The West Australian Social Worker

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Homelessness: Issues For Social Work Practice

The topic of homelessness is featured in this newsletter. A series of interesting articles have been identified by Chris Coopes and Richard Wilkins and are presented in this issue.

The need for a shift in policy and a better approach towards housing for Aboriginal persons was addressed in an article by Ken Boase in 24 February issue of the *Aboriginal Independent Newspaper*. The article has information from the Derbal Yerrigan Health Service of Aboriginal people living in public housing in the South West. This was from a two week survey involving 36 towns from Moora to Albany, with a detailed consideration of the circumstances of 85 families from these towns.

The West Australian has also given prominent attention to homelessness. An article by Ben Harvey on 9 March contains estimates of the size of the problem, with up to 4,000 homeless Aboriginal persons. There had been a big rise in homelessness over the past six to 10 years according to a spokesperson from the Community Housing Coalition of WA. On 12 March homelessness was considered in an editorial, where it was stated that welfare organisations had estimated there were up to 12,000 homeless persons.

A further article by Nick Miller published on 22 March in *The West Australian* focussed on the impact of a severe shortage of crisis accommodation for young people. The article states that up to 80% of homeless young people were unable to find accommodation and that this meant young people had to live on the streets, thus becoming trapped in an itinerant life style. ***ED***

Homelessness and People With Mental Disorders

For many years the popular perception of the homeless population was that they were predominately men who either had a drinking problem or just an inability to cope with the pressures of life. It was a marginalised group supported by the non-government agencies rather than government services.

In 1987 the WACOSS Psychiatric Issues Working Party was formed (the WA Branch of the AASW was the only professional association represented on the Working Party) and was chaired by WACOSS Executive Officer, Robyn Barrow. This working party highlighted a number of significant issues in relation to the mentally ill including that of homelessness. It was pressure from this group which led to the establishment of the Psychiatric Emergency Team and later the Community Psychiatric Support Service.

The rest of the article will quote a number of studies which emphasise the various issues. They are not the most recent studies but the points they raise are valid. I believe there has been some improvement in the lot of people with mental illness in relation to homelessness, but there is still a long way to go.

1. WACOSS was funded to carry out some research into client groups using supported accommodation. In 1990 the paper *Without Support* was published and the following are some quotes: p.4 “Homelessness among psychiatrically disturbed people is thought to have increased significantly in the last ten years." (Eisen and Wolfenden, 1988 p. 348)

p.5 The Haymarket Foundation investigated the impact of psychiatrically ill and drug abusing persons on agencies providing accommodation for the homelessness in NSW in 1985. The study found that “amongst other things 69% were

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An online version of this newsletter can be found at http://westausaasw.highway1.com.au/

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impaired through intoxication, 16-24% were psychiatrically ill, the psychiatrically ill were unable to meet their own needs for shelter, food, clothing, medical needs and rehabilitation".

p.6 The *Homeless People With Severe Mental Disorders In Inner Melbourne* study investigated the number of people with severe mental disorders living in "marginal" accommodation such as rooming houses, private hotels and crisis accommodation centres and found that:

- Almost half the people interviewed could be classified as having a mental disorder or suffering from alcohol abuse
- 18% were schizophrenic
- 12% had mood disorders
- 27% were substances abusers
- 15% if males were psychotic
- 35% of females were psychotic
- There was a high level of mental illness and substance abuse in comparison with other Australian studies.

The researchers thought their findings were conservative (Herrman et al 1988)".

2) In 1992 a research report was published entitled *Schizophrenia and Social Needs* by Maria Harries, Laksiri Jayasuriya, Anne Wearne and Julie Dickinson.

p.31 "Ninety two per cent of the hospital respondents who reported accommodation difficulties had been homeless at some time. A third (21) of these had been frequently homeless. Homelessness had been experienced by 46% of all males and 30% of all females."

"Respondents coped with the problem of homelessness in a variety of ways. Most had slept out and / or used crisis centres or refuges at some stage; several had lived in cars, camped, or stayed with friends. Five stated that they always went back to hospital when homeless."

p.32 "In summary, although 45% of the hospital respondents and 70% of the clinic respondents lived with families and friends, these were often with family of origin or extended family groupings. Neither sample corresponded with the norm for the general Australian adult population, as more of the respondents lived with parents, fewer lived with spouses, far fewer owned their own accommodation, and many relied on boarding houses."

p.33 "Almost half of the hospital population had experienced accommodation difficulties and 43% had been homeless. Finance was cited as a major problem, together with the unpredictability of the illness. In comparison 20% of the clinic population had experienced accommodation difficulties and 8% had been homeless."

3) Very few documents have had the publicity and the influence of the report of the *National Inquiry into the Human Rights of People With Mental Illness* which was published in 1993 and is often referred to as the Burdekin Report. It is worth noting that the WA Branch of the AASW and the AASW itself both put in written submissions to the Inquiry.

Chapter 18 of this Report is titled *Homeless People* and obviously there is only room for a few quotes.

p.549 "Homeless people suffer a high rate of physical and mental health problems. In a 1991 survey in Melbourne, 90 percent of agencies working with homeless adults reported psychiatric illness as a significant problem."

" Most homeless mentally ill people fall into two broad groups. One group is the ageing, destitute, long –term mentally ill. The other comprises younger people who are transient – constantly shuttling between hostels, refuges and hospitals."

"Over the last 20 years the age profile among the homeless has shifted markedly toward the young. The Inquiry was told these younger people are more likely to be aggressive, less amenable to the rules of agencies or organisations, more likely to ' cause trouble' and provoke hostility, and to kill themselves: ' they are the most distressing group to deal with".

p.550 "Apart from the direct effects on the homeless sufferer, mental illness alienates other people. One worker from a Melbourne homeless agency told the Inquiry: ' Just the nature of psychiatric disability is that it is feared by many people. We, as workers, find it difficult to come to grips with; people in the community also have trouble trying to do that. What that means is that they are ostracised, they are alienated, they are isolated, and they are put back into other suburbs, for instance, like St Kilda …where, in fact, there are lots of other people there that are also vulnerable'".

"Suburbs like St Kilda (or Darlinghurst in Sydney or Fortitude Valley in Brisbane) thus become 'a big stewpot of all sorts of different people with all sorts of different vulnerabilities'. This phenomenon increases the pressures on each mentally ill person in the area - because it is not only the 'normal ' community which shuns them: homeless people generally (ie those who are not mentally ill) do not understand psychiatric disability and are afraid of it."

The worker went on to say ' what that means is that the people react in two ways: they either use (the homeless mentally ill) as scapegoats, and heighten and feed into what a psychiatric disability sufferer is going through; or they actually shun them and turn away and they then become isolated. So certainly …having a psychiatric disability in the homeless field or scene can be a very scary (experience), a very isolated one'.

"One unfortunate consequence of this prejudice among the homeless population is that many mentally ill people prefer to stay on the streets rather than endure rejection in a refuge for the homeless."

p.552 "Homelessness itself is increasing, and mental illness is obviously increasing among the homeless. A study in 1974 found 11 per cent of homeless men had had at least for psychiatric hospital admissions - today that figure would be considered extremely low. The National Health and Medical Research Council reports that in Australia, the US and Britain between a quarter and half of all homeless adults are ' suffering severe and perhaps chronic mental disorder'".

"According to evidence presented on behalf of the Royal Australian and New Zealand College of Psychiatrists, 50 – 70 percent of people in shelters for the homeless have histories of major mental illness. A 1988 study of homeless people in

Melbourne indicated that over 70 percent had experienced some period of mental disorder, and almost half of those had current disorders. This evidence is also consistent with studies overseas.

p.555 "A major American study of the health of homeless people found that homelessness and mental illness are causally related. Mental illness can directly or indirectly lead to homelessness – either through deinstitutionalisation or simply because mentally ill people do not get the support they need to cope with normal life. Conversely, homelessness precipitates and exacerbates a wide range of health problems, including mental illness. Homelessness also makes treatment and management of mental illness more difficult, even if appropriate services are available."

4) There was a reconvening in Victoria of the Inquiry in 1995. Mr Burdekin completed his term as Commissioner early that year and chairing the Inquiry was taken over by Mr Chris Sidoti. This report was published in December 1995.

p.41 "A mentally ill person who is homeless will often be caught in a cruel loop: being homeless increases the likelihood of the mental illness going undetected or untreated, which in turn makes the chance of securing appropriate housing more remote."

"A contributing factor to homelessness among those with a mental illness is the gap between the demand and supply of housing, hospital and community support services"

p.97 Homeless people: Findings
Mental illness is extremely prevalent and largely untreated among homeless people. They encounter a severe lack of community support services and a shortage of appropriate and affordable accommodation. Hospital discharge practices often do not include organising accommodation or aftercare.

Because of their circumstances, homeless people with mental illness have special needs which can be particularly costly to meet. For example, being discharged from hospital too early has extremely serious consequences for homeless people, and their need for aftercare is especially acute. In addition they need more intensive support and monitoring in their treatment. They are often transient which can exacerbate mental illness.

The lack of appropriate accommodation and aftercare for people discharged from hospital is placing the burden of care on family members for relatives who would otherwise become homeless".

5) Homelessness is an even greater issue for those people with a mental illness who also have an addiction/alcohol disorder (commonly referred to as Dual Diagnosis) and two overseas studies are quoted.

5.1) Stetcher et al (1994) p.690 "Individuals with coexisting psychiatric illness and substance use disorders pose difficult social and therapeutic problems. Such dually diagnosed individuals have significant difficulties functioning in daily life. (Drake and Wallace 1989). For example, a high proportion of the homeless in the major cities have both severe mental health and substance use disorders (Koegel, Burnam, and Farr 1988; Drake, Osher and Wallace 1991). Furthermore, the dually diagnosed population has proved to be more difficult to treat than patients diagnosed with either substance use or mental disorders alone. Such clients demonstrate increased hospitalization rates, use of acute care services, violent behaviours, and poorer medication compliance (Osher and Kofoed 1989); Drake and Wallace 1989). Homelessness complicates the treatment of either condition individually (eg by reducing access to and continuity of care, increasing stress etc) and exacerbates the difficulties of treatment when both are present". (Gelberg, Linn and Leake 1988)

5.2) Drake et al (1997) p. 298 "Among the homeless, those with co-occurring severe mental illness and substance use disorder (dual diagnosis) comprise a particularly vulnerable sub –group with multiple, interacting impairments and special needs (Drake et al 1991). Persons with dual disorders are strongly predisposed to homelessness, largely because their substance abuse leads to disruptive behaviours, loss of social supports, financial problems and inability to maintain stable housing (Belcher, 1989; Benda and Datallo, 1988; Lamb and Lamb 1990). Once homeless, they have greater difficulties, require more services, and are more likely to remain homeless than any other subgroups of homeless persons". (Fisher, 1990)

by Chris Coopes

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COMMUNICARE

Domestic Violence Co-ordinator (North West Metro)

Six Month locum (May- October 2001)
15 hours per week
Salary dependent on experience

Position: Co-ordinates Regional Domestic Violence Committee. Specific duties include, facilitation of strategic plan to increase community and agency awareness of family and domestic violence issues.

Please send resume outlining relevant experience in domestic violence field.

Director
GPO BOX 730
Cannington WA 6987
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Applications close 9th April 2001

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Executive Summary Without Support, pp. 4 – 6.

Youth Accommodation and Mental Health Crisis

It's 11.25 pm and you hear the young people in the accommodation service getting rather vocal and excited. You get up to check what is happening. A young woman comes to you and informs you that one of the other residents is acting really weird. It is your role to make sure that all residents are provided with safe supported accommodation!

You walk into the lounge room and hear somebody climbing around in the roof. One of the male residents has hidden himself in the roof cavity because he believes that someone is coming after him. You try to reason with him but he will not have any of it. He is scared and confused. The other residents are telling you that they are scared for the male in the roof. One of these other residents has a family history of violence and has recall memories of hiding in dark places.

This is a typical situation where a client has been placed in a youth accommodation service, who on presentation appeared perfectly healthy and competent to live within the crisis housing service. You have been informed that the client has slight mental health problems which are controlled by the medication he takes regularly.

Staff members have no authority or training to control clients' medication. It is the client's responsibility to ensure that they take their medications. Staff only hold the medication under lock and key to ensure that there is no abuse of the medication in the house.

Youth accommodation services, whether crisis or medium/long term, are contracted to deliver safe and supported accommodation to young people in need of secure accommodation. The staff are trained to work with general crisis issues, and when confronted by mental health issues they, and other residents, are faced with various consequences.

On average, crisis accommodation services have a staff client ratio of 1:6, which often prevents the appropriate support being provided to clients with mental health issues. This type of ratio places a great deal of pressure on staff working within youth accommodation services when a client experiences a psychotic episode, feels suicidal or is acting out due to their illness. Often other residents have issues that can be triggered by mental health episodes of others, and they must also be considered.

When a worker is faced with a young person experiencing a psychotic episode, or suicidal behaviour, they not only have to provide intensive support to the young persons concerned, but must also ensure that other residents are not experiencing triggers, flashbacks, or trauma over the situation of the unwell client.

It is not uncommon for other clients to experience intense distress when observing this sort of behaviour and therefore this is a real concern for workers. It also creates a very stressful and volatile workplace where multiple crises can, and often do occur due to the episode of another resident.

The safety of all residents is paramount to accommodation services, and when a client experiences a mental health episode, of whatever nature, everybody is affected.

Many of the difficulties that accommodation services have in regards to working with homeless young people have been highlighted in several reports (see Bisset H, Campbell S & Goodall J, 1998: National Youth Coalition for Housing, 1999). What is called for from within the youth accommodation sector is better and closer links with mental health services.

by Marie Arends, Armadale Accommodation Youth Service
(Originally published in Connect - Mental Health Matters in WA, Vol 5(4), Summer 2000)

LETTERS

President AASW
WA Branch

Dear Dr Meddin

Re: Difficulty Accessing Commonwealth Funded Residential Aged Care

Social Workers in WA working in the area of Aged Care, have observed a significant increase in numbers of patients, labelled as 'care awaiting placement' (cap) in metropolitan public hospitals and Psycho-geriatric Units. The principal difficulties are in accessing community based nursing home and dementia hostel care. At the same time public hospitals have been unable to cope with the demand on their acute beds. We suspect that this is not just a State based problem, but also a national one.

Assisting patients and families in hospitals and Psycho-geriatric Units to access residential aged care is a key role of Social Workers. Social Workers have direct experience of the pressure patients and their families are confronted with when faced with this issue. More than ever, patients and families are faced with having limited residential aged care options, little or no real choice and an uncertain length of time to plan for and choose appropriate residential aged care. Despite this situation, attitudes persist in some quarters that these patients are 'bed blockers' and that patients and their families should be coerced into accepting any vacancies.

We are aware that almost identical issues are found in at least one rural region of WA. In that area, patients awaiting nursing home and hostel care occupy the regional hospital. There are no available residential aged care beds. Surrounding country hospitals and hostels are limited in their capacity to deal with high care and none are equipped to deal with patients with dementia. Families are advised to look for placement in Perth and there has been some pressure placed upon them in this regard by under resourced country hospitals.

Expressions of Interest

Seeking Workshop Presenters

We have been receiving requests to run workshops focussing on the skills needed for providing effective services for men. We are keen to find out if other members are interested in attending and/or presenting at a workshop focussing on men's issues and services available for men.

Workshop content could include issues surrounding addressing how men's positions in society affect their relationships with women and each other, the influence of masculine culture on men's self perception and behaviour, key practice issues arising for professionals working with men.

If you are interested in running a workshop around this general theme, please send a brief expression of interest covering:

- The topics you propose covering;
- Course length (half or full day)
- Expected number of course participants;
- Dates of availability; and
- Your proposed fee.

Expressions of interest should be addressed to Anne Pickard, Vice President (Education), AASW (WA), PO 198, West Perth 6872 and received by 16th April 2001.

Further information may be obtained by contacting Anne Pickard on 9464 7062 or Meredith Doyle-Hafid 9332 0019 during office hours.

At the very least, this contravenes aging in place and choice for seniors to remain in their communities. In addition it is an equally frustrating and difficult process for country people to find placements in Perth, given problems of access to residential aged care in the metropolitan area.

This problem of access to residential aged care has also resulted in development of Care Awaiting Placement (CAP) units in the metropolitan area. Some of these have been poorly planned and implemented in an atmosphere of urgency, which has compromised proper discharge planning.

In addition, patients admitted to State run CAP facilities do not have the protection of user rights under the Aged Care Act. Whilst CAP units may relieve the immediate bed shortage in hospitals, it is yet another transition for vulnerable patients and stressed family members in the quest to find suitable long-term care.

There has been speculation regarding the possible causes of this problem, eg: - the ageing of the population, - insufficient provision of residential aged care beds and facilities, - redevelopment within the nursing home industry, - closure of state government long-term care facilities and Psycho-geriatric beds, - lack of availability of rehabilitation and time for recovery in acute hospitals.

However a comprehensive study regarding the extent of the problem, its ramifications and causes has not been undertaken. Until this is done this issue cannot be addressed satisfactorily.

One of the functions of the Commonwealth Department of Health and Aged Care is to provide residential aged care, appropriate to meet the needs of frail elderly Australians. These difficulties accessing residential aged care, indicate that the needs of this group are not being met satisfactorily.

In addition, we have urgent concerns regarding the quality of life of the vulnerable group moving to CAP units. We believe that it is the responsibility of the Commonwealth Department of Health and Aged Care to respond to this issue and commission a study into the issue of access to nursing home and dementia hostel care from metropolitan, rural and regional hospitals and Psycho-geriatric units.

We recommend that the AASW WA Branch raise this issue with the AASW National Office, and request that the National Office pursue it with the Federal Minister for Health and Aged Care. We also recommend that the AASW WA Branch informs the State Minister of Health regarding these concerns. The AASW (WA) Social Work Administrators in Healthcare Subcommittee shares the same concerns raised in this letter and support its recommendations.

Yours sincerely

Penelope Mogridge
Ivy Vukovich Co-Convenors
Aged Care Sub Committee

14 March 2001

A copy of this submission has also been forwarded to National Office, as requested in the letter.

President AASW
WA Branch

Dear Dr Meddin

Re: Proposed restrcuture of Milpara Interim Residential Rehabilitation Service

Thank you for your letter of 24 January 2001.

I know that a great deal of consultation and discussion has already taken place in framing the new Milpara service. It is expected that the clients in the new facility will have higher levels of activity and more complex needs, including medication requirements, which required a careful analysis of which staff would be most appropriate to be on site.

It is certainly not the intention to restrict access or erode allied health professionals such as social work, occupational therapy etc and I am informed that this component of care will, in fact, be enhanced because it will be provided by other professions on an 'inreach' basis, allowing much better continunity of care for clients.

I hope this allays your concerns. Should you have any other queries or need to discuss the matter further, please do not hestiate to contact Claire Goodson, Operations Director, at the Alma Street Centre.

Yours sincerely

Dr Aaron Groves,
Director, Metropolitan Mental Health Service

15 February 2001

CPE Events

Social Work Awards For Excellence 2001
Student Awards 2000

10 April 2001, 7.00pm – 9.30pm
Broadwater Pagoda Hotel
Guest Speaker: Assoc Professor Kate Mevik
Contact: Meredith Ph: 9332 0019

Can You Really Help Your Clients To Change?

Dr Ray James
Friday 18 May 2001, 10.30am – 12.30pm
City West Lotteries House
2 Delhi St West Perth
Contact: Meredith As Above

Early Childhood Experiences

Dr Julie Stone and the Family Early Intervention Program Team
Wednesday 13 June 2001, 1.00pm – 4.30 pm
City West Lotteries House
2 Delhi St West Perth
Contact: Meredith As Above

Social Work Day

16 May 2001
Keep a lookout for events near you and in your workplace
Contact: Meredith Ph: 9420 7240
or Norma: normaw@fcs.wa.gov.au

Diversity in Health: Sharing Global Perspectives
National conference on multicultural health and well-being

Sydney, 28 – 30 May 2001
Information on website at: www.tmhc.nsw.gov.au/diversity.htm
Contact: Project Officer Jennifer Herron
Mon, Tue & Wed Ph: 02 9840 3800

Social Work in the Marketplace
WA Branch State Conference

21-23 August 2001
Contact: Marian Maughan
9330 2585, Fax:9317 3891
email: mmaughan@telstra.easymail.com.au

IFSW Danube Conference
Managing Conflicts in Social Work

27-30 August 2001
Contact: IFSW Europe Secretariat
PO BOX 69 DK-1003, Copenhagen K, Denmark
Tel +45 4038 6758, email: ifsweu@post8.tele.dk

Think/Act/Local/Global: Social Work in the 21st Century
AASW National Conference

Melbourne, 23-26 Sept 2001
ICMS Conference Secretariat
PH: +61 (0)3 9682 0244
email: aasw@icms.com.au

On a Journey Through Grief To the Heart of Healing
NALAG Biennial National Conference

Perth, 4 -6 October 2001
Contact: Keynote conferences Ph: 9382 3799,
email keynote@ca.com.au
website: www.griefaustralia.org

Strategic Questioning for Social and Personal Change

Perth, 28 & 29 July 2001
One and two day workshops for change agents, community development workers, educators, facilitators and providers of human services
Presented by Fran Peavey, Community social change worker. Author of *Heart politics revisited*.
Contact: Rodney Vlais, Tel: 08 9337 7217,
email: ecoheal@iinet.net.au, website: http://www.gaiawest.iinet.net.au/sg.html

Net Watch

http://www.foreignpolicy.com/

Be careful what you wish for. After decades of struggling to contain the global population explosion that emerged from the healthcare revolution of the 20th century, the world confronts an unfamiliar crisis: rapidly decreasing birthrates and declining life spans that might set back the progress of human development.

It may not be the first way we think of ourselves, but almost all of us alive today happen to be children of the "world population explosion"—the momentous demographic surge that overtook the planet during the course of the 20th century. Thanks to sweeping mortality declines, human numbers nearly quadrupled in just 100 years, leaping from about 1.6 or 1.7 billion in 1900 to about 6 billion in 2000.

This unprecedented demographic expansion came to be regarded as a "population problem," and in our modern era problems demand solutions. By century's end, a worldwide administrative apparatus—comprised of Western foundations and aid agencies, multilateral institutions, and Third World "population" ministries—had been erected for the express purpose of "stabilizing" world population and was vigorously pursuing an international antinatal policy, focusing on low-income areas where fertility levels remained relatively high.

To some of us, the wisdom of this crusade to depress birthrates around the world (and especially among the world's poorest) has always been elusive. But entirely apart from its arguable merit, the continuing preoccupation with high fertility and rapid population growth has left the international population policy community poorly prepared to comprehend (much less respond to) the demographic trends emerging around the world today—trends that are likely to transform the global population profile significantly over the coming generation. Simply put, the era of the worldwide "population explosion," the only demographic era within living memory, is coming to a close.

Continued global population growth, to be sure, is in the offing as far as the demographer's eye can see. It would take a cataclysm of biblical proportions to prevent an increase in human numbers between now and the year 2025. Yet global population growth can no longer be accurately described as "unprecedented." Despite the imprecision of up-to-the-minute estimates, both the pace and absolute magnitude of increases in human numbers are markedly lower today than they were just a few years ago. Even more substantial decelerations of global population growth all but surely await us in the decades immediately ahead.

In place of the population explosion, a new set of demographic trends—each historically unprecedented in its own right—is

poised to reshape, and recast, the world's population profile over the coming quarter century. Three of these emerging tendencies deserve special mention. The first is the spread of "subreplacement" fertility regimens, that is, patterns of childbearing that would eventually result, all else being equal, in indefinite population decline. The second is the aging of the world's population, a process that will be both rapid and extreme for many societies over the coming quarter century. The final tendency, perhaps the least appreciated of the three, is the eruption of intense and prolonged mortality crises, including brutal peacetime reversals in health conditions for countries that have already achieved relatively high levels of life expectancy.

For all the anxiety that the population explosion has engendered, it is hardly clear that humanity will be better served by the dominant demographic forces of the post-population-explosion era. Nobody in the world will be untouched by these trends, which will have a profound impact on employment rates, social safety nets, migration patterns, language, and education policies. In particular, the impact of acute and extended mortality setbacks is ominous. Universal and progressive peacetime improvements in health conditions were all but taken for granted in the demographic era that is now concluding; they no longer can be today, or in the era that lies ahead.

Editing & Proof Reading Available

Experience in revision of health, policy, women's services/ violence against women, youth and academic publications.

Qualifications in arts (humanities), social work and advanced editing.

Contact Josephine Bartley
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The Global Baby Bust

In arithmetic terms, the 20th-century population explosion was the result of improvements in health and the expansion of life expectancy. Human life expectancy at birth is estimated to have doubled or more between 1900 and 2000, shooting up from approximately 30 years to nearly 65 years. Population growth rates accelerated radically thanks to the concomitant plunge in death rates. Despite tremendous population growth, rough calculations suggest that the world's population would be over 50 percent larger today in the absence of any other demographic changes.

The world's population currently totals about 6 billion, rather than 9 billion or more, because fertility patterns also changed over the course of the 20th century. And of all those diverse changes, without question the most significant was secular fertility decline: sustained and progressive reductions in family size due to deliberate birth control practices by prospective parents.

Within the full sweep of the human experience, secular fertility decline is very, very new. It apparently had not occurred in any human society until about two centuries ago in France. Since that beginning, secular fertility decline has spread steadily, if unevenly, embracing an ever rising fraction of the global population. In the final decades of the 20th century, subreplacement fertility made especially commanding advances: According to estimates and projections by the U.S. Census Bureau and the United Nations Population Division, fertility levels for the world as a whole fell by more than 40 percent between the early 1950s and the end of the century—a drop equivalent to over two births per woman per lifetime.

Indeed, subreplacement fertility has suddenly come amazingly close to describing the norm for childbearing the world over. In all, 83 countries and territories are thought to exhibit below-replacement fertility patterns today [see map]. The total number of persons inhabiting those countries is estimated at nearly 2.7 billion, roughly 44 percent of the world's total population.

Secular fertility decline originated in Europe, and virtually every population in the world that can be described as of European origin today reports fertility rates below the replacement level. But these countries and territories today currently account for only about a billion of the over 2.5 billion people living in "subreplacement regions." Below-replacement fertility is thus no longer an exclusively—nor even a predominantly—European phenomenon. In the Western Hemisphere, Barbados, Cuba, and Guadeloupe are among the Caribbean locales with fertility rates thought to be lower than that of the United States. Tunisia, Lebanon, and Sri Lanka have likewise joined the ranks of subreplacement fertility societies.

The largest concentration of subreplacement populations, however, is in East Asia. The first non-European society to report subreplacement fertility during times of peace and order was Japan, whose fertility rate fell below replacement in the late 1950s and has remained there almost continuously for the last four decades. In addition to Japan, all four East Asian tigers—Hong Kong, the Republic of Korea, Singapore, and Taiwan—have reported subreplacement fertility levels since at least the early 1980s. By far the largest subreplacement population is in China, where the government's stringent antinatal population control campaign is entering its third decade.

The singularity of the Chinese experience, however, should not divert attention from the breadth and scale of fertility declines that have been taking place in other low-income settings. A large portion of humanity today lives in countries where fertility rates are still above the net replacement level, but where secular fertility decline is proceeding at a remarkably rapid pace.

A glance at the 15 most populous developing countries illustrates the magnitude of fertility change over the last quarter century These countries account for about three quarters of the current population of the "less developed regions," and three fifths of the total world population. In addition to China, Thailand is believed to be below the replacement level. Three other countries (Brazil, Iran, and Turkey) are thought to be just barely above the replacement level. Another four (Bangladesh, Indonesia, Mexico, and Vietnam) are slightly higher. Today, in other words, nine of the 15 largest developing countries are believed to register fertility levels lower than those that characterized the United States as recently as 1965. And over the last quarter century, fertility decline in this set of countries has been pronounced: In eight of those 15, fertility dropped by over half.

The remarkable particulars of today's global march toward smaller family size fly in the face of many prevailing assumptions about when rapid fertility decline can, and cannot, occur. Poverty and illiteracy (especially female illiteracy) are widely regarded

as impediments to fertility decline. Yet, very low income levels and very high incidences of female illiteracy have not prevented Bangladesh from more than halving its total fertility rate during the last quarter century. By the same token, strict and traditional religious attitudes are commonly regarded as a barrier against the transition from high to low fertility. Yet over the past two decades, Iran, under the tight rule of a militantly Islamic clerisy, has slashed its fertility level by fully two-thirds and now apparently stands on the verge of subreplacement. For many population policymakers, it has been practically an article of faith that a national population program is instrumental, if not utterly indispensable, to fertility decline in a low-income setting. Iran, for instance, achieved its radical reductions under the auspices of a national family planning program. (In 1989, after vigorous doctrinal gymnastics, the mullahs in Tehran determined that a state birth control policy would indeed be consistent with the Prophet's teachings.) But other countries have proven notable exceptions. Brazil has never adopted a national family planning program, yet its fertility levels have declined by well over 50 percent in just the last 25 years.

Two points, however, can be made with certainty. First, the worldwide drop in childbearing reflects, and is driven by, dramatic changes in desired family size. (Although even this observation only raises the question of why personal attitudes about these major life decisions should be changing so commonly in so many disparate and diverse locales around the world today.) Second, it is time to discard the common assumption, long championed by demographers, that no country has been modernized without first making the transition to low levels of mortality and fertility. The definition of "modernization" must now be sufficiently elastic to stretch around cases like Bangladesh and Iran, where very low levels of income, high incidences of extreme poverty, mass illiteracy, and other ostensibly "nonmodern" social or cultural features are the local norm, and where massive voluntary reductions in fertility have nevertheless taken place.

Send Your Huddled Masses ASAP

Barring catastrophe, the world's total population can be expected to grow substantially over the coming quarter century: U.S. Census Bureau projections for 2025 would place global population at over 7.8 billion, almost 30 percent larger than today. Yet, due to declining fertility, population growth is poised to decelerate markedly over the coming generation. The projected annual rate of world population growth in 2025 is just under 0.8 percent, considerably slower than the current projected rate of 1.3 percent, and far below the estimated 2.0 percent annual growth rate of the late 1960s. The great global birth wave will have crested and begun ebbing by 2025. In fact, by those projections, slightly fewer babies will be born worldwide in the year 2025 than in any year over the previous four decades.

The prospective pace of population growth for the different regions of the world is highly uneven over the coming generation The most dramatic increases will occur in sub-Saharan Africa, followed by countries in North Africa and the Middle East. By 2025 more people may be living in Africa than in all of today's "more developed countries" taken together.

The natural growth of population in the more developed countries has essentially ceased. The overall increase in population for 2000 in these nations is estimated at 3.3 million people, or less than 0.3 percent. Two thirds of that increase, however, is due to immigration; the total "natural increase" amounts to just over 1 million. Over the coming quarter century, in the U.S. Census Bureau's projections, natural increase adds only about 7 million people to the total population of the more developed countries. And after the year 2017, deaths exceed births more or less indefinitely. Once that happens, only immigration on a scale larger than any in the recent past can forestall population decline. (The specter of population decline in more developed countries looms even larger if the United States, with its relatively high fertility level and relatively robust inflows of immigrants, is taken out of the picture. Excluding the United States, total deaths already exceed total births by almost half a million a year.)

For Europe as a whole (including Russia), the calculated long-term volume of immigration required to avert overall population decline is nearly double the recent annual level—an average of 1.8 million net newcomers a year, versus the roughly one million net entrants a year in the late 1990s. To prevent an eventual decline in the size of the 15 to 64 grouping (often termed the "working-age" population), Europe's net migration will have to nearly quadruple to a long-term average of about 3.6 million a year. Migration of this magnitude would change the face of Europe: By 2050, under these two scenarios, the descendants of present-day non-Europeans will account for approximately 20 to 25 percent of Europe's inhabitants.

Even more dramatic are the prospects for Japan, where current net migration levels are close to zero. To maintain total population size, Japan would have to accept a long-term average of almost 350,000 newcomers a year for the next 50 years, and it would need nearly twice that number to keep its working-age population from shrinking. Under the first contingency, over a sixth of Japan's 2050 population would be descendants of present-day gaijin (foreigners); under the second contingency, that group would account for nearly a third of Japan's total population.

Europe and Japan will not lack immigration candidates in the years ahead. If Europe's needed immigration flows continue to come largely from North Africa, the Middle East, sub-Saharan Africa, and South Asia, those migrants will account for only about 3 to 7 percent of the population growth in their home countries. By the same token if Japan, for reasons of history and affinity, relies upon China and Southeast Asia for all its new national recruits, it will require just 2 to 4 percent of those countries' total envisioned population increase over the next 25 years. And as long as a huge income gap separates these more developed and less developed locales, there will be a compelling motive for such migration.

The issue clearly will not be supply, but rather demand. Will Western countries facing population decline opt to let in enough outsiders to stabilize their domestic population levels? Major and sustained immigration flows will entail correspondingly consequential long-term changes in a country's

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Susan Douglas	New Graduate
Kathy Fenner	
Magdalena Flynn	Student
Lindy Gleeson	Warwick Clinic
Mindy Horseman	Kinway
Ivana Jelinek	Student
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ethnic composition, with accompanying social alterations and adjustments. Such inflows will also require a capability to assimilate newcomers, so that erstwhile foreigners (and their descendants) can become true members of their new and chosen society.

The current outlook for "replacement migration" varies dramatically within the more developed regions. Throughout Europe, vocal (but still marginal) antiforeign political movements have taken the stage in recent years, while more tolerant sectors of the public have worried about the impact of immigration on their welfare states. Yet the continent, populated as it has been by successive historical flows of peoples, possesses traditions and capacities of assimilation that are not always fully appreciated.

The situation looks very different for Japan, where no major influxes of newcomers have been recorded over the past thousand years, and where the delicate distinctness of the Japanese minzoku (race) is a matter of intense, if not always enunciated, public consciousness. Despite reforms in Japanese immigration laws, a community of ethnic Koreans in Japan—many of them fourth-generation residents of the country—still does not enjoy Japanese citizenship. Indeed, Japan naturalizes fewer foreigners each year than tiny Switzerland.

It is extraordinarily difficult to imagine any circumstances under which the Japanese public might acquiesce in "replacement migration." Socially and politically, long-term demographic decline seems likely to be a much more acceptable alternative. But these are the only two choices, and over the coming decades all the more developed countries must decide between them. For all societies with long-term fertility rates significantly below the replacement level, the only alternative to an eventual decline of the total population—or of key age groups within that total population—is steady and massively enhanced immigration.

A Grey World

The world's population is set to age markedly over the coming generation: The longevity revolution of the 20th century has foreordained as much. The tempo of social aging, however, has been accelerated in many countries by extremely low levels of fertility. In 2025, there will likely remain a few pockets of the world in which populations will remain as youthful as those from earlier historical epochs. For example, the median age in sub-Saharan Africa in 2025 will be just 20 years, that is, as many people would be under 20 as over 20. (Such a profile probably characterized humanity from the Neolithic era up until the Industrial Revolution.) Throughout the rest of the world, however, the phenomenon of aging will transform the structure of national populations, often acutely. Population aging will be most pronounced in today's more developed countries. By the U.S. Census Bureau's estimates, the median age for this group of countries today is about 37 years. In 2025, the projected median age will be 43.

Due to its relatively high levels of fertility and immigration (immigrants tend to be young), the population of the United States is slated to age more slowly than the rest of the developed world. By 2025, median age in the United States will remain under 39 years. For the rest of the developed world, minus the United States, median age will be approximately 45 years. And for a number of countries, the aging process will be even further advanced.

In Germany, for example, the projected median age in the year 2025 is 46. Greece and Bulgaria are both ascribed median ages in excess of 47. Japan would have a median age of over 49. In this future Japan, more than a fifth of the citizenry would be over 70 years of age, and nearly one person in six would be 75 or older. In fact, persons 75 and older would outnumber children under 15 years of age.

Population aging, of course, will also occur in today's less developed regions. Current developed countries grew rich before they grew old; many of today's low-income countries, by contrast, look likely to become old first. One of the most arresting cases of population aging in the developing world is set to unfold in China, where relatively high levels of life expectancy, together with fertility levels suppressed by the government's resolute and radical population control policies, are transforming the country's population structure. Between 2000 and 2025, China's median age is projected to jump by almost 9 years. This future China would have one-sixth fewer children than contemporary China, and the 65-plus population would surge by over 120 percent, to almost 200 million. These senior citizens would account for nearly a seventh of China's total population. Caring for the elderly will inexorably become a more pressing issue for China under such circumstances, but nothing remotely resembling a national pension system is yet in place in that country. Even with rapid growth over the next quarter century, China will still be a poor country in 2025. Coping with its impending aging problem promises to be an immense social and economic issue for this rising power.

Death Makes a Comeback

Given the extraordinary impact of the 20th century's global health revolution, well-informed citizens around the world have come to expect steady and progressive improvement in life expectancies and health conditions during times of peace. Unfortunately, troubling new trends challenge these happy presumptions. A growing fraction of the world's population is coming under the grip of peacetime retrogressions in health conditions and mortality levels. Long-term stagnation or even decline in life expectancy is now a real possibility for urbanized, educated countries not at war. Severe and prolonged collapses of local health conditions during peacetime, furthermore, is no longer a purely theoretical eventuality. As we look toward 2025, we must consider the unpleasant likelihood that a large and growing fraction of humanity may be separated from the planetary march toward better health and subjected instead to brutal mortality crises of indeterminate duration.

In the early post-World War II era, the upsurge in life expectancy was a worldwide phenomenon. By the reckoning of the U.N. Population Division, in fact, not a single spot on the globe had a lower life expectancy in the early 1970s than in the early 1950s. And in the late 1970s only two places on earth—Khmer Rouge-ravaged Cambodia and brutally occupied East Timor—had lower levels of life expectancy than 20 years earlier. In subsequent years, however, a number of countries unaffected by domestic disturbance and upheaval began to report lower levels of life expectancy than they had known two decades

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earlier. Today that list is long and growing. U.S. Census Bureau projections list 39 countries in which life expectancy at birth is anticipated to be at least slightly lower in 2010 than it was in 1990. With populations today totaling three quarters of a billion people and accounting for one eighth of the world's population, these countries are strikingly diverse in terms of location, history, and material attainment.

This grouping includes the South American countries of Brazil and Guyana; the Caribbean islands of Grenada and the Bahamas; the Micronesian state of Nauru; 10 of the 15 republics of the former Soviet Union; and 23 sub-Saharan African nations. As might be surmised from the heterogeneity of these societies, health decline and mortality shocks in the contemporary world are not explained by a single set of factors, but instead by several syndromes working simultaneously in different parts of the world to subvert health progress.

Russia has experienced a prolonged stagnation and even decline in life expectancy, and its condition illuminates the problems facing some of the other former Soviet republics [see graph]. After recording rapid postwar reductions in mortality in the 1950s, Russian mortality levels stopped falling in the 1960s and began rising for broad groups of the population. By 1990, overall life expectancy at birth in Russia was barely as high as it had been 25 years earlier. With the end of communist rule in 1991, Russia suffered sudden and severe declines in mortality, from which it has not yet fully recovered. By 1999, overall life expectancy at birth in Russia had regressed to the point where it had been four decades earlier.

Although many aspects of Russia's continuing health crisis remain puzzling, it appears that lifestyle and behavioral risks—including heavy smoking and extremely heavy drinking—figure centrally in the shortening of Russian lives. A weak and rudderless public health system, combined with apparent indifference in Moscow to the nation's ongoing mortality crisis, also compromises health progress. Although Russia is an industrialized society with an educated population and a large indigenous scientific-technical cadre, such characteristics do not automatically protect a country from the sorts of health woes that have befallen the Russian Federation.

In sub-Saharan Africa, a different dynamic drives mortality crises: the explosive spread of the HIV/AIDS epidemic. In its most recent report, the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimated that 2.8 million died of AIDS in 1999, 2.2 million in sub-Saharan Africa alone. UNAIDS also reported that almost 9 percent of the region's adult population is already infected with the disease. By all indications, the epidemic is still spreading in sub-Saharan Africa. As of 2000, UNAIDS projected that in several sub-Saharan countries, a 15-year-old boy today faces a greater than 50 percent chance of ultimately dying from AIDS—even if the risk of becoming infected were reduced to half of current levels.

Given sub-Saharan Africa's disappointing developmental performance and conspicuously poor record of governance over the post-independence period, the pervasive failure in this low-income area to contain a deadly but preventable contagion may seem tragic but unsurprising. Yet it is worth noting that the AIDS epidemic appears to have been especially devastating in one of Africa's most highly developed and best-governed countries: Botswana.

Unlike most of the region, Botswana is predominantly urbanized; its rate of adult illiteracy is among the subcontinent's very lowest; and over a generation in which sub-Saharan economic growth rates were typically negative, Botswana's was consistently positive. Yet despite such promising statistics, Botswana's population has been decimated by HIV/AIDS over the last decade. Between 1990 and 2000, life expectancy in Botswana plummeted from about 64 years to about 39 years, that is to say, by almost a quarter century. Recent projections for 2025 envision a life expectancy of a mere 33 years. If this projection proves accurate, Botswana will have a much lower life expectancy 25 years from now than it had nearly half a century ago.

One of the disturbing facets of the Botswanan case is the speed and severity with which life expectancy projections have been revised downward. Assuming most recent figures are accurate, as recently as 1994 expert demographers were overestimating Botswana's life expectancy for 2000 by about 30 years. Such abrupt and radical revisions raise the question of whether similar brutal adjustments await other sub-Saharan countries—or, for that matter, countries in other regions of the world. This question cannot be answered with any degree of certainty today, but we would be unwise to dismiss it from consideration. HIV/AIDS may not be the only plague capable of wrenching down national levels of life expectancy over the coming quarter century. Twenty-five years ago, HIV/AIDS had not even been identified and diagnosed.

Surprisingly, sub-Saharan Africa's AIDS catastrophe is not projected to alter the region's population totals dramatically. That speaks to the extraordinary power of high fertility levels. Given the region's current and prospective patterns of childbearing,

the subcontinent's population totals in 2025 may prove to be unexpectedly insensitive to the scope or scale of the disasters looming ahead. Yet it is the mortality patterns that will do much to define the quality of life for those human numbers—and to circumscribe their economic and social potential.

The Shape of Things to Come

Looking toward 2025, we must remember that many 20th-century population forecasts and demographic assessments proved famously wrong. Depression-era demographers, for example, incorrectly predicted depopulation for Europe by the 1960s and completely missed the "baby boom." The 1960s and 1970s saw dire warnings that the "population explosion" would result in worldwide famine and immiseration, whereas today we live in the most prosperous era humanity has ever known. In any assessment of future world population trends and consequences, a measure of humility is clearly in order.

Given today's historically low death rates and birthrates, however, the arithmetic fact is that the great majority of people who will inhabit the world in 2025 are already alive. Only an apocalyptic disaster can change that. Consequently, this reality provides considerable insight into the shape of things to come. By these indications, indeed, we must now adapt our collective mind-set to face new demographic challenges.

A host of contradictory demographic trends and pressures will likely reshape the world during the next quarter century. Lower fertility levels, for example, will simultaneously alter the logic of international migration flows and accelerate the aging of the global population. Social aging sets in motion an array of profound changes and challenges and demands far-reaching adjustments if those challenges are to be met successfully. But social aging is primarily a consequence of the longer lives that modern populations enjoy. And the longevity revolution, with its attendant enhancements of health conditions and individual capabilities, constitutes an unambiguous improvement in the human condition. Pronounced and prolonged mortality setbacks portend just the opposite: a diminution of human well-being, capabilities, and choices.

It is unlikely that our understanding of the determinants of fertility, or of the long-range prospects for fertility, will advance palpably in the decades immediately ahead. But if we wish to inhabit a world 25 years from now that is distinctly more humane than the one we know today, we would be well advised to marshal our attention to understanding, arresting, and overcoming the forces that are all too successfully pressing for higher levels of human mortality today.

This provocative article, ***The population implosion***, was written by Nicholas Eberstadt and originally published in *Foreign Policy Magazine*, March April 2001. This and other material of interest to social workers can be found at the Foreign policy website <http://www.foreignpolicy.com/issue_marapr_2001/>.