill, drug abusers, or alcoholics (Knecht & Martinez, 2009). It is estimated that two-thirds of people experiencing homelessness suffer from mental illness and/or substance abuse, which is 100 times higher than people who are not experiencing homelessness (Cassady, 2018). Additionally, people experiencing homelessness are disproportionately impacted by injustices, such as crime or violence. Data indicate that at least 1,657 homeless people over the last 17 years have been victims of crime and violence strictly due to their being homeless (National Coalition for the Homeless, 2016). Crime against people experiencing homelessness is likely drastically underreported.

Additionally, being homeless impacts a person’s sense of self-efficacy, self-worth, and identity (Boydell et al., 2000). The homeless are also impacted by multiple losses. When homeless, people not only lose their physical dwelling, but may also lose their sense of belonging or connectedness, since a home represents time lived in that location and associated social connections (Vandemark, 2007). Furthermore, anxiety results not only from societal
exclusion and possible loss of contact with family, but also from a lack of a private place to rejuvenate, thus eroding self-efficacy (Vandemark, 2007).

**ADHD**

**Definition**

ADHD is marked by an ongoing pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development (National Institute of Mental Health, 2021). ADHD is distinguished by hyperactivity, impulsivity, and an inability to sustain attention, (Barkley, 2015). According to the *DSM-5*, in diagnosing an adult with ADHD, there must be at least five symptoms of inattentiveness present for a minimum of six months and at least six symptoms of hyperactivity and impulsivity must have persisted for a minimum of six months, with several symptoms having been present prior to age 12 (American Psychiatric Association, 2013).

The etiology of ADHD is not just one pathophysiological entity. ADHD is described as an interaction of many environmental and genetic factors with genetic factors being implicated but not precisely understood (Curatolo et al., 2010). Neuroimaging shows delays in prefrontal regions affecting cognitive processes including motor planning and attention (Curatolo et al., 2010). According to Krueger and Kendall (2001), “ADHD is a disorder of performance, not skill—they know what and how to do something, but know less about when and where they should act” (p. 62). People with ADHD are often stereotyped as lazy, aggressive, or “bad,” and are perceived as having behavioral problems rather than a mental health disorder requiring treatment (Kooij et al., 2010). ADHD involves impairment of executive functions, which is the self-management system of the brain. Compromised executive functions leads to difficulty with organization, planning, problem-solving, and time management (Rodden, 2021).
Individuals with ADHD suffer from social skills deficits and poor self-esteem as compared to those individuals without ADHD (Mannuzza & Klein, 2000). Adults with ADHD often are forgetful, inattentive and lack impulse control which can come across to others as irresponsible, ill-mannered and rude (Children and Adults with Attention-Deficit Hyperactivity Disorder [CHADD], 2021). They are characterized as poor decision makers with impulsive, reward-driven behavior, who are unable to consider the longer-term consequences of their actions (van Meel et al., 2005). Furthermore, they often fail to graduate from school, may have been fired from or quit a job potentially due to inability to focus, have poor-quality relationships, poor driving records, and problems with saving money and paying bills; they are also more likely to abuse drugs or be arrested compared to non-ADHD peers (Waite et al., 2013). In addition, those with ADHD frequently feel incompetent, insecure, and ineffective, and live with a chronic sense of frustration and underachievement (Davidson, 2008). Since many adults with ADHD have lived with these symptoms all their lives, they may not realize that they have a problem or that it can be treated (Weiss & Weiss, 2004).

Prevalence of ADHD

Estimates of the prevalence of mental illness, including ADHD, and substance abuse among the homeless vary depending upon the interview site, assessment procedures, sampling strategy, and how homelessness is defined (Buckner et al., 1993). However, as of January 2016, the Substance Abuse and Mental Health Services Administration (SAMHSA, 2017) estimated that 30% of homeless people also suffer from a serious mental illness and about 66% have a chronic health condition or substance use disorder.

The prevalence of ADHD in adults nationally is estimated to be 5.2%, and worldwide adult prevalence is approximately 2.8%, with the inattentive presentation of ADHD being most
prominent (ADHD Institute, 2021). Although some symptoms of ADHD subside with age, significant impairments—both clinical and psychosocial—continue to persist (Waite et al., 2013). The prevalence of ADHD comorbid with homelessness is not clear. If homelessness and ADHD in fact have high rates of co-occurrence, more effort will be needed towards helping those who are both homeless and are suffering with ADHD because successful integration of mental health treatment and services to find stable housing is lacking (Polcin, 2016).

**Risk Factors for ADHD**

Decades of research have shown that genetics are a crucial factor regarding ADHD and its comorbidity with other disorders (Faraone & Larsson, 2019). There are several other risk factors associated with ADHD including: if the mother used drugs, drank alcohol, or smoked during the pregnancy, a premature birth, and/or having a blood relative with a mental health disorder including ADHD (Mayo Clinic, 2019). Environmental risk factors including exposure to toxins such as lead found in pipes and paint in older buildings are also associated with ADHD (Mayo Clinic, 2019). In addition, socioeconomic risk factors associated with the development of ADHD symptoms include young maternal age, lower maternal education, maternal depression, single family household/non-intact family, paternal history of antisocial behavior, lower social class, and social welfare recipient households (ADHD Institute, 2019). Furthermore, research has shown that combinations of environmental factors and certain genes such as stressful life events and dopaminergic genes, or adverse psychological distress and serotonergic genes, may be associated with an increased likelihood of ADHD symptoms (ADHD Institute, 2019).
**Comorbidity**

Studies suggest that up to 90% of adult patients with ADHD have one or more comorbid psychiatric disorder. The most common comorbid disorders in adults are anxiety disorders, affective disorders, substance abuse and antisocial personality disorder (Torgersen et al, 2008).

In 20 to 30% of patients with ADHD, there is a comorbid diagnosis of depression and in 25% of patients with ADHD, there is a comorbid diagnosis of anxiety (Sherman & Tarnow, 2013). These psychiatric symptoms, as well as other somatic and physical symptoms, can sometimes overshadow or mask the ADHD symptoms (Hamed et al., 2015). However, patients with anxiety or depression may suffer from these symptoms as a direct result of their undetected ADHD (Feifel, 2007). If only the secondary disorders are treated, the ADHD can become worse. Antidepressant medication decreases dopamine, which decreases motivation, enthusiasm, and concentration, thus exacerbating ADHD (Shapiro, 2013a). Successfully treating ADHD can result in improvement of secondary disorders including anxiety, depression, or substance abuse (Tesar & Seballos, 2010).

**Adult ADHD**

ADHD is often overlooked in adults and left untreated; in some cases, the adult is labeled with the more salient comorbid condition, such as depression or bipolar disorder (Shapiro, 2013b). Historically, ADHD was considered a childhood disorder; however, evidence indicates that almost 66% of individuals diagnosed with ADHD as children report at least one ADHD symptom causing a significant impairment into adulthood (Kolar et al., 2008). Adult ADHD tends to occur equally in women and men whereas ADHD in children is more common in males (Weiss & Weiss, 2004). Adults with ADHD tend not to exhibit the obvious symptom characteristics that are typically recognized in children with ADHD, such as overactive,
impulsive behavior (Tesar & Seballos, 2010). Instead, the symptoms of ADHD in adults include impatience, irritability, explosiveness, taking on new tasks before finishing others, waiting until the last moment to finish a task, and completing all but the most important tasks (Tesar & Seballos, 2010). Longitudinal data reveal that there is a decrease of hyperactive and impulsive symptoms over time and an increase of inattentive symptoms into adulthood (Wilens et al., 2009). Additionally, studies reveal that children diagnosed with only ADHD are at risk for negative behaviors as adults, including substance abuse and criminal behavior (Murillo et al., 2016).

**Challenges to Accurate Diagnosis**

Diagnosis of ADHD in adults can be challenging since, as mentioned above, other disorders are frequently comorbid with ADHD or its symptoms, including anxiety, depression, antisocial personality disorder, and conduct disorder (Barkley, 2008). Typically, adults with ADHD present for treatment of their comorbid disorders rather than for ADHD, thus the ADHD symptoms are overlooked (Ginsberg et al., 2014). For example, adults with ADHD are treated for substance abuse or mental disorders, such as abnormal mood or interpersonal problems, which may be more salient, although again, the latent primary diagnosis is actually ADHD (Tesar & Seballos, 2010).

Additionally, the pathophysiologic symptoms of ADHD are not completely understood, which makes it challenging to accurately diagnose ADHD in adults (Tesar & Seballos, 2010). Given that ADHD can be comorbid with and can have similar symptoms to other disorders, it is important to be aware of differential diagnoses and to seek an accurate diagnosis as there are implications for treatment (Tesar & Seballos, 2010). Primary Care Physicians (PCPs) who typically treat adults may not be as familiar with ADHD in adults as in children. The PCPs are
likely to be more familiar with the comorbid difficulties and they may fail to recognize subtle differences in symptom characteristics that would lead to an ADHD diagnosis (Waite et al., 2013).

ADHD diagnosis is usually based on subjective factors, including a patient’s recollection of functional impairment and symptoms characteristic of ADHD as well as a clinician’s assessment of whether the patient meets diagnostic criteria (Okie, 2006). Neuropsychiatric testing can screen for ADHD. However, if the examinee does well during the testing, this does not necessarily mean that the examinee does not have ADHD since the testing is typically performed over a short period of time (Shapiro, 2013a). Although, there are many effective, empirically supported behavioral and psychopharmacologic interventions for ADHD that have helped to improve symptoms. However, such gains are seldom maintained after treatment is terminated (Halperin & Healey, 2011).

**Impact of ADHD**

Attention-Deficit Hyperactivity Disorder is one of the costliest medical conditions in the United States with an annual estimated income loss of $77 billion (Shapiro, 2013a). In addition to the financial impact, ADHD deprives people of major life opportunities through low work productivity, unemployment, and substance abuse, resulting in billions of dollars in costs annually (Hinshaw & Sheffler, 2015). There is a significant financial impact due to the lack of overall mental health treatment in the United States. Lack of treatment of mental illness costs Americans $193.2 billion in lost productivity (National Alliance on Mental Illness, 2015).

Unrecognized, undiagnosed, and untreated ADHD in adults is a major public health concern with considerable sociocultural implications, such as being at a greater risk for motor vehicle accidents and committing more antisocial acts than those without ADHD (Brod et al.,
It is estimated that 75% of adults with ADHD are under-treated and under-diagnosed (Shapiro, 2013a). Adults with undiagnosed or undetected ADHD face many consequences including experiences of failure and self-blame, thus perpetuating social problems and socioeconomic disadvantage (Waite et al., 2013). Generally, untreated ADHD in adults also leads to poor functional and clinical outcomes despite the comorbid symptoms being treated (Ginsberg et al., 2014).

Studies indicate that untreated ADHD can impact the chances of satisfaction and success in many areas of life by damaging self-esteem, interfering with relationships, impeding work performance, and increasing the risk of substance use, psychiatric disorders, and car accidents (Okie, 2006). According to Rosenbaum (2010 as cited in Okie, 2005), “Life is especially hard for people who do not know they have ADHD. They feel so bad about themselves. They spend their lives apologizing” (p. 2640). Rosenbaum emphasized the importance of treatment and continued:

But for a lot of people, it makes the difference between failure and making it. You go to work and your boss gets frustrated. You don’t get things completed, you don’t show up on time, you lose things . . . You let people down. (Okie, 2005, p. 2640)

Therefore, it is critical for community health centers to address this challenge (Waite et al., 2013).

**Homelessness and ADHD**

**Mental Illness**

Research has shown that people who have mental illness often find themselves homeless due to poverty and a lack of low-income housing (Tarr, 2018). Homelessness is associated with familial, social, and economic problems that can lead to mental deterioration (Salavera et al., 2014). More than 10% of people seeking mental health or substance abuse treatment are homeless (National Alliance to End homelessness, 2017). A debatable issue is whether mental
illness leads to homelessness or homelessness causes mental illness. Cross-sectional design studies have not been able to distinguish mental health related precursors of homelessness from mental health consequences (Buckner et al., 1993). However, it is recognized that elevated rates of severe mental disorders are prevalent among poor and homeless persons (Draine et al., 2002). In most communities, it is legal to discriminate against the homeless, creating an environment of judgment and prejudice vs. caring and compassion (National Coalition for the Homeless, 2016).

Unfortunately, necessary resources have not kept pace with the needs of people who are homeless (National Coalition for the Homeless, 2016). Despite these problems, not all hope is lost for those who are homeless. Many individuals experiencing homelessness have a vision that encompasses a reformulated self-identity focusing on health, well-being, and personal strengths (Boydell et al., 2000). Helping those who are experiencing homelessness improve their health and find stable housing involves understanding and addressing their mental health needs (National Coalition for the Homeless, 2017).

**ADHD**

Although childhood ADHD is not necessarily associated with homelessness, there is some research indicating a connection between being diagnosed with ADHD as a child and being homeless as an adult (Murillo et al., 2016). It is possible that those with ADHD are at risk for homelessness due to ADHD being hidden beneath substance abuse or other chronic problems, which are more evident. However, there has not been sufficient research to clarify the accuracy of this representation (Hesse & Thiesen, 2013). In other words, it is possible that the ADHD is hidden behind other more visible problems. For example, in the words of a formerly homeless person with ADHD, Book (2015) stated,
ADD is an invisible disability. As a person struggling with this invisible demon, I frequently find myself in awful situations with no good reason why. I am articulate, thoughtful, and I care so much about others, but success eludes me, because I don’t seem to follow through when it matters . . . It’s as though my disability doesn’t exist, I’m just lazy or manipulative. (p. 1)

In a 33-year, prospective longitudinal study of boys aged 6 to 12 diagnosed with ADHD and those without ADHD, results indicated that 23.7% of those with ADHD became homeless vs. 4.4% of those without ADHD (Murillo et al., 2016). Additionally, in a sample of 51 homeless adults, 42% had ADHD (van Wormer, 2003). Furthermore, in a program evaluation of 95 homeless youth and young adults, 76% of the sample had multiple psychiatric symptoms, 29% were found to be diagnosed with ADHD, and 4% were found to have no psychiatric symptoms (Busen & Engebretson, 2008).

Moreover, research conducted in Spain studied comorbidity of ADHD with personality disorders in 196 homeless people (Salavera et al., 2014). The findings indicated that nearly two out of three persons diagnosed with ADHD in childhood were still diagnosed with this disorder as adults (Salavera et al., 2014). The results also indicated that the people experiencing homelessness displayed more significant ADHD and personality disorder symptoms than the general public (Salavera et al., 2014). Additionally, in a study of homeless veterans, 50 of 81 participants screened positive for ADHD (Lomas & Gartside, 1997). Given the few studies that have been conducted, evidence points to a strong relationship between ADHD and homelessness. Whatever the causal direction may be, it is important to diagnose and treat this disorder (Hamed et al, 2015). Research often focuses more on easily studied groups such as children, college students, or prison populations vs. a broader population of at-risk adults (Waite et al., 2013).

The symptoms of ADHD in childhood, such as personal, emotional, and social instability have been found to occur in the adult homeless population, however, given that this has not been
extensively studied, the prognosis for those with ADHD may be affected (Salavera et al., 2014). Additionally, an important consideration related to a connection between ADHD and homelessness is the negative effect that ADHD has on executive functioning. When executive functions are not working properly, this can lead to difficulties in life such as inability to sustain a job, negotiating with a boss or landlord, managing finances, and remembering to pay the rent or mortgage, which could be associated with homelessness. Based upon the paucity of existing research cited regarding the potential connection between ADHD and the homeless, it seems prudent to further explore the presence and challenges of this disorder in the homeless population.

**Implications for Treatment of Co-occurring Homelessness and ADHD**

Although first treating the mental illness may help reach mental health goals, for many, this strategy can result in failure, as most homeless individuals’ primary motivation is to satisfy their basic needs of food, clothing, shelter, and companionship (Gillig & McQuistion, 2006). Typically, homeless individuals try to survive; if clinicians can help them with meeting their basic needs while also establishing rapport, success is more likely to occur when mental health care is introduced (Gillig & Mcquistion, 2006). Furthermore, in treating homeless individuals, clinicians need to be aware of countertransference, as the traumatic and extreme histories of homeless individuals can evoke strong emotions such as depression, anxiety, guilt, anger, or even extreme optimism (Gillig & McQuistion, 2006). Consequently, clinicians can develop idealized expectations, coercion, and therapeutic withdrawal (Gillig & McQuistion, 2006). In order to optimize care, it can be helpful for clinicians to employ a strengths-based approach. For example, to maximize outcomes in working with a person experiencing homelessness, a clinician’s approach should ideally include engaging these clients as collaborators in their own
care, encouraging them to share their stories, highlighting how they demonstrate resilience, and reconnecting them with supportive communities (Thomas et al., 2013).

Clinicians who treat patients for anxiety or depression instead of treating them for ADHD could actually make the patients’ ADHD symptoms worse (Shapiro, 2013a). Treatment for adult ADHD ideally encompasses a clinical management strategy, a medication (stimulant or non-stimulant), as well as adjunctive cognitive skills, psychotherapy, vocational skills guidance, behavior modification, and professional coaching to assist with time management and organization skill development (Waite et al., 2013). Pharmacologic options including psychostimulants have demonstrated the greatest level of efficacy for treating the core symptoms of ADHD in adults (Jain et al., 2017). Non-pharmacologic options that have also shown benefits include mindfulness, physical exercise, Dialectical Behavioral Therapy, and Cognitive Behavioral Therapy (Jain et al., 2017). Additionally, skills training can be effective in teaching patients how to recognize symptoms of ADHD, how to treat it, and how ADHD affects different aspects of their relationships and lives. In skills training, patients learn a number of strategies for problem-solving; the benefits may include improved self-esteem (Kolar et al., 2008), as adults with ADHD can experience feelings of powerlessness, failure, and a poor self-image (Schrevel et al., 2015). Other ADHD treatment considerations are complementary and alternative medicine, such as yoga, massage, homeopathy, use of green outdoor spaces, and essential fatty acid supplementation (Rojas & Chan, 2005). Although these treatment options are sometimes recommended, evidence is lacking.

**Rationale and Purpose of Study**

Despite clinical awareness of the chronicity of this disorder and an increasing presentation of ADHD in adults, there is a shortage of data on treating ADHD in adults (Wilens
et al., 2009). There is a fundamental misunderstanding of ADHD in adults among medical professional due to a lack of training on how to assess and treat ADHD in adults (Brown, 2013). Many healthcare providers (HCPs) lack confidence in their ability to diagnose and treat adult ADHD (Adler et al., 2019). Numerous professionals are unaware of the clinical presentation and prominence of ADHD in adults, therefore many adults are undiagnosed or misdiagnosed and do not receive proper treatment (Kooij et al., 2010). For the patients, there can be a reluctance to address ADHD due to shame or stigma. The lack of treatment can lead to serious repercussions, including homelessness (Matteson, 2017). While the majority of patients have lived with ADHD since childhood, they may not realize that some of their associated symptoms such as unpredictable moods, irritability, or temper outbursts, are treatable.

The purpose of this study was to gain a better understanding of the prevalence and manifested symptoms of ADHD in homeless adults as compared to not homeless adults. If ADHD is in fact common in homeless adults, efforts will be needed to improve the detection and treatment of adult ADHD in this population (Kessler et al., 2006). There is limited research on treating adults with ADHD who are also experiencing homelessness. ADHD is not treated as often in adults as compared to children, as many adults with ADHD have never been diagnosed (Goldman, 2021). The significance of this study is based upon the serious difficulties of adults with ADHD and those who are experiencing homelessness. This study will contribute to the knowledge needed to create awareness of the significance of ADHD in adults experiencing homelessness in an effort to inform detection and treatment.

The research question is: What is the frequency of ADHD in the adult homeless population as compared to the non-homeless adult population among patients at a comprehensive health center?
Method

Participants

The target population for this study was adult patients who had been seen within the last 24 months at a federally qualified health center in southern New Hampshire. The health center provides behavioral health, primary care, and preventive care to adults and children, including those who are experiencing homelessness, at risk of homelessness, are uninsured, or who have low incomes. Electronic files were randomly selected from the 2,980 patient records collected between 2016–2018. In the first analysis, participants were 150 patients experiencing homelessness and 150 patients who were not experiencing homelessness. In the second analysis, participants were 150 patients who were diagnosed with ADHD and 150 patients who were not diagnosed with ADHD. In both analyses, all participants were at least 18 years old at the time of their most recent appointment and attended at least one appointment with a behavioral health or primary care professional at the center within the past 24 months.

Measure

This research study used a non-experimental quantitative archival design utilizing existing records at a comprehensive health center to determine the prevalence of ADHD symptoms and diagnosis in homeless adult patients as compared to not homeless adult patients. The records of homeless and not homeless patients from 2016–2018 at a comprehensive health center in New Hampshire, which provides primary medical care as well as behavioral health support services to patients, was examined and evaluated for the presence of ADHD symptoms and diagnoses. The intent of this research was to examine rates of occurrence of ADHD in a sample of 150 homeless patients compared to a sample of 150 not homeless adult patients at the health center.
Procedure

Before I began this research, I met with the director of operations at the health center to discuss the study; after our meeting, the director granted approval to conduct the study. In addition, written consent for treatment and dissemination of information for education purposes and program evaluation was given by the participants prior to joining the center.

First, data regarding patients’ ADHD homelessness status was drawn from the patient records at the health center. An initial report was run via the health center’s Electronic Medical Record (EMR) Centricity software to randomly pull the 300 patient records. The report contained the following patient characteristics: birthdate, age at the last behavioral health or medical appointment, sex, race, language, diagnosis, date of first admission to the health center, date of last appointment, and homeless vs. not homeless status.

Results

The purpose of this study was to discern the relationship between homelessness and ADHD in a homeless population compared to a not homeless population among patients at a comprehensive health center. Analyses were conducted using IBM SPSS version 25. Starting from a master dataset that included all of the patients at the Health Center (N=2980), two separate samples of 300 were randomly selected for inclusion in separate analyses in this study. The first dataset contained 50% (n = 150) individuals who were homeless and 50% (n = 150) individuals who were not homeless. The second dataset contained 50% (n = 150) individuals with a diagnosis of ADHD and 50% (n = 150) individuals without a diagnosis of ADHD. Due to separate random selection processes, it was possible for some patients to appear in both data sets. Chi-square analyses were used to discover group differences (Homeless vs. Not Homeless and ADHD vs. no ADHD) after checking for differences in the samples in gender, race, and
homeless status or ADHD, depending on the dataset in question. An independent samples t-test was used to examine the differences in age between groups.

**Frequency of ADHD in Homeless vs Not Homeless Samples**

**Demographics**

The majority of the full sample of 300 used in the first analysis was male (n = 159, 53%) with a mean age of 37.09 (SD = 17.29). The racial and ethnic composition of the sample was 86% White, 4.3% Black/African American, 2.3% Asian, 0.7% Other Pacific Islander, 0% Hispanic/Latino, 2.7% more than one race, and 3.7% did not report their race or ethnicity. There were no significant differences between the homeless and the not homeless groups on gender (χ² [1, N= 300] = 0.13, p = .908); race (χ² [5, N= 300] = 5.642, p = .343), or age (t [298] = -0.20, p = .842). See Table 1 for demographics of the overall sample and the subgroups of individuals who were homeless and those who were not homeless.
Table 1

Demographics for Analysis 1: Homeless vs. Not Homeless

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total Sample (n = 300)</th>
<th>Homeless (n = 150)</th>
<th>Not Homeless (n = 150)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n(%)</td>
<td>n(%)</td>
<td>n(%)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>159(53)</td>
<td>79(53)</td>
<td>80(53)</td>
</tr>
<tr>
<td>Female</td>
<td>141(47)</td>
<td>71(47)</td>
<td>70(47)</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>259(86)</td>
<td>135(90)</td>
<td>124(83)</td>
</tr>
<tr>
<td>Black/African American</td>
<td>13(4)</td>
<td>6(4)</td>
<td>7(5)</td>
</tr>
<tr>
<td>Asian</td>
<td>7(2)</td>
<td>3(2)</td>
<td>4(3)</td>
</tr>
<tr>
<td>Other Pacific Islander</td>
<td>2(0.7)</td>
<td>1(0.7)</td>
<td>1(0.7)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Latino</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>More than one race</td>
<td>8(3)</td>
<td>3(2)</td>
<td>5(3)</td>
</tr>
<tr>
<td>Unreported/refused</td>
<td>11(4)</td>
<td>2(1)</td>
<td>9(6)</td>
</tr>
<tr>
<td><strong>ADHD</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>259(86)</td>
<td>129(86)</td>
<td>130(87)</td>
</tr>
<tr>
<td>Yes</td>
<td>41(14)</td>
<td>21(14)</td>
<td>20(13)</td>
</tr>
</tbody>
</table>
Were There Differences in ADHD Rates Between Homeless and Not Homeless Groups?

In this random sample of 300, 50% of the individuals were homeless ($n = 150$) and 50% were not homeless ($n = 150$). Of those who were homeless, 14% had a diagnosis of ADHD and 86% did not have an ADHD diagnosis. Of those who were not homeless, 13% had ADHD and 87% did not have ADHD. A chi-square analysis was used to test whether there was a significant difference in ADHD diagnosis between those who were homeless and those who were not. The analysis showed that there was not a difference in ADHD diagnosis between homeless and not homeless individuals ($\chi^2 [1, N = 300] = 0.28, p = 0.867$), which is contrary to the hypothesis of ADHD being more frequent in homeless adults than in those who were not homeless.

Frequency of Homelessness in Samples With and Without ADHD

Demographics

This sample of 300 was exactly 50% male and 50% female with a mean age of 35.18 (SD = 16.86). The racial and ethnic composition of the sample was 89% White; 3% African/Black American; 1% Asian; 1% American Indian/Alaskan Native; 1% Other Pacific Islander; 0% Hispanic/Latino; 2.3% more than one race and 2.3% did not report their race or ethnicity. There were no significant differences between the groups on gender ($\chi^2 [1, N = 300] = 0.853, p = .356$) or race ($\chi^2 [6, N = 300] = 8.918, p = .178$). Individuals with a diagnosis of ADHD were significantly younger ($M = 30.65, SD = 16.742$) than those without a diagnosis of ADHD ($M = 39.71, SD = 15.781$; $t [298] = 4.819, p < .001$). See Table 2 for demographics of the overall sample and the subgroups of individuals who were diagnosed with ADHD and those who were not.
Table 2

Demographics for Analysis 2: ADHD vs. No ADHD

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total Sample (n = 300)</th>
<th>ADHD (n = 150)</th>
<th>No ADHD (n = 150)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n(%)</td>
<td>n(%)</td>
<td>n(%)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>150 (50)</td>
<td>79(53)</td>
<td>71(47)</td>
</tr>
<tr>
<td>Female</td>
<td>150 (50)</td>
<td>71(47)</td>
<td>79(53)</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>268 (89)</td>
<td>140(93)</td>
<td>128(86)</td>
</tr>
<tr>
<td>Black/African American</td>
<td>9(3)</td>
<td>3(2)</td>
<td>6(4)</td>
</tr>
<tr>
<td>Asian</td>
<td>3(1)</td>
<td>1(0.7)</td>
<td>2(1)</td>
</tr>
<tr>
<td>American Indian/ Alaskan Native</td>
<td>3(1)</td>
<td>2(1)</td>
<td>1(0.7)</td>
</tr>
<tr>
<td>Other Pacific Islander</td>
<td>3(1)</td>
<td>0</td>
<td>3(2)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Latino</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>More than one race</td>
<td>7(2)</td>
<td>3(2)</td>
<td>4(3)</td>
</tr>
<tr>
<td>Unreported/refused</td>
<td>7(2)</td>
<td>1(0.7)</td>
<td>6(4.0)</td>
</tr>
<tr>
<td>Homeless</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>141(47)</td>
<td>74(49)</td>
<td>67(45)</td>
</tr>
<tr>
<td>Yes</td>
<td>159(53)</td>
<td>76(51)</td>
<td>83(55)</td>
</tr>
</tbody>
</table>
Were there differences in homelessness rates between those diagnosed with ADHD and those who were not?

In this random sample of 300, 50% of the individuals were diagnosed with ADHD \((n = 150)\) and 50% were not diagnosed with ADHD \((n = 150)\). Of those who were diagnosed with ADHD, 51% were homeless and 49% were not homeless. Of those who were not diagnosed with ADHD, 55% were homeless and 45% were not homeless. A chi-square analysis was used to test whether there was a significant difference in homelessness between those who had been diagnosed with ADHD and those who had not. The analysis showed that there was not a difference in homelessness between individuals with and without ADHD \((\chi^2 [1, N = 300] = 0.656, p = .418)\), which is contrary to the hypothesis of homelessness being more frequent among adults with than those without ADHD.

To summarize, the hypothesis of a relationship between homelessness and ADHD was not supported in this study. Neither Analysis One nor Analysis Two found a significant difference in the frequency of ADHD diagnoses between patients who were homeless and those who were not homeless, or in homelessness between those who were diagnosed with ADHD vs those who were not diagnosed with ADHD.

**Discussion**

There have been limited studies regarding a potential connection between ADHD and homelessness; however, one of the most pertinent studies followed 134 men over 33 years who had been diagnosed with ADHD as children. When researchers asked the men if they had ever been homeless for a week or more, 24% answered yes, which was five times more than that of the comparison group of men without ADHD (Murillo et al., 2016). The data from these earlier studies suggested that there might be a high prevalence of ADHD among homeless populations,
such that continued clinical attention should be applied to assessing ADHD in these populations, and in preventing homelessness among adults with ADHD, even if active symptoms are no longer apparent (Murillo et al., 2016). Nonetheless, the present study did not find this relationship, potentially due to the lack of consistent ADHD screening. Furthermore, homelessness status of patients was based upon the point at which patients checked into the center, thereby not capturing patients who may have been homeless at another point in their lifetime.

Research shows that ADHD remains difficult to detect in many adults who may have been diagnosed as children. Adult ADHD is often embedded with other comorbid psychiatric conditions, making it difficult to diagnose and treat (Wasserstein, 2005). In some European countries, research has also shown that ADHD is often not diagnosed and remains a hidden comorbidity, overshadowed by other psychiatric disorders (Bitter et al., 2019).

The purpose of this study was to gain a better understanding of the prevalence of ADHD in adults who were homeless compared to adults who were not homeless. In the present study, no significant difference was found in the prevalence of ADHD between those who were homeless and those who were not. However, this study used archival data from patients who were not consistently screened for ADHD. This finding conflicts with the findings of earlier studies, perhaps because of the lack of routine ADHD screenings, and further supports the importance of routine ADHD screening for adults. When people are experiencing homelessness, they may not always seek professional diagnosis for physical and mental health issues, particularly for concerns that are not a threat to their survival. In addition, people who are experiencing homelessness may have limited ability to access extensive diagnostic procedures or
professional consultations. Yet, prior research that included consistent and routine screening has shown a relationship between ADHD and homelessness.

In a study of homeless veterans, 81 participants who were part of a long-term rehabilitation program were screened for ADHD using a four-item questionnaire (Lomas & Gartside, 1997). They were asked if they had trouble in grade school or were hyperactive as a child, if anyone in their family was treated for ADHD, if they had ever used stimulants, and how much coffee they drank. Fifty of the 81 participants screened positive for ADHD. The study reported that none of the clinicians or patients had considered ADHD as a potential impact in their lives. Similarly, in a study conducted in Spain, 196 homeless people who were receiving psychological and social support services were screened using the Adult Self-Report Scale 1 (ASRS 1.1) and the Wender-Utah Rating Scale (WURS), a 25-item self-applied questionnaire asking about behavior in childhood. The results indicated that 57% met criteria for ADHD (Salavera et al., 2014). If patients were routinely screened for ADHD at the health center for this study, the results may have been different.

The conflicting results between prior studies and the present study imply that ADHD screening for adults should become more consistent, thorough, and routine at primary care clinics. Consistent ADHD screenings are important because they enable physicians to efficiently and accurately identify cases of ADHD that may need further evaluation and subsequent treatment. Screening and assessment instruments can aid clinicians in diagnosing adults with probable ADHD; however, to ensure an accurate diagnosis, it is imperative that a comprehensive clinical interview is also conducted, including longitudinal and family histories (Jain et al., 2017).
However, some clinicians may be hesitant to diagnose patients with ADHD because they may not be familiar with the diagnosis or they may be concerned that the patients are reporting symptoms in an effort to obtain a prescription for stimulants (Dodson, 2021).

Research reveals that although an estimated 4 to 5% of Americans have ADHD, less than one quarter of them have been diagnosed (Feifel, 2015). Accurate diagnosis of ADHD can be challenging as ADHD symptoms can be concealed by more prominent symptoms of comorbid disorders, making it easy to overlook ADHD. Many adults with ADHD also have co-occurring psychiatric disorders, including anxiety (47%), mood (38%), impulse control (20%), and substance use disorders (15%) (The Primary Care Companion, 2009). Estimating the prevalence of adult ADHD can also be challenging because the clinical presentation of ADHD tends to change over an individual's lifespan, and specifically, because problems are expressed differently in adults than in children or adolescents. For example, in adults, impulsivity may occur when starting new relationships or jobs and may present as an inability to relax or an inner restlessness (Hallerod et al., 2015). If an adult was never diagnosed with ADHD as a child, it may not even occur to them that having ADHD could be a possibility, and symptoms could be discounted as simply stress, anxiety, disorganization, or lack of motivation.

Adults may not realize that they have ADHD since they most likely have been living with these symptoms since childhood (Culpepper & Mattingly, 2008). Screening for ADHD typically includes a comprehensive clinical interview and use of self-report scales. Quick screenings are available and could lead to proper treatment and enhanced quality of life.

At primary health care clinics, adults could also be screened at intake for housing instability to inform treatment and care, as well as to gain a better understanding of whether ADHD may be related to housing instability or insecurity. Asking about housing status and
potential risk of instability are vital to clinical care and should become routine (Chhabra, 2019). A review of research on ADHD and homelessness conducted between 2007 and 2017 found that cognitive impairment, such as ADHD, was both a perpetuator of and risk factor for homelessness (Stone et al, 2018).

**Demographic Findings**

In the present study, there were three observations in the demographic data: the majority of patients in Analysis One were men, the majority of patients in Analysis One and Two were White, and the average age of patients in the ADHD sample in Analysis Two were significantly younger than the non-ADHD sample.

**Majority of Patient Experiencing Homelessness in Analysis 1 (Homeless vs. Not Homeless) were Men**

Within the Homeless sample of this analysis, there were slightly more men (53%) than women (47%). This may seem consistent with other studies that have shown that there are more men than women who are homeless in the United States overall (National Alliance to End Homelessness, 2020). However, in this study, it is precisely the percent that we would expect in the homeless group because overall in Analysis One, 53% of the combined samples were men (see Table 1).

**Majority of Patients in Analysis 1 (Homeless vs. Not Homeless) and Analysis 2 (ADHD vs No ADHD) Samples were White**

Within both of this study’s analyses, the majority of the patients were White. This is not surprising since 93% of the population in New Hampshire, where this research was conducted, is White (United States Census Bureau, 2018), thus people of color had been diagnosed with ADHD in the expected proportion given New Hampshire’s population. However, it is interesting
to note that prior research has indicated that people of color, especially Black and Latino individuals, are less likely to be diagnosed with ADHD than White individuals, even though they show symptoms at the same rate as White people (Frye, 2021). In fact, multiple studies conducted during the 1990s and early 2000s found that there were lower rates of diagnosis and treatment of non-White vs. White populations for mental disorders, including ADHD (Carratala & Maxwell, 2020). It is not entirely clear why prior research has found this disparity, but it could possibly be due to affordability of care, racial bias, or stigma (Frye, 2021). Stigma may play a role regarding mental health and diagnoses given, for example, if the behavior of children of different races is interpreted differently by adults. In addition, mistrust of the medical system may play a role. For example, some people may think that being diagnosed with ADHD means that a patient may be automatically prescribed drugs that could cause negative side effects (Frye, 2021). Frye (2021) found a perception among the Black community that if a person were to be diagnosed with ADHD, they could be prescribed antipsychotics, which could be dangerous. In any case, the number of people of color included in the present analyses may have been too small to provide a definitive answer regarding the relationship between race and ADHD diagnostic frequency.

*Average age of patients in Analysis 2 (ADHD vs. no ADHD) were younger than non-ADHD sample.*

The average age of patients in the sample who had been diagnosed with ADHD was significantly younger, by almost 10 years, than those without ADHD. ADHD may be viewed as a childhood problem, as people are typically diagnosed at a young age. Practitioners may be less likely to evaluate patients for ADHD in adulthood, when other symptoms may mask ADHD (McQueen, 2020). Alternatively, ADHD symptoms are sometimes not identified as part of a
disorder but rather as typical behaviors of children, and thus may be disregarded in childhood, leading to a missed ADHD diagnosis. An adult who was never diagnosed with ADHD as a child may not think it is possible to get diagnosed with ADHD as an adult, despite symptoms that interfere with adult functioning. As awareness of ADHD has increased over time, the younger patients may have been more likely to be diagnosed with ADHD as children, whereas the older patients may not have been assessed for ADHD when younger due to less awareness at that time. If ADHD screenings had been conducted consistently on the adult patients included in this study, the numbers of patients diagnosed with ADHD may have been higher in one or all of the groups.

Limitations

There were several limitations in this study. First, the participants were derived from a single health center in a midsize city in the northeast region of the United States; therefore, the results cannot necessarily be generalized to other centers or geographic areas. Second, the sample was not very diverse; although there were other races represented, the majority of the patients were White. Third, the patients were not all formally screened for ADHD. Patients were only considered to have ADHD if they had been diagnosed with ADHD prior to their visit at the clinic or specifically reported symptoms consistent with a diagnosis of ADHD. Patients who may have had ADHD symptoms and had not been diagnosed as children might not have been identified as having ADHD, potentially resulting in a mislabeling of some participants. In other words, there may have been patients who actually had ADHD, but since they had not been screened or diagnosed, they were misrepresented in the sample as not having ADHD. Fourth, if patients reported having a home when they checked into the clinic, they were labeled as not being homeless in this study, However, having a home at the time of a clinic visit does not mean
that they had never been homeless, therefore potentially resulting in an incomplete picture of their housing stability.

The duration of homelessness and status per person can change over time based upon their trajectory in life, including youth to adult, mental health, substance abuse, family breakdown, and housing crisis (Chamberlain & Johnson, 2011). Individuals who have been homeless for more than a year or who have had repeated episodes of homelessness, specifically at least four times in the last three years for a combined length of time of at least one year, account for 19% of the US homeless population (National Alliance to end Homelessness, 2020). Various factors can affect the duration of homelessness, including the local housing and labor markets, whether there are accessible services for early intervention and prevention, and the number and type of services that are available in communities (Chamberlain & Johnson, 2011). The present study may have undercounted homeless adults, as the occurrence of homelessness was only recorded upon intake, omitting earlier or subsequent periods of homelessness.

Finally, this study only included individuals who had accessed health care at a clinic. Although services were offered at no cost, the individuals included in this study may not be representative of homeless individuals overall.

**Implications for Future Research**

Research should continue to assess rates of growth in ADHD diagnosis and treatment, both overall and by demographic groups (Fairman et al., 2017). Consideration is needed to develop culturally sensitive strategies for identifying and treating ADHD across different races and ethnicities (Chung et al., 2019). Future studies might also include qualitative studies with individuals who are homeless to help us understand if and when ADHD was diagnosed and if it
was a factor contributing to their homelessness. Recent analyses indicate that there is a lack of qualitative data regarding the relationship between homelessness and cognitive impairment, including ADHD (Stone et al., 2018). For example, the present study could be repeated with the addition of a qualitative component to gain first-hand knowledge of not only the patients’ life experiences of being homeless but also their life experiences leading up to homelessness. There have been few studies examining the life experiences related to becoming homeless. This knowledge could prove vital to informing public health interventions (Mabhala et al., 2017). This study could also be repeated to include a screening component for ADHD and for housing stability to better determine if a relationship between ADHD and homelessness in this type of health clinic does indeed exist. Furthermore, longitudinal studies, including gathering data from a larger sample and across multiple settings, might be beneficial in sorting out the question of the relationship between ADHD and homelessness.

**Conclusion**

This study did not find that ADHD was related to homelessness. However, in the context of prior studies that did find a relationship, this study highlights the importance of consistent ADHD screening for all adults to clarify if ADHD is a factor impacting their lives. Many adults with ADHD may not even be aware that they have it. They will continue to live with struggles and difficulties, assuming that these are just a part of everyday life. However, if they are screened and diagnosed with ADHD, they have the opportunity to receive the proper treatment, which could potentially lead to a better life by helping them to manage their symptoms, minimize their struggles, and overcome their difficulties.
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