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Poverty 423

6 April 2013

The Homeless Mentally Ill

Introduction

Karen moved to Charlotte, North Carolina with a friend in 2010 (Urban Ministry Center, 2012). She was told that there were jobs in Charlotte and that it would be better for her there. She could get away from the terrible things she had experienced in the state in which she was born. At the age of 12 her mother's boyfriend began repeatedly raping her, while her mother was often high on drugs. By the age of 13, she found out her mother's boyfriend had impregnated her. When she confronted her mother about the situation her mother accused her of coming on to her boyfriend and began beating her, which forced her to miscarry. At this point, her mother cut the fetus from the umbilical cord with a knife and hid it in the attic in their house. Karen began having stomach pains, which caused to her to see the nurse frequently at school. The nurse began questioning Karen, and although she would not speak to her about what was happening at home at first, the nurse eventually got her to open up about it. After telling the nurse about the pregnancy and miscarriage, Social Services was sent to her home where they found the evidence of her story in the attic.

Karen was sent to live with her older sister who had a few children of her own. At the age of fourteen Karen had her first child and continued having children until the age of twenty-two, when she had six children total and was pregnant with another. Her first experience of homelessness occurred when she began living with her sister in an old car because her sister was

too prideful to seek help from her grandmother. Her sister was very harsh and abusive with her, and because of her situation she ended up dropping out of school before reaching high school. When her friend told her about this great opportunity in Charlotte, she couldn't wait to get out. She took three of her children with her and went to Charlotte where she lived with her friend for a few months. After this, Karen was forced onto the street because she could not pay rent and had nobody else to stay with. The promise of jobs in Charlotte ended up being untrue and Karen had no way of supporting herself. Her children were taken by Social Services and she began moving from boyfriend to boyfriend, seeking protection from the violence experienced living on the streets. This caused Karen to get pregnant again. When she did not have a boyfriend for protection, she was raped multiple times and was in constant fear of being raped wherever she chose to sleep. She lived in cars, under bridges, and in a tent in the woods for some time. Karen often chose this over shelter life because of the violence, theft, and overcrowding in shelters.

After two years of being homeless Karen sought help from an organization that promoted sustainable housing for the chronically homeless. It was around this time that she diagnosed with bipolar and substance abuse disorders and began being treated for them. For much of the time she was homeless, she used alcohol to self medicate and deal with the extreme stress she was facing. This program allowed Karen to visit a therapist weekly, work toward her GED, and have a house of her own for the first time in her life. She was also working on getting custody of her children.

Many people exist today in America living in the same conditions that Karen did. Many have horrendous backgrounds and mental illnesses that prevent them from combating their homelessness. In fact, as of 2009, 3.5 million people in America were considered homeless (National Coalition for the Homeless, 2009). Homelessness is defined as "an individual who

lacks a fixed, regular, and adequate nighttime residence." This includes: residing in an area not traditionally used for housing (e.g. cars or under bridges), people residing in shelters, people who will lose housing within 14 days, people living with friends or family, or anybody residing in any other impermanent unstable housing situation (The National Health Care for the Homeless Counsel, 2009). Over the past two decades homelessness has increased substantially with 12 out of 23 cities in one survey forced to turn away the homeless because of overcrowding in shelters (National Coalition for the Homeless, 2009). Of these people, many are mentally ill. Although there is a portion of homelessness mostly caused by lack of employment opportunities and housing, this type of homelessness is not explored in this paper. This paper specifically focuses on the homeless population suffering from mental illness that need much more support than only housing and employment opportunity. While these are important for the homeless mentally ill population, they are not able to ensure sustainable housing and treatment standing alone.

As of 2009, 20 to 25 percent of homeless people suffered from mental illness, which is three to four times greater than people suffering from mental illness in the general population (National Coalition for the Homeless, 2009). In fact, when 25 cities were surveyed and asked what the main factors contributing to homelessness were, mental illness ranked as the third most influential cause of homelessness among single adults (National Coalition for the Homeless, 2009). When mental illness is left untreated, it can result in a number of serious issues including an inability to complete common tasks like taking care of personal hygiene, problems forming and maintaining social connections, and an inability to function normally in society (National Coalition for the Homeless, Mental Illness, 1). Poor hygiene and substance abuse among the mentally ill homeless are two of the biggest issues that prevent them from finding permanent housing and support. Considering these factors, it is no surprise that the mentally ill are much

more likely to become homeless when compared to people lacking psychopathology (National Coalition for the Homeless, Mental Illness, 1).

Similarly high rates of substance use disorder have been found among the homeless, with about 30 percent of homeless people suffering from them (National Coalition for the Homeless, Substance Abuse, 1). Substance use disorders and mental disorders can be viewed as both stemming from homelessness and contributing to it (National Coalition for the Homeless, Substance Abuse, 1). Substance use disorders are also more than three times more common among the homeless population than the general population (National Coalition for the Homeless, Substance Abuse, 1). They can contribute to homelessness by causing people to lose jobs and harm relationships with families and friends. In fact when twenty-five cities were surveyed, substance abuse was the number one cause of homelessness (National Coalition for the Homeless, Substance Abuse, 1). These disorders also often result from homelessness. Many homeless people use drugs as a method of coping with both their mental disorders and homelessness, which exacerbates their precarious situations (National Coalition for the Homeless, Substance Abuse, 2).

For example, Karen did not begin drinking alcohol until she became homeless. She used it as a way of curbing her appetite and making her forget about the horrible things that had happened to her and were happening to her (Urban Ministry Center, 2012). If Karen was drunk, her emotions seemed less severe and more manageable. especially because bipolar disorder causes severe periods of mood swings. Living on the streets in its self also caused her constant panic and worry about where she would sleep and how she would protect herself. It is also possible that an alcoholic could lose a job, break social connections, exacerbate mental illness, and become homeless as a result of the addiction. Because drugs are so often used to self

medicate, it is difficult to determine if the mental illness facilitates the drug addiction or vise versa. People stuck in this situation have a poor prognosis often revolving around jail, emergency rooms, and street life (National Coalition for the Homeless, Substance Abuse, 2).

Homeless mentally people who have been abusing drugs have little motivation to overcome the addiction and seek treatment when they are simply seeking to survive and meet their basic needs (National Coalition for the Homeless, Substance Abuse, 1). Substance abuse among the homeless mentally ill only worsens their condition by making it less likely that they will be able to find employment and a steady housing situation, as they cannot do these things without treatment. The homeless mentally ill are frequently alienated from their families, who cannot or will not provide these services to their family members (National Coalition for the Homeless, Mental Health, 1).

This also creates a serious economic burden that one study found adds up to about 22,372 dollars per year spent on each homeless mentally ill individual (Poulin, 1095). This study found that much of the cost was due to emergency psychiatric services and jail stays (Poulin, 1097). This figure is likely lower than the real cost because it does not include the cost spent on police, courts, and medical care not related to psychiatric disabilities (Poulin, 1097). In Philadelphia alone, this cost combined among all the homeless mentally ill people was about 20 million dollars (Poulin, 1095). Another study incorporating shelter use, hospital stays and duration, duration of time spent in jail, and other costs associated with being homeless and mentally ill found that the annual cost of leaving the mentally ill homeless totaled 40,451 dollars per person (Culhane, 1).

Many questions follow from these facts. Should something be done to help the homeless mentally ill? If so, what should be done and why? It will no doubt require that both mental

illness and substance use disorders be treated together, as each so greatly inhibits the homeless from meeting their basic needs. Many people would likely answer yes to the first question. The answers begin with a brief history of the homeless mentally ill.

A Historical Review of the Homeless Mentally Ill

Mentally ill individuals have a long history of stigmatization. This group went from being considered "village fools" in the Middle Ages to being thrown into large groups living in horrendous conditions isolated from society during The Inquisition (Melamed et al., 210). This pattern of isolating and ostracizing the mentally ill existed for many years until society began to treat them. Psychiatric institutions were built, and soon after in the 1950's the mentally ill were treated with medication. In the United States, advances in medication coupled with increasing numbers of mentally ill patients and stories of the poor treatment of people in mental institutions, who were seen as imprisoned, led to deinstitutionalization in the 1960s (Melamed et al., 211).

People were supposed to return home to their communities and receive private treatment there (Bassuk, 9). Their communities were not prepared to receive them. Communities did not have the money, organizations, or social acceptance necessary to provide for this mentally ill population (Bassuk, 9). Without a supportive infrastructure, the mentally ill were not able to cope with the stress of caring for their own needs. Not surprisingly, this led to a significant increase in homelessness, as well as use of nursing homes and jails as housing for the mentally ill (Bassuk, 9). Between a third and a fifth of the people who were treated in mental institutions became homeless (Bassuk, 9). In fact, mentally ill people who did return home are also at risk for homelessness when their caretaker dies or can no longer support them (Bassuk, 9).

Why do the Homeless Mentally Ill Deserve Treatment?

An Ethical Perspective: Capability and Fair Equality of Opportunity

There is no doubt that the homeless mentally ill lack many of one of the most basic needs, especially shelter. This population is deserving of society's help. Amartya Sen helps address this question through his discussion of capabilities. There is a set of doings and beings that every individual should have the potential to engage in, which Sen calls functionings (31). Functionings range from basic qualities like being properly nourished to the more complicated, like having self-respect or engaging in a community (Sen, 31). Capability is essentially the autonomy individuals have to choose among a variety of possibilities of things they can "do or be" (Sen, 31). It is the availability of functionings that a person is able to choose among (Sen, 31).

In terms of capability, quality of life can be determined by the ability an individual has to attain functionings of some worth (Sen, 32). These capabilities contain both "personal characteristics and social arrangements" (Sen, 33). Karen's, for example, lived in a terrible environment in which she was constantly exposed to drugs and sexual abuse at a very young age, which eventually led to her living homeless in a car (Urban Ministry Center, 2012). We can easily see that Karen was not provided with basic capabilities and did not have the capability to attain an education. With no education or home, she did not have the capability to attain employment or a stable living situation. With lack of education and support Karen was not capable of raising children, and did not fully comprehend why she should prevent herself from getting pregnant. When she moved to Charlotte she did not even have the capability of preventing pregnancy because she used men for protection from street violence. Karen's mental illness also impaired her capability for employment and stability in her life, which is necessary to maintain a home and family. Her use of alcohol to self-medicate further impaired her capability to attain a meaningful position in life and seek treatment, which would allow her some amount of

stability. Karen was never given the capability to function in valuable ways in society at the beginning of her life, which resulted in her lacking capability to overcome homelessness, mental illness, and addiction. With so many factors working against her, it is not surprising that she ended up in her position. Of the 3.5 million people who are homeless in the United States today, many are similar to Karen with as many as a quarter suffering from mental illness and a third suffering from substance abuse (National Coalition for the Homeless, 2009).

Norman Daniels's similar approach to health care can help answer our question about deservedness. Extending John Rawls's conception of justice, he says that health care is necessary because it promotes fair equality of opportunity for normal functioning (Daniels, 29). He says that health supports opportunity for normal functioning and because of this healthcare is necessary (Daniels, 29). If something inhibits opportunity for normal functioning, it should be prevented (Daniels, 43). Daniels argues that a range exists for normal functioning that includes "the array of life plans reasonable people are likely to develop for themselves" (43). A pathology, like mental illness, is something that might prevent a person from fair equality of opportunity (Daniels, 37). Daniels defines pathology as deviation from normal functioning (45). Daniel's normal functioning here is similar to Sen's idea of functionings. Capability and fair equality for opportunity aim to promote normal functioning.

Karen's story illustrates the absence of fair equality of opportunity. Karen was never given fair equality for normal functioning because she was not given the opportunity to engage in school, a life free of abuse, or provided safety. Much of her life was damaged and uncertain. Her early home life afforded her no opportunity to think more of meeting more than just her most basic needs. She did not have the ability even to think of possibilities for her future when she was not provided the most basic of opportunities. We can see that she was not given fair

equality of opportunity to function normally, which resulted in her homelessness. Her mental illness and use of alcohol to self-medicate only further robbed her of opportunities.

There are some extremely vital capabilities, which Sen refers to as basic capabilities (Sen, 40). These can be used to assess and measure the degree of poverty from which people are suffering. Poverty, viewed from the capability approach, can be thought of as the inability "to reach minimally acceptable levels of basic capabilities" (Sen, 41). The capability approach provides a standard through which to judge what should be done for certain people. If the homeless mentally ill are viewed from this perspective, it is clear that they lack basic capabilities, including shelter, adequate nutrition and hygiene, and proper mental health. They are also lacking a variety of other capabilities including the ability to engage in society and gain self-respect, among others. As in Karen's case, they are not given the capability to seek housing, find employment, and live a productive life, as measured by society, so it is necessary to restore their capability to do these things. For example, a person suffering from a mental disorder may be stigmatized by her family and lack therapeutic treatment, which might make that person unable to pursue an education and a career. Lacking these capabilities, that person may not adequately provide for their basic needs like housing and food. This person must be given the capability to have opportunities restored in order to provide for her basic needs. Therefore, it is the responsibility of society to aid her in doing this.

Daniels refers to pathologies that might inhibit individuals, one of which is mental illness. The mentally ill have brains that "deviate from normal functioning" (Daniels, 37). For fair equality of opportunity to be restored to the homeless mentally ill, both mental illness and homelessness must be treated. There are also the issues with self-respect and social skills in this population. Daniels calls these social determinants (42). Social determinants contribute to the

main problems of homelessness and mental illness. They include education, employment, and mental health treatment. Fair equality of opportunity means also treating these social determinants (Daniels, 42). One important example of a social determinant that greatly effects the interaction between homelessness and mental health is housing. These social determinants affect capability. Karen experienced many of the social determinants of homelessness, including ability to find and maintain housing, availability of treatment, education, employment, and social support.

Remembering that substance abuse and mental illness among the homeless are highly comorbid is a reminder that there is a choice, to some degree, for a person to choose to engage in self-harming behaviors. For example, a girl may have grown up living with an alcoholic mother and started drinking her mother's alcohol at a very young age. This girl might develop a substance use disorder because of her unhealthy environment and the fact that she might be predisposed to do so. Sen specifies that people may *choose* from a set of functionings (Sen, 31). People will choose different sets of functioning out of those available and some people will not use that choice as well as others (Beckley, 113). Are we to say she is not deserving of help because she made the wrong choice? One of the factors that affect equality of opportunity, as stated by Beckley (108), is it "holds each person or family responsible for translating this possibility into an achievement by reciprocating what society provides." Essentially, a person may be provided with the capability to choose from a valuable set of functiongs and waste that opportunity by abusing substances, but if we view the girl described above with this idea in mind we see that she was lacking capability long before she "chose" to abuse alcohol. Therefore the girl's decision to abuse alcohol appears to be less of a choice and more a product of her lack of capability. After all, she had no other form of refuge and grew up in a situation that could have

only served to exacerbate her ability to withstand drinking. She would likely then be stuck in pattern that allowed no capability or opportunity very early in life. If she was given the opportunity to be treated for her substance use disorder and squandered it, what should be done? Beckley recognizes that bad decisions may produce an array of harmful effects to a person, including development of bad habits, guilt, and loss of self-efficacy, which all work together to inhibit a person's capability (126). Like the girl, many homeless mentally ill people may know no other way of life.

Beckley proposes that the best way to deal with poor decisions, which cause the squandering of capabilities, is to keep in mind how failure can negatively affect a person (Beckley, 126). Remember the girl described above. Even if she had squandered her opportunity for capability through treatment, she was then left with no capability for normal functioning. Her failure would only serve to deplete what little opportunity she had, if any. The negative effects of failure only make it less likely that she would seek treatment, housing, employment etc. Therefore, it is necessary to care for the negative consequences of failure in order to assure the girl capability of normal functioning (Beckley, 129). Although some homeless mentally ill people may originally be at fault for their conditions, they would not then have the capability to pursue new functioning due to the negative consequences of failure. Thus, society must allow for renewal of their capability, as it is a necessary step to once again providing them with normal functioning (Beckley, 129).

Many mentally ill homeless people suffer from pathology and do not have fair opportunity for normal functioning. They need to be provided with it. It is important to remember that the homeless mentally ill have limited choice and frequently choose to squander what little capability they have through drug abuse. This is not a reason to discredit their need for

society's help in providing capability. Beckley's concept allows "renewal of capability" for those who have squandered it because they do not have capability to pursue new functioning. We should also consider the social determinants of homelessness and mental illness to better understand the treatment that is necessary to improve the capability of the homeless mentally ill. Some of these are more obvious like housing, while others are less obvious and harder to deal with like stigma. Nonetheless, each social determinant that significantly affects the homeless mentally ill must be addressed to adequately restore their ability to function normally.

Social Determinants

Housing

Between the 1970s and 1980s availability of low-income housing began falling significantly, with a decrease from 1.6 million low-income housing units to 1.1 million units in 12 of the 20 largest cities in America (Devine, 168). This occurred through gentrification, loss of "flophouse hotels" which served the most needy people in the population, arson, and abandonment (Devine, 168). In the same 12 cities during the same time period, the number of impoverished people grew from 2.5 to 3.4 million (Devine, 168). There were fewer housing options and even fewer options that were equipped to deal with the problems of the mentally ill. The decline in supportive housing availability and increased poverty rate was one factor that led to an increase in the homeless population. Along with the underlying structural issues, the mentally ill had an added challenge. As a result of their illness, many have cut familial ties, suffered from unemployment, and lacked other social connections (Devine, 168). The comorbidity of mental disorders and alcohol abuse only serves to exacerbate these issues.

Structural approaches to poverty, which simply targeted improving housing throughout the 1980's and 1990's with the use of low-income high-rise apartments, were inadequate for

dealing with the root causes of homelessness among the mentally ill (Devine, 620). These simply focused on housing instead of focusing on other very pertinent issues like mental health and drug abuse, which also needed to be treated in order for individuals to obtain secure sustainable housing. Neither mental illness nor drug abuse nor housing issues alone cause homelessness, which is why it is important to target the treatment of all three of these in a housing plan (Devine, 620).

Unfortunately, the most common way of housing all homeless people in America today is through shelters with over half of the homeless population utilizing emergency shelters as a form of housing (Gilmer, 645). These shelters were originally designed for short stays in emergency situations, but with the growing number of homeless individuals they expanded to become the main form of housing (Toro, 126). When people end up in homeless shelters they have often exhausted all other possibilities for housing (Meadows-Oliver, 132). Karen even preferred sleeping on the streets to sleeping in shelters because of the overcrowding, threats of violence and theft. Many cities devote most of their resources for treating homelessness to shelters (Bassuk, 1097). Shelters have rules that must be abided by and offer very little lenience or treatment for the homeless mentally ill (Meadows-Oliver, 133). For example, a homeless mentally ill person not receiving treatment in the standard homeless shelter could be denied access to shelter for breaking curfew. Curfew might be hard to maintain for somebody who is schizophrenic and having paranoid delusions. A shelter does not allow for this. Many shelters also have rules pertaining to drug use. If drugs are found in possession of a person, they are thrown out without the opportunity for treatment. This is not desirable for a homeless mentally ill person lacking the capability to seek treatment for mental illness and drug abuse. Although lack

of housing is a vital component that affects the capability of the mentally ill homeless, alone it cannot promise that they will maintain a permanent home.

Substance Abuse

The mentally ill homeless are at higher risk for substance abuse even when compared to the mentally ill housed (Sullivan, 446). They are twice as likely to abuse alcohol and six times as likely to abuse drugs compared to mentally ill people who are not homeless (Sullivan, 446). One study, conducted in an effort to determine the primary causes of homelessness among the mentally ill, found that substance abuse was a crucial predictor of homelessness (Schutt, 135). This study randomly assigned people living in homeless shelters to live in group homes or independent apartments. The only condition on the situation was that their behavior could not interfere with their own or others' welfare (Schutt, 136). This study supported previous literature that shows having been diagnosed with both a mental disorder and substance abuse predicts a poorer prognosis than one condition alone or the absence of both conditions (Schutt, 135). Substance abuse can also have negative effects on income that contributes to an even poorer prognosis. In another study, the average participant spent 600 dollars per month on drugs or alcohol (Devine, 624). Although it may appear that the people using 600 dollars per month on drugs are essentially squandering their capability, the income the same people receive is largely a result of drugs (Devine, 624),

Substance abuse treatment has been found to greatly improve the outcomes of the homeless mentally ill, but many do not have access to it (Folsom, 374). It is also much more difficult to get homeless mentally ill people to access treatment when compared to people who are only homeless (Folsom, 374). Substance abusing mentally ill participants are more likely to refuse treatment by clinicians for their condition, which significantly predicts housing loss

(Schutt, 136). In fact, one study found that despite variability in human capital among the homeless mentally ill, substance abuse was able to make individuals equally disadvantaged in terms of homelessness (Devine, 629). For example, one might predict that a homeless mentally ill person with higher income, better education, job history, and skills would have a better prognosis and might only remain homeless for a short time when compared to a person without those qualities. If that person abuses substances, those qualities were found to no longer benefit the person in ways we might expect. Substance abuse essentially removed the benefits these things would normally have for an individual and made their prognosis similar to that of a homeless mentally individual who did not have those benefits (Devine, 629). This illustrates the inappropriateness of providing housing without treatment. Left untreated, the homeless mentally ill cannot use their various skills to their advantage. Despite possibly having job history, skills, and education, they will not be able to utilize these without treatment, nor can they gain the capability to acquire these things if they do not already have them. Housing alone cannot account for this need.

Early Life Stressors

When homeless mentally ill people are compared to homeless people lacking mental illness, they have experienced about the same amount of childhood poverty, but the mentally ill group experiences drastically more instability in family life (Sullivan, 446). This is one reason the homeless mentally ill require different treatment than the segment of the homeless population who simply experience homelessness due to lack of availability of housing or employment. Karen experienced instability and violence to an extreme degree. It is not surprising that twice as many homeless mentally ill people experienced regular physical or sexual abuse compared to the population lacking mental illness, and more than half of the mentally ill population had either a

mentally or physically disabled caregiver (Sullivan, 446). Twenty-five percent of the homeless mentally ill were also placed in either foster care or institutionalized (Sullivan, 446). In fact, in this study the homeless mentally ill had "significantly higher scores on every indicator of childhood family instability and violence or abuse used" when compared to housed mentally ill people and homeless people without mental illness (Sullivan, 448). In general, troubled family relationships occur significantly more among mentally ill people across many situations including homelessness (Toro, 447). It is sometimes difficult to tell whether the family situation has contributed to the mental illness or the mental illness has contributed to the family situation. Either way, capability is diminished because of early life stressors. These stressors contribute to the existence and severity of mental illness, substance abuse, and housing instability. Karen abused alcohol to escape the trauma early life stressors produced, and used it as a means of self-medicating her mental illness, which was made worse by these stressors.

Stigma

The homeless mentally ill are typically unwashed, unkempt, behave in odd ways, and communicate in ways that deviate from normal behavior (Bassuk, 7). These things generally make people uncomfortable and afraid (Bassuk, 7). The homeless mentally ill must rely on others for much of their treatment and support, which only serves to make many people very judgmental about the population (Bassuk, 7). This is especially true because many people view mental illness as something that can be controlled individually. We see an example of this in the case of deinstitutionalization. Although the mentally ill were supposed to return back to their communities for treatment, many communities were both unable and unwilling to accept them in their neighborhoods (Bassuk, 11). Even though many of these same communities supported deinstitutionalization, they were not willing to accept the mentally ill as neighbors (Bassuk, 11).

The homeless mentally ill "evoke strongly negative attitudes in others" (Bassuk, 11). Surprisingly, this is not an attitude that simply pertains to the nonmedical public. It is seen among mental health professionals who often cannot "cure" the mental illness because it is a life long condition (Bassuk, 12). The professionals are taught to focus on curing and give less priority to long-term illness, which takes much more effort to treat (Bassuk, 12). The fact that the homeless mentally ill are often either negative or passive about their treatment does not help the rapport between the doctors and their clients (Bassuk, 12).

Unfortunately this stigma also affects family relationships. Many homeless mentally ill people are disconnected from their families and social supports, and this could be largely due to effect of stigma on their relationships (Toro, 448). This stigma can also prevent the homeless mentally ill from achieving employment. After all, Karen was homeless for years before finding treatment. If this population was not so stigmatized, she would have found the help she needed much sooner. In fact in my interviews with homeless men, some suffering from mental illness in a New York City Shelter, most of the men reported people looking down upon them with disgust and being unable to contact family because of the shame associated with their situations (Bowery Mission, 2012). Stigma is also a factor that prevents the homeless mentally ill from attaining critical services like housing. In one study, a homeless mentally ill woman reported that landlords were more likely to turn her away if they knew of her mental illness (Tsai, 384).

Public Assistance

One study found that an important risk factor for homelessness was long waiting periods for government benefits (Tsai, 384). During these long waiting periods, the homeless mentally ill may not be in contact with assistance providers or have addresses to send checks to, which could prevent them from obtaining benefits. In another study, about two-thirds of the homeless

mentally ill were receiving no form of public assistance (Devine, 626). Forms of public assistance like Temporary Assistance for Needy Families, a governmental cash assistance program, have work requirements, which are unrealistic for many of the homeless mentally ill (Nurrborck, 719). This is also only an option for people with dependents, which many of the homeless mentally ill, like Karen, do not have (Nuttbrock, 719). Unfortunately, because many homeless mentally ill people do not have employment, they are not eligible for the Earned Income Tax Credit, which helps many low-income individuals survive (Toro, 127). Another issue that prevents the homeless mentally ill from receiving benefits is that they are not eligible to receive Social Security Income (SSI), a form of governmental assistance for disabled people, if they are abusing drugs (Nuttbrock, 719). SSI is a vital form of public assistance for the homeless mentally ill because it targets people with disabilities like mental illness, but is not frequently used by the homeless population (Sun, 26).

Medicaid, a federally funded health service provider for low-income people, is also particularly important for the homeless mentally ill. One study found that the people who did not receive Medicaid were two times as likely to be homeless when compared to those that did receive these benefits (Folsom, 374). Of this population, people with mental illness had trouble completing the requirements to receive benefits and keep them (Folsom, 374). The homeless mentally ill have nobody who can connect them with the necessary tools and information needed to procure these benefits, and in their debilitated state they cannot go out and seek them on their own (Sun, 26). They also often view conventional medical care providers as inaccessible (Nuttbrock, 719). Medicaid is likely one of the most helpful forms of assistance to the homeless mentally ill because it would provide them with an opportunity to treat their mental illness, which is a huge barrier that prevents them from accessing housing.

Governmental assistance programs are also monitored and many homeless mentally ill people have trouble scheduling interviews and filling out the necessary paperwork to retain benefits if they are able to gain them originally (Nuttbrock, 719). This population has similar difficulties when seeking employment. Another study found that homeless mentally ill people were less likely to receive food stamps and housing assistance when compared to homeless people without mental illness because of the difficulty they experience receiving and maintaining services (Nuttbrock, 721). This study also found that one fifth of the homeless mentally ill lost benefits when they received their follow up interview, and the average amount of benefits declined among those who were receiving them upon the follow up (Nuttbrock, 721). Unfortunately, it is very difficult to obtain housing, health care, employment, and have the opportunity for normal function in a community if the homeless mentally ill are not utilizing these services (Nuttbrock, 719).

Treatments

It is important to explore the best method of upholding capability by addressing the social determinants that contribute to homelessness among the mentally ill. The most effective means of treating the homeless mentally ill is an ethical concern because we have determined that they are deserving of society's help and helping them will benefit society as a whole.

Housing First

This model of providing housing for the homelessness mentally ill is unconventional because it does not require that they are abstinent from substances or receiving treatment for mental illness or substance use disorders (Gulcur, 214). Conventional methods of providing supportive housing for the homeless mentally ill operate on the Continuum of Care approach (Gulcur, 215). This approach consists of transitional housing and other community living settings

where rules about sobriety and participation in treatment are set forth (Gulcur, 215). Participants must be drug free and have their psychological symptoms managed before entering the program (Burt, 214). The Housing First model also integrates the homeless mentally ill into the community placing people in housing in various neighborhoods (Gulcur, 214). Treatment is offered if the client chooses to utilize it and clients can access it off-site (Gulcur, 214). They are provided with a treatment team and community support (Gilmer, 646).

The idea behind Housing First is that the homeless mentally ill must move beyond the survival mode of seeking basic necessities like shelter to even begin to think about treating mental illness and substance abuse (Urban Ministries Center, 2012). While still seeking to survive on a day-to-day basis, the homeless mentally ill cannot focus on their addiction or mental health issues and seek treatment. Housing with the availability of these treatments is necessary first. This differs from the shelter approach, which is not adequate because it does not provide a method of obtaining sustainable housing through treatment. Shelters also have rules and regulations about drug use and mental health that are not imposed upon the homeless mentally ill in the Housing First approach. Housing alone is not adequate to address the needs of this population, which is not recognized by the shelter approach. Housing in the Housing First program is essentially "viewed as a necessary but not sufficient step toward independent living" (Henwood, 81).

This has found to differ significantly from treatment first programs in that the treatment first programs have pressure to focusing on housing, and Housing First is focused on treatment of individuals who are already housed (Henwood, 83). Treatment First could be detrimental because it may cause providers to overlook the issues of treating mental illness and addiction in pursuit of housing when treatment is necessary to procure permanent housing (Henwood, 83).

This form of treatment also places value on people who are "worthy" to receive housing because of their sobriety (Hennwood, 83). This is not consistent with the capability approach, which says that the homeless mentally ill may not have the capability to remain sober because of a variety of social determinants including housing. Housing is a necessary social determinant for treatment of mental illness and addiction. Although Housing First may be a controversial approach it appears to be effective. One study found Housing First reduced time spent homeless by 68 percent (Gilmer, 650).

Stigma

Another study found that The Housing First approach predicted higher psychological and social integration when compared to the Continuum Care method (Gulcur, 223). Psychological integration is the level of belonging an individual feels he or she shares with the community, and social integration is the amount of interaction a person has with people in their community (Gulcur, 212). Higher social and psychological integration have been associated with less negative symptoms of mental illness and greater likelihood of maintaining housing (Gulcur, 213). The increased sense of autonomy homeless mentally ill individuals have due to receiving and maintaining housing in a normal residential community without restrictions placed on them has been shown to increase well-being and feelings of fitting in with the community (Gulcur, 225). Thus this model is effective in both treating mental illness and reducing the impact of stigma. Simply having housing seems to be an effective tool to reduce stigma (Gulcer, 225). This is likely due to that fact that people are not sleeping on the streets openly confronting their issues with substance use disorders and mental illness. Because of this, others do not look down upon them.

Employment

When the homeless mentally ill receive housing through Housing First they can then begin to address various issues that contribute to their situations such as substance use disorders, mental illness, employment and education. These programs typically also offer a wide variety of services including: case management, job skills training, mental health treatment, substance use therapy, and support to retain housing and employment (Burt, 215). Employment specifically is vitally important to the homeless mentally ill, as one study found that being employed or having work history reduced time spent being homelessness (Sun, 26). Case managers are typically assigned to people utilizing Housing First and help them to prepare for jobs including learning things like interview skills and connecting them with work centers that have information on job availability (Burt, 210). These case managers can similarly help the homeless mentally ill to connect with GED programs and with resources for studying and taking the GED, which improves employment opportunity (Burt, 215).

Some Housing First programs have a person solely responsible for promoting employment among their clients (Burt, 210). This employment specialist not only works to allow a person to gain employment, but also helps to sustain it (Sun, 27). This includes providing work uniforms, skills, ability to apply to competitive jobs, and long-term support (Burt, 210). This person is most effective if she works in cooperation with substance use specialists and mental health professionals to develop a plan for employment that best suits the homeless mentally ill individual (Sun, 27). This person should also help to deal with issues of lacking self-efficacy and connect with other treatment plans (Sun, 27). When the homeless mentally ill participate in these programs that specifically target their issues, they are able to maintain housing and employment despite their disabilities (Burt, 215).

Public Assistance

One study found that only 11 percent of the eligible homeless mentally ill receive Social Security Income and only 8 percent were receiving Social Security Disability Insurance (Sun, 26). Luckily, case managers in Housing First programs have the information to connect the homeless mentally ill with the necessary services (Sun, 26). They can help with the application process, the retention of benefits, and general knowledge through a program called The SSI/SSDI Outreach, Access, and Recovery from The Substance Abuse and Mental Health Services Administration (Sun, 26). It specifically gives caseworkers the knowledge necessary to connect their clients with these services (Sun, 26). This program has increased the percentage of eligible homeless mentally ill utilizing these benefits from 10 to 15 percent to 71 percent in the states where it has been implemented (Sun, 26). This program also reduced time waiting for benefits to process by nearly half (Sun, 26).

Mental Health and Substance Abuse Treatment

Housing First also includes providing tools for diagnosing and treating mental illness and substance use disorders (Burt, 210). This can be done through a variety of ways. One method of doing it is through Assertive Community Treatment (ACT). ACT is typically state funded, and used for severe cases of mental illness, which may be necessary for the homeless mentally ill population (Sun, 30). It includes service that is available for 24 hours per day, working with all needs of the person including housing and case management, involvement in a community of peers, and realistic and rigorous care (Sun, 30). ACT has been shown to decrease time the homeless mentally ill stay in hospitals, increase time spent in housing, and improve the symptoms of the mental illness and substance use (Sun, 30). In fact, ACT reduces hospital stays by 58 percent when compared to simply case management treatment and 78 percent when compared to outpatient treatment (National Alliance on Mental Illness, 1). In one study, ACT

reduced mentally ill peoples' stay in jails by 78 percent and use of hospitals by 89 percent, which saved the state 1.114 million dollars in a year (National Alliance on Mental Illness, 1). Although this may not be necessary for all of the homeless mentally ill, it has been shown to treat them more effectively than case management from a clinical standpoint (Sun, 30). It does require a degree of personal commitment because it is such an intensive therapy, which might not be present in many of the homeless mentally ill.

Another effective method of treating the homeless mentally ill is through the use of Modified Enhancement Therapy (MET) (Sun, 30). The first step necessary for this treatment is for the practitioner to form a empathetic bond with the client that ensures the client that stigma and lack of self-efficacy will not prevent treatment (Sun, 31). The next step entails educating the person about his disorder and facilitating compliance with necessary medication, which can be difficult in this population because the homeless mentally ill are more susceptible to mistrust and denial when required to take medication (Sun, 31). They also often self-medicate with alcohol or have difficulty maintaining a schedule, which is why psychoeducation is vital to their understanding of why it is important to take their medication (Sun, 31). This therapy is also able to help by making medication requirements simpler, frequently discussing compliance, and helping to encourage others to be involved with the process (Sun, 31). MET also utilizes small goals like reducing alcohol consumption rather than total abstinence because mental illness contributes to difficulty processing cognitively (Sun, 31). Practical steps are also taken to ensure knowledge is retained and daily tasks are managed like creating checklists and providing the homeless mentally ill with opportunity to practice the skills they learn frequently (Sun, 30). MET has been shown to decrease negative symptoms of mental illness and substance abuse, while increasing time spent in therapy thus saving money on jail stays and emergency room visits (Sun,

30). This may be a more effective means of treating the homeless mentally ill who do not have severe cases of mental illness when compared to ACT because it does not require a high level of commitment and has been proven effective for people who have low motivation to alter their lifestyle (Good Therapy-MET, 1). For those with severe mental illness and addiction problems, it is not as intensive as ACT and may not be as effective.

The most widely used method of treating the homeless mentally ill is with modified Cognitive Behavioral Therapy (Sun, 30). This method is founded on being able to recognize feelings, surroundings, and behaviors that trigger desire to use drugs or increase negative psychological symptoms (Sun, 32). This treatment can only be offered when homeless mentally ill people have their symptoms managed, and it is also founded on a relationship with the practitioner (Sun, 32). This method takes time as it begins very slowly with building trust and allowing the homeless mentally ill person to understand triggers and receive education on their disease (Sun, 32). When the person has learned her triggers she can then begin learning skills to cope with them as long as the skills are not too complicated because the person may have been inhibited cognitively (Sun, 32). When coping skills are developed and used effectively the person is reinforced in an effort to improve their feelings of self-efficacy (Sun, 32). This method is commonly used to treat disorders and has been demonstrated to be very effective in reducing drug issues and improving mental health through reducing symptomatology (Son, 32). Its savings outweigh its costs by about 10,000 dollars per person (Department of Health-Drug Misuse Research Initiative, 5). In comparison to ACT and MET, it has been shown to produce very long lasting effects, but is very time consuming and requires that symptoms are managed enough to engage in therapy (Son, 32). Still, it is the most commonly used method out of the

three and receives the most support: therefore, it is more likely to be recognized a deserving of more government funding.

Cost Effectiveness

Housing First is also a far more cost effective means of treating the homeless mentally ill than leaving them to live on the streets. The costs of the utilization of emergency services, jails, inpatient programs, and drug abuse and mental health treatments for this population are astronomical (Gilmer, 645). In one study, Housing First was shown to reduce the probability of using emergency services by 20 percent, inpatient services by 11 percent, and justice system services by 20 percent, which accounted for 82 percent of the cost of the Housing First program (Gilmer, 649). The program does not entail a significant increase in cost and produces greater long-term benefits (Gilmer, 645). Another study found that homeless mentally ill individuals had average expenses of about 39,000 dollars per year because of their use of jails, emergency rooms, hospital stays, and use of shelters (Urban Ministry Center, 2010). Using Housing First and placing the homeless mentally ill into an apartment complex suited to meet their needs with staff to help them deal with mental health and addiction issues if they so choose to utilize them, costs about 13,983 per person annually (Urban Ministry Center, 2010). This housing includes case managers, mental health professionals, a nurse, and substance abuse professionals who are able to address the most vital social determinants to homelessness among the mentally ill. This is about 16,000 dollars in savings per mentally ill person placed in an efficient Housing First apartment complex (Urban Ministry Center, 2010).

Not only was this program more cost efficient, it improved outcomes for chronically homeless individuals in the domains of health, sobriety, and stabilizing psychotic symptoms (Urban Ministry Center, 2010). The homeless mentally ill also used outpatient services for

treatment far more frequently. They had an average of 78 more days out of a year of mental health treatment than those not utilizing Housing First (Gilmer, 649). This produces greater quality of life for the homeless mentally ill utilizing services including improved living situation, safety, daily activities, social relationships, leisure, health, family relationships and general life satisfaction when compared to currently homeless individuals (Gilmer, 650).

Treatment from an Ethical Perspective

Investment in the Housing First method, which incorporates treatment of the social determinants of homelessness among the mentally ill, satisfies the standards set forth by the capability perspective. It recognizes housing as a vital social determinant that is necessary for the homeless mentally ill to receive treatment for mental illness and addiction, which would prevent them from retaining stable housing. A mentally ill person suffers from pathology, which must be treated in order to assure capability for normal functioning. This cannot be treated without first meeting the basic needs of the person with housing. Karen would have had difficulty living on the streets and becoming sober or maintaining her psychological symptoms if she was not able to first meet her most basic of needs, which is why she was not able to begin treatment before being assigned housing. In providing Karen with housing, she has been provided with capability to begin treating the social determinants that contributed to her homelessness. Mental health and addiction treatment then provide her with the capability to work toward her GED and employment. All of these things together help to reduce stigma by rehabilitating the homeless mentally ill to engage in normal functioning. Although they may have made poor decisions, The Housing First perspective does not assign people "worthiness" for receiving housing. Poor decisions result in even less capability, therefore Housing First does make a social determinant

like housing contingent upon actions that the homeless mentally ill do not have the capability to fulfill.

This method is not only economically wise, but it has also been proven to improve housing outcomes specifically in people with serious mental illness (Gilmer, 646). Karen is able to demonstrate this. This was the type of housing being utilized by Karen when I met her, and provided her with the capability to accomplish things she had never been able to do. She is living in her own house in a neighborhood in Charlotte. She is working to obtain her GED, find employment, and actively treating her mental illness and addiction. She was also working toward retaining custody of the children she had living in North Carolina. Along with all of this, the Housing First model allowed her to regain confidence and re-enter society, while still frequently traveling to Urban Ministry Center to help the homeless people receiving services from their soup kitchen to overcome their problems. Housing First gave Karen the capability to end the cycle of homelessness and drug abuse in her family and prevent the same early life stressors to negatively impact her children further. This model provides a method for treatment and prevention that enhances capability for normal functioning.

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