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**Stuck on the Streets, But in Hope of a Home:  
The Long-Term Homeless**

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On my honor, I have neither given nor received any unacknowledged aid on this paper.

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One of the most extreme forms of modern-day poverty in the United States, homelessness has been steadily increasing in urban prevalence since the 1970's.<sup>1</sup> Although many people admit that homelessness is a problem in many of America's most prominent cities, fewer are willing to commit the time, money, and effort that would be necessary to address the problem and get people off the streets. This lack of attention is particularly disconcerting because homelessness is a complex problem in need of a multi-faceted solution. In order to create policies that are likely to be successful, the most significant causes and impacts of long-term homelessness in urban adult populations will be thoroughly examined. For this paper, long-term homelessness is defined as homelessness that is greater than one year in duration, and urban adult populations designate those groups of homeless individuals between the ages of 35 and 55 living in cities. This type of carefully defined target population increases the likelihood that new policies will have a positive impact on the long-term homeless. Although long-term homelessness occurs for a variety of reasons, the most significant causes for the defined population are substance abuse, chronic mental illness, and inadequate social services. Given these causes, the most practical and advantageous policy options to alleviate and diminish long-term homelessness in urban adult populations are the following: increased funding for construction of different low-income housing facilities, expansion of rehabilitation and mental health treatment centers, and improved accessibility to current social services.

Homelessness is not a new problem in the United States, and it steadily developed greater recognition as the number of homeless individuals continued to rise coming into the new millennium. In the 1980's and 1990's especially, the number of poor people who became

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<sup>1</sup> Robertson, Marjorie, and Milton Greenblatt, eds., *Homelessness: A National Perspective*, New York: Plenum Press, 1992, pg. 3.

homeless increased substantially.<sup>2</sup> Unfortunately, the poorest of the poor - many of whom are just barely able to meet their most basic needs - are at the highest risk for becoming homeless.<sup>3</sup> It is important to understand, however, that homelessness is a heterogeneous problem that affects various groups of people for different lengths of time and to different levels of severity.<sup>4</sup> These differences demonstrate why long-term homelessness is so difficult to treat and also explain how the number of homeless individuals in the United States has continued to fluctuate. Recent data demonstrates that some efforts to combat homelessness have been effective in major U.S. cities, but that the number of long-term homeless individuals could still be diminished from its current number through improved strategies.<sup>5</sup>

Nationwide estimates concerning rates of homelessness are broad in scope and controversial in nature, with figures ranging from 250,000 to over 3 million homeless individuals in the country.<sup>6</sup> Because the actual number is so contested, a specific target population ought to be defined before making any policy prescriptions for the homeless. A more specific definition of the target population will not only minimize wasteful spending, but also increase the likelihood that policies will produce beneficial results. In this paper, homelessness will be defined as the problem experienced by individuals who lack a permanent home and frequently end up living on the streets, in shelters, or in other make-shift and often temporary lodgings. Specifically, it examines individuals between the ages of 35 and 55 who have been homeless for more than a year in urban areas, determines the most significant causes of their homelessness, and proposes policies that are focused and practical in relation to these causes.

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<sup>2</sup> Timmer, Doug, D. Eitzen, and Kathryn Talley, *Paths to Homelessness: Extreme Poverty and the Urban Housing Crisis*, Boulder: Westview Press, 1994, pg. 11.

<sup>3</sup> Timmer, Doug, 1994, pg. 11.

<sup>4</sup> Robertson, Marjorie, 1992, pg. 4.

<sup>5</sup> "Chronic Homelessness Policy Solutions", *Chronic Homelessness Brief*, National Alliance to End Homelessness, March 2010, pg. 2.

<sup>6</sup> Robertson, Marjorie, 1992, pg. 3.

Although estimates of the number of adults experiencing long-term homelessness in urban settings often vary, the most recent available data shows that there are approximately 124,000 chronically homeless individuals in the United States.<sup>7</sup> From this total, approximately 60% are estimated to be between the ages of 35 and 54.<sup>8</sup> Therefore, roughly 74,000 individuals (possibly a few thousand less to account for the long-term homeless in rural settings) fit within the parameters of the previously defined target population. Even with all the difficulties and controversy in measuring the number of individuals who suffer from long-term homelessness in urban areas, it is safe to assume that around 70,000 individuals fit into the target population. This is because even if the estimate of 74,000 long-term homeless individuals seems high to some critics, any inflation in this estimate is buffered by the number of long-term homeless individuals who were not able to be counted.

We ought to remember, however, that numbers and statistics about homelessness should not overshadow the reality that individuals - each with his or her own story - suffer as a result of long-term homelessness. We should not become unduly focused on the numbers because they deflect us from the problem itself and the homeless themselves.<sup>9</sup> Programs and services should be in place so long as long-term homelessness exists; they should not be eliminated merely because the number of long-term homeless has appeared to go down. In fact, there will always be individuals in need of these programs and services since it would be impossible to permanently eradicate every case of long-term homelessness. Without these provisions for sustaining critical services, individuals suffering from long-term homelessness will become more hopelessly entangled in a way of life that is neither healthy for themselves nor advantageous to society. In order to best predict what types of provisions are necessary to minimize the number of long-term

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<sup>7</sup> "Chronic Homelessness Policy Solutions", 2010, pg. 1.

<sup>8</sup> "Chronic Homelessness Policy Solutions", 2010, pg. 1.

<sup>9</sup> Timmer, Doug, 1994, pg. 12.

homeless individuals, we must first examine the root causes of long-term homelessness in our target population.

First, substance abuse is a direct cause of long-term homelessness in urban adult populations.<sup>10</sup> This includes alcohol and drug abuse, or even a combination of the two in some cases. There is general agreement that approximately 30% of the overall homeless population suffer from substance abuse problems.<sup>11</sup> However, this percentage would be much higher among the target population defined in this paper since alcohol and drug abuse are factors that cause and perpetuate long-term homelessness.

Until the mid-1980's, alcohol was more commonly abused than other drugs among homeless populations.<sup>12</sup> This is because alcohol was the cheapest and also the most available substance to the homeless until that time, while other drugs were more expensive and harder to obtain.<sup>13</sup> However, all of this changed with the arrival of crack. During the mid-1980's, crack became widely available to individuals living on the street, and it was sold almost everywhere the homeless congregated.<sup>14</sup> Back in the 1980's, a single hit of crack cost around ten dollars, whereas today it can be found for as little as five or even three dollars.<sup>15</sup> Crack gives homeless individuals the opportunity to pursue highs that are similar to more expensive drugs, and these highs can be obtained daily if an individual is able to scrounge up the few dollars it takes to purchase a hit. Today, crack is just as popular as alcohol among the homeless who suffer from substance abuse, and this has only made treatment more difficult.<sup>16</sup>

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<sup>10</sup> Jencks, Christopher, *The Homeless*, Cambridge, Massachusetts: Harvard University Press, 1994, pg. 43.

<sup>11</sup> Jencks, Christopher, 1994, pg. 43.

<sup>12</sup> Jencks, Christopher, 1994, pg. 41.

<sup>13</sup> Jencks, Christopher, 1994, pg. 41.

<sup>14</sup> Jencks, Christopher, 1994, pg. 42.

<sup>15</sup> Jencks, Christopher, 1994, pg. 42.

<sup>16</sup> Jencks, Christopher, 1994, pg. 43.

Substance abuse is a root cause of long-term homelessness because of its detrimental effects on an individual's capabilities. For example, individuals addicted to alcohol or other drugs often have a difficult time maintaining their jobs or finding new ones when their old jobs are lost.<sup>17</sup> These addicted individuals also have a hard time obtaining and maintaining long-term housing. Substance abusers will sometimes spend money on alcohol or drugs instead of the rent or other necessities.<sup>18</sup> In addition, they have a difficult time managing the responsibilities that come with owning or renting a home. These difficulties with employment and long-term residence can often push already poor individuals onto the streets and into a lifestyle of long-term homelessness.

Being homeless and addicted puts individuals at an added disadvantage because there are not many outreach programs to help them, and they usually lack alternative support systems.<sup>19</sup> In many cases, drug and alcohol abuse results in broken support networks with family and friends.<sup>20</sup> Addictions can cause individuals to act in uncharacteristic ways and even betray the trust of people who care about them. When this happens, families and friends can sometimes react by withdrawing from the addicted individual, particularly when they feel that the individual needs to want to get help before any progress can be made. Without support networks from family and friends, addicted individuals lose a key safety net that might have prevented them from a homeless lifestyle.

Of course, drug and alcohol abuse can also be a factor that perpetuates long-term homelessness without being the original cause.<sup>21</sup> For instance, some individuals who become

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<sup>17</sup> Jencks, Christopher, 1994, pg. 44.

<sup>18</sup> Jencks, Christopher, 1994, pg. 44.

<sup>19</sup> Robertson, Marjorie, 1992, pg. 8.

<sup>20</sup> Jencks, Christopher, 1994, pg. 31.

<sup>21</sup> Hombs, Mary, *American Homelessness*, Santa Barbara, California: ABC-CLIO, 1990, pg. 38.

homeless did not start out with a drug or alcohol problem. Rather, the initial reaction to being homeless was to turn to drugs or alcohol as a coping mechanism or an outlet to escape the reality of their situation. In these cases, individuals who might have only been homeless in the short-term develop addictions that keep them on the streets for the long-term. Substance abuse is a difficult problem to treat, especially because addicted individuals have to want to overcome their problems in order for treatment to be successful and for relapse after treatment to be a minimal possibility.<sup>22</sup> This complexity of treatment and the lack of treatment options currently available have allowed substance abuse to continue causing and perpetuating long-term homelessness.

Second, chronic mental illness is a significant cause of long-term homelessness in urban adult populations. The main mental illnesses that cause homelessness are schizophrenia, major depression, and bipolar disorder.<sup>23</sup> Of course, other disorders can lead to homelessness, but these are the most prevalent. Overall, it is estimated that around one-third of all homeless individuals suffer from some form of chronic mental illness.<sup>24</sup> Again, this percentage would be much higher among the target population because chronic mental illness is a factor that causes and perpetuates long-term homelessness.

Chronic mental illnesses, particularly the top three that cause long-term homelessness, are difficult to treat. Even when treated, these mental illnesses can cause later problems if an individual relapses or fails to take the proper medication.<sup>25</sup> Schizophrenia, for example, is a mental illness that often causes individuals to hallucinate or hear voices.<sup>26</sup> Paranoia and severe distrust of others is also associated with different forms of this mental illness.<sup>27</sup> Major depression

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<sup>22</sup> Hombs, Mary, 1990, pg. 43.

<sup>23</sup> Hombs, Mary, 1990, pg. 43.

<sup>24</sup> Hombs, Mary, 1990, pg. 43.

<sup>25</sup> Hombs, Mary, 1990, pg. 43.

<sup>26</sup> Jencks, Christopher, 1994, pg. 26.

<sup>27</sup> Jencks, Christopher, 1994, pg. 26.

is another debilitating mental illness where individuals often lack motivation to get through the day and have low feelings of self-esteem.<sup>28</sup> Bipolar disorder, although not as prevalent as schizophrenia and major depression among the long-term homeless, is characterized by severe mood swings with intense ups and downs.<sup>29</sup> Spontaneous decision-making is also a product of this mental illness, which can lead to decisions that negatively affect individuals for the rest of their lives.<sup>30</sup>

All three of these mental illnesses make it very difficult for individuals to obtain or maintain jobs. It is equally as difficult for them to keep long-term housing, function regularly within society, and maintain support networks with family and friends.<sup>31</sup> Schizophrenia, for instance, usually affects individuals during their late teens to early thirties if not for their entire lives; this means that most individuals suffering from schizophrenia are most vulnerable during the years at which they are expected to grow independent from their parents, get a higher education, receive job skills, and ultimately get employed.<sup>32</sup> Schizophrenia, as well as bipolar disorder, can also be associated with periodic episodes of violence or breakdown.<sup>33</sup> This can create tension between individuals suffering from chronic mental illness and the people who care about them. Severe depression, on the other hand, is a very constant feeling of helplessness and decreased motivation to fulfill everyday responsibilities, such as making the rent payments or getting to work on time.<sup>34</sup>

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<sup>28</sup> Belmaker, R.H., and Galila Agam, 2008, "Major Depressive Disorder," *The New England Journal of Medicine* (358): 55-68.

<sup>29</sup> Calabrese, J.R., R.M. Hirschfeld, M.A. Freed, and M.L. Reed, 2004, "Impact of Depressive Symptoms Compared with Manic Symptoms in Bipolar Disorder," *Journal of Clinical Psychiatry* (11): 1499-1504.

<sup>30</sup> Calabrese, J.R., R.M. Hirschfeld, M.A. Freed, and M.L. Reed, 2004, pgs. 1499-1504.

<sup>31</sup> Jencks, Christopher, 1994, pg. 31.

<sup>32</sup> Chapman, James, 1966, "The Early Symptoms of Schizophrenia," *The British Journal of Psychiatry* (112): 225-251.

<sup>33</sup> Chapman, James, 1966, pgs. 225-251.

<sup>34</sup> Belmaker, R.H., and Galila Agam, 2008, pgs. 55-68.



For individuals with these chronic mental illnesses, the risk of losing their homes and jobs to lives on the street is further heightened by the common breakdown of support networks from family and friends.<sup>35</sup> Because individuals with these illnesses are so difficult to treat, families and friends are often at a loss for what they can do to help. In some cases, individuals can intentionally pull away from their families and friends; this is characteristic of paranoid schizophrenia and sometimes major depression.<sup>36</sup> In other cases, such as with schizophrenia and bipolar disorder, families and friends can become the victims of violent episodes. In all of these cases, families and friends are distanced from their loved ones, who are brought closer to independent lives on the streets because they do not have safety nets when they experience failure at remaining employed or keeping permanent housing.

Although a less common phenomenon than with substance abuse, chronic mental illness can also be a factor that perpetuates long-term homelessness without being the original cause.<sup>37</sup> For example, major depression is a mental illness that individuals can develop in response to things that are happening in their lives, particularly crises.<sup>38</sup> Becoming homeless can be one of the crises leading to the onset of major depression, which only elongates the amount of time that individuals are likely to be stuck on the streets. This further demonstrates why chronic mental illnesses are a root cause of long-term homelessness.

In some cases, long-term homeless individuals suffer from chronic mental illness in combination with substance abuse.<sup>39</sup> These cases are particularly complex because treatment options are few and in between. There is generally disagreement over how these individuals should be treated and, in particular, which problem should be treated first. For example,

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<sup>35</sup> Jencks, Christopher, 1994, pg. 31.

<sup>36</sup> Belmaker, R.H., and Galila Agam, 2008, pgs. 55-68.

<sup>37</sup> Jencks, Christopher, 1994, pg. 23.

<sup>38</sup> Belmaker, R.H., and Galila Agam, 2008, pgs. 55-68.

<sup>39</sup> Hombs, Mary, 1990, pg. 43.

medications for the chronic mentally ill are usually not supposed to be taken in proximity with drugs or alcohol; on the other hand, mentally ill individuals need to be stabilized before they can begin to deal with a substance abuse problem that requires the ability to realize that a problem exists and want to get better.<sup>40</sup> Chronic mental illness and substance abuse in coalition limit treatment options and often compound one another as problems experienced by the long-term homeless.

Third, the social services currently available to assist the homeless are inadequate. Perhaps the most significant obstacle for the long-term homeless is the lack of sufficient low-income housing units in comparison to the high demand for those units.<sup>41</sup> Over time, demand for low-income housing has been steadily increasing, while the supply of low-income housing has stayed relatively the same.<sup>42</sup> Although greater efforts have been undertaken in more recent years to expand the number of low-income housing facilities, there is still a lot of room for improvement.<sup>43</sup> This is evident from the long wait lists for low-income housing that occur today.

Even when an individual is deemed qualified to receive low-income housing, the average wait period before housing can be received is two years.<sup>44</sup> This wait period is extremely detrimental to long-term homeless individuals, who often migrate from one place to another, lack a permanent address, and would be difficult to contact even if they got off of the two year wait list for more permanent housing.

There are several explanations for the supply and demand gap in low-income housing units. The inflation of the 1980's is often referenced as one source of decline in low-income

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<sup>40</sup> Hombs, Mary, 1990, pg. 43.

<sup>41</sup> Timmer, Doug, 1994, pg. 18.

<sup>42</sup> Timmer, Doug, 1994, pg. 18.

<sup>43</sup> "Chronic Homelessness Policy Solutions," 2010, pg. 1.

<sup>44</sup> Robertson, Marjorie, 1992, pg. 6.

housing.<sup>45</sup> During this time, the cost of housing at all levels rose rapidly without significant parallel changes in the subsidies available to individuals stuck on the streets but in search of more permanent housing.<sup>46</sup> In fact, the number of federally subsidized low-income housing programs decreased substantially in the 1980's during the Reagan presidency.<sup>47</sup> For example, the \$32.2 billion dollars spent in 1981 to support subsidized housing made the \$6 billion allocated in 1989 look inconsequential.<sup>48</sup> Amidst this inflation and decreased government support for subsidized housing, demand continued to rise for low-income housing. More recently, greater efforts have been made to reduce this supply and demand gap, but there is still significant room for improvement in these efforts. For example, it was estimated in 2000 that approximately 150,000 units of low-income housing were needed to combat chronic homelessness, but only 60,000 units have since been constructed.<sup>49</sup> That leaves a gap of at least 90,000 low-income units. Although there is a lack of data currently available, the recent recession has likely increased demand for low-income housing even more.

Even considering the low-income housing units that are currently available, the long-term homeless experience structural impediments to access that are not as much of a problem for other applicants. For example, applications for low-income housing often require a previous and/or current address.<sup>50</sup> This presents several problems to homeless individuals. On the one hand, the application for housing requires that the applicant remember a previous address (which was probably a very temporary one for an individual suffering from long-term homelessness). Also, the application often requires that a current address be listed at which the applicant may be

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<sup>45</sup> Timmer, Doug, 1994, pg. 18.

<sup>46</sup> Timmer, Doug, 1994, pg. 18.

<sup>47</sup> Timmer, Doug, 1994, pg. 22.

<sup>48</sup> Timmer, Doug, 1994, pg. 22.

<sup>49</sup> "Chronic Homelessness Policy Solutions," 2010, pg. 3.

<sup>50</sup> Robertson, Marjorie, 1992, pg. 10.

contacted, but long-term homeless individuals, usually lacking the support system to even use the address of a friend or family member, do not have current addresses to provide when housing is exactly what they are pursuing.<sup>51</sup> These individuals might be able to list the names or addresses of homeless shelters, but there is no guarantee that they can be reached there in the future. Through these types of application requirements, current low-income housing programs virtually shun long-term homeless individuals from more permanent housing; consequently, the programs limit the ability of the long-term homeless to acquire a means by which to transition into a life with more opportunities for personal fulfillment.

Formal identification can also be a barrier for homeless individuals who are applying for low-income housing.<sup>52</sup> Individuals on the streets, due to factors such as substance abuse and chronic mental illness, are less likely to have some form of formal identification than other individuals seeking low-income housing.<sup>53</sup> Because homeless individuals are difficult to contact and keep track of, it is equally as difficult for them to apply for a new birth certificate, driver's license, or other form of identification that could be used for this application. It could take months just to get the identification that would allow a long-term homeless individual to get onto an even longer waitlist for low-income housing; few long-term homeless individuals have the capability to get through all of these processes, and life on the streets becomes the norm as a result for many of them.

Programs that provide healthcare services to the long-term homeless exemplify yet another area in which the long-term homeless are underserved. Aside from free clinics and shelter services that vary in availability depending on the area in question, long-term homeless individuals do not have many available options in terms of receiving healthcare services for

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<sup>51</sup> Robertson, Marjorie, 1992, pg. 10.

<sup>52</sup> Robertson, Marjorie, 1992, pg. 10.

<sup>53</sup> Robertson, Marjorie, 1992, pg. 10.

illnesses or other health issues that are not immediate emergencies.<sup>54</sup> Even the services that are currently available are unable to provide specialty care to long-term homeless individuals with unique needs.<sup>55</sup> Even now, the legislation for universal healthcare is in the process of being finalized before it can be implemented by the different states. Prior to this legislation and until it is implemented in full, individuals suffering from long-term homelessness would often resort to emergency treatment from hospitals or mental health facilities.<sup>56</sup> Being uninsured, these individuals were not able to receive healthcare that would prevent the onset or increased severity of various illnesses and health problems. This lack of progressive healthcare services to the long-term homeless would often lead to a slow build-up of the problem until the emergency room or another health facility was needed to treat an extreme case.<sup>57</sup> Not surprisingly, the treatment of these types of extreme cases in emergency rooms is quite expensive.

In fact, this method of dealing with health issues in relation to the long-term homeless is extremely costly to society because the long-term homeless are able to use healthcare services during emergencies, which often costs more than the progressive treatment that could have prevented the crisis.<sup>58</sup> It is estimated that the cost of providing emergency services can be as high as tens of thousands of dollars per year for an individual who is constantly cycling in and out of hospitals and mental health institutions.<sup>59</sup> This burden to society could be substantially diminished if the long-term homeless were presented with a greater range of less expensive treatment options to prevent health crises; simultaneously, the burden on the long-term homeless would be lifted if they were able to receive the types of progressive care that they are currently

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<sup>54</sup> Robertson, Marjorie, 1992, pg. 7.

<sup>55</sup> "Chronic Homelessness Policy Solutions," 2010, pg. 3.

<sup>56</sup> "Chronic Homelessness Policy Solutions," 2010, pg. 3.

<sup>57</sup> "Chronic Homelessness Policy Solutions," 2010, pg. 3.

<sup>58</sup> "Chronic Homelessness Policy Solutions", 2010, pg. 1.

<sup>59</sup> "Chronic Homelessness Policy Solutions", 2010, pg. 1.

lacking. Depending on how the pending universal healthcare legislation is implemented in different states, the long-term homeless may stand to benefit in terms of the non-emergency care they may be eligible to receive. In fact, the healthcare legislation that has been passed allows all homeless individuals to receive Medicaid insurance beginning in 2014.<sup>60</sup> In addition, a greater number of community-based programs will be implemented to target services to low-income populations, including homeless populations; this also has a tentative start date in 2014.<sup>61</sup> In the meantime, however, access to healthcare services continues to be a major problem for the long-term homeless, and outreach services to persuade the long-term homeless to take advantage of the available services are particularly lacking.

Besides general health services, mental healthcare has been a problem for the long-term homeless. Since the deinstitutionalization of many mental health services and the shut-down of many state facilities, there are fewer options available to the long-term homeless who suffer from mental health problems.<sup>62</sup> After the elimination of many direct mental health services for the homeless, there has been a lack of transitional programs for individuals leaving state mental health facilities and hospitals.<sup>63</sup> More often than not, the long-term homeless who suffer from mental illness do not have the resources or support systems to continue to cope with their problems after they have left a professional facility.<sup>64</sup> Unfortunately, many mentally ill individuals today who are homeless only receive treatment for their health problems after they reach extremes.<sup>65</sup> Even after long-term homeless individuals have been treated for extreme episodes of mental illness, few of them can afford to continue taking the necessary medicines or

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<sup>60</sup> Kaiser Family Foundation, *Side-by-Side Comparison of Major Health Care Reform Proposals*, modified March 24, 2010, <[http://www.kff.org/healthreform/upload/housesenatebill\\_final.pdf](http://www.kff.org/healthreform/upload/housesenatebill_final.pdf)>.

<sup>61</sup> Kaiser Family Foundation, *Side-by-Side Comparison of Major Health Care Reform Proposals*, modified March 24, 2010, <[http://www.kff.org/healthreform/upload/housesenatebill\\_final.pdf](http://www.kff.org/healthreform/upload/housesenatebill_final.pdf)>.

<sup>62</sup> Jencks, Christopher, 1994, pg. 31.

<sup>63</sup> Jencks, Christopher, 1994, pg. 31.

<sup>64</sup> Jencks, Christopher, 1994, pg. 31.

<sup>65</sup> "Chronic Homelessness Policy Solutions," 2010, pg. 3.

even maintain the self-discipline to take the required regimens at the proper times.<sup>66</sup> Without some form of subsidized facility, long-term homeless individuals who are beyond recovery in terms of their ability to readapt to society or find and maintain work will never be able to get the attention and stability that they need.

Rehabilitation programs are also limited in the specialty services that they can provide to the long-term homeless who suffer from alcohol abuse or drug addiction.<sup>67</sup> Currently, many cities have detox facilities that can be accessed by individuals looking to combat their addictions, and groups such as Alcoholics Anonymous work with multiple individuals together who want to rid themselves of bad habits. However, these types of services are not usually offered in direct correlation with homeless shelters that individuals frequent, and long-term homeless individuals are rarely targeted by existing programs.<sup>68</sup> This reduces the number of long-term homeless individuals who might participate and be helped by rehabilitation programs if they were offered in close proximity to housing programs. Moreover, many of the long-term homeless who suffer from drug or alcohol abuse need more than group therapy or short-term detox to overcome what have been long-term problems. However, one-on-one therapy and counseling are often not available to long-term homeless individuals who could significantly benefit from them.<sup>69</sup> Without easier accessibility to drug and alcohol rehabilitation programs that can address the complex needs of the long-term homeless, those individuals who fall within the target population will continue to live in a cycle of self-degradation on the streets and be unlikely to receive the help that they need to combat their addictions.

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<sup>66</sup> Jencks, Christopher, 1994, pg. 31.

<sup>67</sup> Robertson, Marjorie, 1992, pg. 8.

<sup>68</sup> Robertson, Marjorie, 1992, pg. 8.

<sup>69</sup> Robertson, Marjorie, 1992, pg. 8.

Based on this review of the factors that cause and perpetuate long-term homelessness in urban adult populations, there are several ways in which current policies can be reformed and new policies can be created to better serve those who are most in need. These primarily include the creation of more permanent housing facilities, expansion of rehabilitation and mental health centers, and increased accessibility to current social services. This combination of reforms would promote capabilities within the target population that would aid in diminishing long-term homelessness, but also prevent at-risk individuals from getting stuck on the streets in the future.

Above all else, one of the most immediate and important needs of the long-term homeless is permanent housing. After all, a stable and permanent residence is the base from which all other needs can be addressed for many of the long-term homeless.<sup>70</sup> A recently created subsidized housing program, called Housing First, espouses an ideology that recognizes the urgent needs of homeless individuals for housing. Housing First advocates for providing more stable housing to homeless individuals before mandating any treatment options for individuals suffering from substance abuse or chronic mental illness.<sup>71</sup> Housing First offers individuals the stability of a permanent residence without conditions making that stability dependent upon compliance with a set of rules or regulations.<sup>72</sup> This makes Housing First far less paternalistic than other housing programs currently available to the homeless, which in turn makes it a more attractive program for the long-term homeless who have historically been more reticent to take advantage of subsidized housing. Housing First is a particularly beneficial program for those long-term homeless individuals who are looking for more stability in their lives but are not at a stage where they can recognize their other problems - whether with drugs, alcohol, or mental health - and

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<sup>70</sup> Hombs, Mary, 1990, pg. 52.

<sup>71</sup> Stefancic, Ana, and Sam Tsemberis, 2007, "Housing First for Long-Term Shelter Dwellers with Psychiatric Disabilities in a Suburban County: A Four-Year Study of Housing Access and Retention, *The Journal of Primary Prevention* 28(3-4): pg.265.

<sup>72</sup> Stefancic, Ana, and Sam Tsemberis, 2007, pg.265.



begin dealing with them independently. Providing stable housing is the necessary first step towards pursuing help with these other problems and overcoming them successfully.

Of course, some critics would argue that a lack of conditionality on housing subsidies would create environments for blatant abuse of drugs and increased severity of other problems such as chronic mental illness.<sup>73</sup> Although Housing First is a relatively new program, there have been studies to compare the Housing First model with current housing models that place conditions on the behavior of their residents. One study, which took place in New York City over two years, demonstrated that there were no significant differences in alcohol or drug use between residents from the Housing First model and the treatment first model.<sup>74</sup> This evidence suggests that Housing First at least provides individuals who would otherwise be on the streets with increased stability.<sup>75</sup> In this way, Housing First residents can get closer to dealing with their problems than they would have been on the streets, and there is little chance that their problems will become significantly worse once they are provided with a home.

However, there will almost always be outliers within any group. Providing more permanent housing to some individuals without conditions may lead to disruptions in the housing environment from a select few cases for the greater majority of residents. For this reason, there ought to be a universal set of policies and procedures with the Housing First model so that residents who disrupt the stability of others and are unable to live independently without abusing the opportunity for permanent housing are removed from the Housing First facility. In some of these cases, disruptive residents who are experiencing an extreme breakdown and could be considered a threat to themselves or to others should be provided emergency support services

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<sup>73</sup> Padgett, Deborah, 2006, "Housing First Services for People Who Are Homeless with Co-Occurring Serious Mental Illness and Substance Abuse," *Research on Social Work Practice* 16(1): pg. 74.

<sup>74</sup> Padgett, Deborah, 2006, pg. 74.

<sup>75</sup> Padgett, Deborah, 2006, pg. 74.

until they are stable enough to be released from care.<sup>76</sup> However, this type of intervention should only be used in extreme cases in accordance with pre-written procedures so that an individual's free will is not violated without due cause - namely, the immediate and perceived threat to the individual or to others.

The Housing First model also creates a base around which other social services can be offered to residents. For example, providing housing to individuals who have previously been homeless allows for easier communication with caseworkers and more efficient delivery of SSI, SSDI, Food Stamps, and other benefits.<sup>77</sup> Besides these advantages, Housing First would also designate locations at which rehabilitation and mental health services can be offered to aid individuals who were previously homeless. Although Housing First does not engage in direct acts of paternalism, it would be possible to implement strategies of soft paternalism for the benefit of residents. In this manner, residents suffering from substance abuse or chronic mental illness could be persuaded and encouraged to take advantage of nearby services without being forced to do so upon receiving more permanent housing. This would be a huge step for many of the long-term homeless, who usually lack support systems and are hesitant to trust service providers. By increasing the visibility of service providers in Housing First areas and other places that the homeless congregate, individuals may be more likely to take advantage of the services being offered. Placing services in direct proximity to permanent housing for the homeless would also create an environment where service providers could begin to build relationships of trust with prospective patients.

Besides placing rehabilitative and mental health services in close proximity to Housing First facilities, future policies need to emphasize the importance of outreach to the long-term

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<sup>76</sup> Hombs, Mary, 1990, pg. 45.

<sup>77</sup> Hombs, Mary, 1990, pg. 45.

homeless. Even if Housing First facilities and other programs are able to get increased funding from the government, there is no guarantee that the long-term homeless will take advantage of them without corresponding outreach services. Historically, the long-term homeless have been the most difficult group of individuals to reach. Many of these individuals are not looking to get help or have had bad past experiences with service providers.<sup>78</sup> In these cases, outreach services could encourage homeless individuals to take advantage of Housing First. From there, other needs can be addressed over time.

Reforms and other new policies will also need to be developed in order to help the long-term homeless who are suffering from mental illness. One of the most important reforms that will be needed to make treatment efforts successful is increased coordination. Currently, there is not enough coordination between departments of local, county, and state governments in providing mental health services to the long-term homeless. For example, the development of supervised housing for the mentally ill involves a combined effort between the public housing authority (local or county level) and community mental health centers (county or state level).<sup>79</sup> However, relationships between these two departments are informal and lack established procedures for how the mental health centers can acquire and manage new supervised housing units for the mentally ill.<sup>80</sup> If we hope to offer the types of services that will be necessary to get the mentally ill off the streets, we first need to create greater cohesion between the departments and agencies that work together to institute them in our communities.

In order to create this cohesion, formal procedures should be written and adopted by different departments and agencies that work together to treat mental illness among long-term homeless populations. Through these procedures, communities will have a better understanding

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<sup>78</sup> Robertson, Marjorie, and Milton Greenblatt, eds., 1992, pg. 104.

<sup>79</sup> Robertson, Marjorie, and Milton Greenblatt, eds., 1992, pg. 71.

<sup>80</sup> Robertson, Marjorie, and Milton Greenblatt, eds., 1992, pg. 71.

of how to access the mental health services that they are currently lacking. In addition, these procedures will create increased transparency and accountability for the departments who are responsible for working with local communities to treat the mentally ill. These changes will make it easier for local communities to seek the resources and services that they need. Of course, easier access to mental health services will likely lead to increased demand for them from communities across the country. For this reason, eligibility criteria and a fair set of selection procedures will need to be created to manage this heightened demand, and greater levels of federal funding will likely be necessary to provide for those who meet the selection criteria. Funding needs will be dependent on how many community mental health centers apply for and are eligible to receive government-sponsored services.

Once coordination between departments and agencies has been achieved and access to services has been improved, there must be a re-evaluation of the types of services that are offered to the mentally ill in different communities. Mental health services designed to serve the chronic mentally ill who are homeless need to be made both accessible and attractive if they are to be utilized to their full potential. Because many homeless individuals with chronic mental illnesses are resistant to treatment, trust must be built within local communities by mental health providers.<sup>81</sup> This can be done through the use of outreach workers in local communities, potentially even including individuals who are or used to be homeless.<sup>82</sup> Outreach workers would work to form interpersonal, trust-based relationships with homeless individuals and start to persuade them of their need for help and of the legitimacy of local treatment providers.<sup>83</sup>

However, mental health services should not be forced upon homeless individuals. Treatment is not as likely to be successful in cases where the patients have not agreed to

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<sup>81</sup> Robertson, Marjorie, and Milton Greenblatt, eds., 1992, pg. 104.

<sup>82</sup> Robertson, Marjorie, and Milton Greenblatt, eds., 1992, pg. 105.

<sup>83</sup> Robertson, Marjorie, and Milton Greenblatt, eds., 1992, pg. 105.

treatment of their own free will. In fact, forced treatment could make the chronic mentally ill even more resistant to treatment in the future.<sup>84</sup> Instead, general assessment and care must be made available at places where homeless individuals congregate.<sup>85</sup> Teams of health providers should maintain a visible presence in soup kitchens and overnight shelters, possibly offering services like blood-pressure screening.<sup>86</sup> This could begin motivating homeless individuals to pursue additional health services. Treatment should only be forced upon an individual during times of extreme crisis, when the chronic mentally ill individual is a danger to himself/herself or others.<sup>87</sup>

When possible, long-term homeless individuals with chronic mental illness should be persuaded to accept stable housing before anything else. If individuals are resistant to pursuing treatment for their mental illness right away, then they could be placed in Housing First facilities where they could be encouraged to take advantage of other services. However, immediately providing the mentally ill with the same types of single, independent living arrangements that are given to other homeless individuals would not be ideal; these types of independent, unsupervised units are insufficient to meet the unique needs of the chronic mentally ill who have often been homeless for extended periods of time.<sup>88</sup> Rather, homeless individuals afflicted with mental illness should be encouraged to take advantage of progressive, step-wise style housing opportunities as they slowly work towards an independent living arrangement that will be

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<sup>84</sup> Robertson, Marjorie, and Milton Greenblatt, eds., 1992, pg. 104.

<sup>85</sup> Hombs, Mary, 1990, pg. 45.

<sup>86</sup> Robertson, Marjorie, and Milton Greenblatt, eds., 1992, pg. 105.

<sup>87</sup> Hombs, Mary, 1990, pg. 45.

<sup>88</sup> Hombs, Mary, 1990, pg. 44.

stable.<sup>89</sup> Studies have shown that organized and supervised living arrangements greatly improve the stability of the chronic mentally ill.<sup>90</sup>

After all, supervised housing for the mentally ill would ensure that they take the proper medications and have an address at which they can be reached to receive additional services.<sup>91</sup> This would be extremely helpful for individuals who have caseworkers and also for individuals who receive SSI, SSDI, Medicare, and Medicaid payments.<sup>92</sup> By first providing the mentally ill with supervised housing, they will be given a support system to help them pursue a more stable life. Given these benefits, mentally ill individuals should initially be provided with supervised group housing, progressively advance to smaller group homes, and finally be provided with individual apartments or homes when they are stable enough to care for themselves.

An additional advantage to group homes is that they provide an opportunity for chronic mentally ill residents to regain social capabilities. Socialization experiences and training in the skills of everyday living are vital in rehabilitating the chronic mentally ill to one day live independently in society.<sup>93</sup> Programs could be implemented within group homes to model the types of programs that are found in senior centers, for example.<sup>94</sup> This would create the type of social support network that many chronic mentally ill individuals lacked while they were on the streets. Besides in-house programming, managers of these group homes could also begin forging ties within the local community to continue expanding social support for residents. Buddy systems, rap groups, joint activity programs, and other group therapies are just a few of the

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<sup>89</sup> Hombs, Mary, 1990, pg. 44.

<sup>90</sup> Hombs, Mary, 1990, pg. 44-45.

<sup>91</sup> Hombs, Mary, 1990, pg. 44-45.

<sup>92</sup> Hombs, Mary, 1990, pg. 44-45.

<sup>93</sup> Hombs, Mary, 1990, pg. 45.

<sup>94</sup> Hombs, Mary, 1990, pg. 45.

possible ways for residents to become more socially involved in their communities.<sup>95</sup> Once positive support networks have been created, progressive transitions to independent living can occur more smoothly and with greater chances of success.

But even if and when a chronic mentally ill individual has advanced to independent living, he or she should still have access to the support network of mental health services described earlier. With chronic mental illnesses, possibilities for relapse always exist.<sup>96</sup> To ensure that individuals who have received mental health services and started living independently do not relapse, they need to have access to the same mental health services that helped get them off the streets. One of the keys to successful policy reform will be underwriting follow through procedures for individuals who have received mental health treatment. Once a chronic mentally ill individual has been treated and provided with housing, our institutions must do everything that they can to ensure that he or she does not fall back into an unstable lifestyle.

Similar to the chronic mentally ill, homeless individuals who suffer substance abuse problems also need to have access to services that meet their unique needs. Again, increased outreach will be key in getting addicted individuals to take advantage of rehabilitative services. If individuals could be persuaded to take advantage of Housing First programs, then they might be able to pursue drug or alcohol rehabilitation through the outlets that would be in close proximity to the housing facilities. For those individuals who decide to pursue treatment for substance abuse, there ought to be individual as well as group rehabilitative options for the patient's primary recovery.<sup>97</sup> Afterwards, there need to be sustained recovery services to prevent

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<sup>95</sup> Robertson, Marjorie, and Milton Greenblatt, eds., 1992, pg. 104.

<sup>96</sup> Robertson, Marjorie, and Milton Greenblatt, eds., 1992, pg. 69.

<sup>97</sup> Hombs, Mary, 1990, pg. 38.

against relapse and to continue developing capabilities for recovered patients to readjust to a more fulfilling life in society.<sup>98</sup>

In conclusion, long-term homelessness is a complex problem in need of a multi-faceted solution. Substance abuse, chronic mental illness, and lack of sufficient social services have all played a role in causing and perpetuating life on the streets for individuals in the target population. In order to diminish the current number of long-term homeless and prevent future at-risk individuals from getting stuck on the streets, new policies will be necessary to eradicate current weaknesses and develop new strengths. Increased outreach services will be necessary to reach the homeless. Greater funding is needed for permanent housing that follows the Housing First model as well as for progressive-style housing that implements treatment for substance abuse and chronic mental illness. Clearer coordination between different levels of government and service providers will be necessary to assess needs and implement these programs before problems become unmanageable in local communities. All of these reforms can make a real difference in the lives of individuals who need our support. Resisting reform will only perpetuate the cycle of long-term homelessness that has been allowed to plague our fellow citizens for too long.

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<sup>98</sup> Hombs, Mary, 1990, pg. 38.



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