



The Journal of Sociology & Social Welfare

Volume 17
Issue 4 *December*

Article 4

December 1990

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Recommended Citation

Linhorst, Donald M. (1990) "A Redefinition of the Problem of Homelessness Among Persons with a Chronic Mental Illness," *The Journal of Sociology & Social Welfare*: Vol. 17 : Iss. 4 , Article 4.
Available at: <https://scholarworks.wmich.edu/jssw/vol17/iss4/4>

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A Redefinition of the Problem of Homelessness Among Persons with a Chronic Mental Illness

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Two definitions of the problem of homelessness among persons with a chronic mental illness are examined, along with their implied solutions and ramifications for policy. Homelessness among this group is first viewed as the result of deinstitutionalization, and secondly, as the outcome of a critical shortage of low-income housing. Solutions stemming from the deinstitutionalization definition of homelessness, reinstitutionalization or improvement in the mental health system, are seen as inadequate to deal with the problem of homelessness among the mentally ill. Instead, state departments of mental health are called upon to provide a leadership role in the development of affordable housing.

How a problem is defined is a critical step in the process of solving that problem. Problem definition provides a framework within which certain activities are defined as solutions (Dery, 1984). This concept is useful in examining the various ways the problem of homelessness among persons with a chronic mental illness has been defined. Two definitions will be discussed along with the resulting solutions and the ramifications for policy.

The problem of homelessness among persons with a long-term mental illness is commonly defined as being primarily the result of deinstitutionalization (Jones, 1983; Lamb, 1984). By perceiving it in this manner, two possible solutions are forthcoming: reinstitutionalizing the chronically mentally ill or improving the mental health system involved in the deinstitutionalization process.

An alternative definition of the problem considers the critical shortage of affordable housing to be the foremost cause of homelessness among this group. This definition offers a solution outside of the exclusive domain of the mental health system, calling for increased low-income housing options.

The Incidence of Homelessness

The actual number of homeless individuals is uncertain. Estimates range from 250,000 to 3 million people. The number of homeless people having a mental illness is also unknown, with estimates ranging from 10% to 61% (Levine & Stockdill, 1986; Morrissey & Dennis, 1986). While estimates of the number of homeless people vary considerably, it is generally accepted that the number of homeless people, including the homeless mentally ill, has grown rapidly and steadily the past decade (APHA, 1985).

During this period of increased homelessness, there has been a large decline in the number of available low-income rental units. A study of 12 cities determined the number of low-income rental units decreased 30% over the last 10 years (Wright & Lam, 1987). The availability of public or subsidized housing is often not an option. In many cities the waiting list for such housing is so long, new applications are no longer being taken (Whitman, 1988).

Of particular importance in the examination of homelessness is the loss of many single room occupancy (SRO) units, a type of low cost housing frequently utilized by persons with a chronic mental illness (DHHS & DHUD, 1983; Hopper & Hamberg, 1984; Levine & Stockdill, 1986; Lipton, Sabatini, & Katz, 1983; Segal & Baumohl, 1980). Between 1970 and 1980, almost one million SRO units, one half of the total available were either destroyed or converted to other uses with few being replaced (DHHS, 1984).

Homelessness and Chronic Mental Illness Defined

It is essential to define homelessness and chronic mental illness, because in both cases, there is no clear definition that is consistently used (Bachrach, 1984; Levine, 1984). In a Department of Health and Human Services report (1984), homelessness is defined as both lack of shelter and the financial resources necessary to acquire it, and as a result, food and shelter are sought from public or private facilities. A broader definition of homelessness includes not only the lack of shelter and resources, but also the lack of community ties (Levine, 1984). For the purposes of this paper, this latter definition of homelessness is used.

The label "chronically mentally ill" actually refers to two rather different groups of people: the older client with a long history of hospitalization and the young adult chronic client generally considered to be between the ages of 18 to 35 years. In the past persons with a mental illness were considered to be chronic only if they had been institutionalized in a state mental facility (Bachrach, 1988). This definition had to be expanded because of deinstitutionalization. The vast majority of persons with a mental illness are now being treated in the community rather than being hospitalized for extended periods of time.

Unlike the older chronic client that is often seen as being passive and unmotivated, the young adult chronic client is usually characterized by medication noncompliance, drug and alcohol abuse, and frequent incidents of acting-out behavior. They are also often seen as misusing mental health services because they tend to seek out professional services when acutely ill, but then they do not complete the aftercare prescribed (Pepper, Kirshner & Ryglewicz, 1981). Although these two groups are dissimilar in some ways, they do share a commonality in that they have a major mental illness that is severe and persistent, and they need psychiatric services on a long-term basis (Bachrach, 1984).

For policy reasons, it is important to make a distinction between a person with a chronic mental illness and a person that exhibits psychiatric symptoms because of being homeless. There is considerable evidence that the stress caused by a temporary loss of shelter can produce psychiatric symptoms (Lipton, Nutt, & Sabatini, 1988). These individuals would not be considered "chronically mentally ill" because their symptoms, while they may be severe, have a situational cause and are not persistent. When housing is found, the symptoms should no longer be present and the individual should be able to resume his or her normal mental state without receiving long-term psychiatric and supportive services.

Deinstitutionalization and Homelessness

Deinstitutionalization is the policy whereby many mental patients living in state mental hospitals throughout the United States were released to the care of community facilities, to their

families, or without supervision. This resulted in a decrease in state hospital census from almost 559,000 in 1955 to approximately 138,000 in 1980 (Goldman, 1983). In addition to the removal of patients from the state facilities, deinstitutionalization also involves prevention of hospitalization through the use of community-based facilities and services (Bachrach, 1983).

It is generally agreed that deinstitutionalization has not been a success, or stated another way, the concept of deinstitutionalization is sound but its implementation has been flawed (Jones, 1983; Lamb, 1984). In the majority of cases, patients were discharged to their families, were transferred to nursing and boarding homes where treatment and rehabilitation were generally not available, or were released on their own without adequate supportive and rehabilitative services. The system of community care in many areas has been underfunded and fragmented in such a way that no agency assumes ultimate responsibility for the patient. Finally, the system has been inaccessible to many patients, creating the young adult chronic population that has not responded to traditional mental health services (Gralnick, 1985; Lamb, 1984; Levine, 1984).

While homelessness among persons with a chronic mental illness clearly has multiple, often interrelated causes, including the economic recession, unemployment, cutbacks in federal support programs, more restrictive hospital admission policies, and the lack of adequate low-cost housing, the failure of the deinstitutionalization process to adequately meet the needs of the people it is supposed to serve is considered by many to be the foremost cause of homelessness among this group (Dear & Wolch, 1987; Jones, 1983; Lamb, 1984). The inadequacies of the system, described above, are considered to have resulted in the condition of homelessness among persons with a mental illness as it exists today.

Policy Implications of the Deinstitutionalization

Definition of Homelessness

By defining homelessness among persons with a chronic mental illness as being an outcome of the failure of deinstitutionalization, some people take the view that the state hospital system should be revitalized (Dear & Wolch, 1987; Gardner,

1984; Gralnick, 1985). Through involuntary commitment, many mentally ill people, including the homeless mentally ill, would then be rehospitalized. The implications of this proposed change in mental health policy are twofold: it offers a quick solution to the problem of the homeless mentally ill by rehospitalizing them, and it restores the power base to the state hospital system which it lost during deinstitutionalization.

It is unlikely that state mental hospitals will be restored to their previous levels for the very reasons deinstitutionalization was initiated in the first place. For most clients institutional treatment is inappropriate and unnecessary. Clients can effectively be treated and supported in the community when ample resources are provided (Lamb, 1984; Okin, 1985). Also, the revitalization of the state mental hospitals would probably be prevented for legal reasons (Rachlin, 1983). Most state courts allow involuntary commitment only when the individual is a danger to self or others. Therefore, it is unlikely that most of the persons with a chronic mental illness living in the community, or even most individuals that are homeless, could be committed (Okin, 1985).

The second policy option developing from the deinstitutionalization definition of homelessness among persons with a chronic mental illness is to improve the overall community care system, which would ultimately decrease homelessness among this group. Lamb (1984), chairman of the American Psychiatric Association's task for the homeless mentally ill, summarizes the recommendations resulting from this definition of the problem. He calls for a full range of residential placements, aggressive case management, increased involuntary treatment, crisis intervention services, and access to acute hospitalization and other community services.

The primary benefit to the mental health system for defining homelessness as being the result of the failure of deinstitutionalization is that it keeps the solution within its own domain. Defined in this manner, the issue of homelessness among persons with a mental illness can be used to draw attention to the lack of resources allocated to the mental health system. Funds designated for homeless services can be used to improve the overall system, benefiting the entire mentally ill population, not

just the homeless mentally ill. Also, when new programs have to be created, it enlarges and strengthens the power base of the mental health community.

There are two major problems with the solution resulting from this definition. First, the changes offered above by Lamb are service intensive, resulting in large appropriations for various types of mental health services and very little for actual housing options. This point is exemplified by the plans of the Missouri Department of Mental Health (MDMH) to disburse \$970,111 in federal and state funds designated specifically for the homeless mentally ill. None of the funds are to be used for permanent, long-term housing. Instead, the money will be used to purchase intensive case management services, mobile outreach and crisis intervention services, supportive and supervisory services for the homeless mentally ill staying in shelters, psychosocial rehabilitation services, and stabilization apartments. The stabilization apartments are the only form of housing funded by this grant, but it is not permanent housing, and it accounts for only 1% of the total allotment (MDMH, 1988).

The second problem with this solution concerns the expansion of the residential continuum model, a rehabilitation approach adopted by most states. This model is composed of different housing and service programs, each with its own level of structure and service intensity. As residents develop the skills and meet the service requirements of one setting, they are usually transferred to the next level of care, with the ultimate goal being independent living. Common elements of the continuum include nursing homes, intermediate care facilities, boarding homes, group homes, semi-independent apartments, and supervised or cooperative apartments. Most of these classifications can be subdivided based on the level of services offered (Carling, Randolph, Blanch, & Ridgway, 1988).

The residential continuum model has recently been criticized for a number of reasons. It forces persons with a mental illness to adjust to a predetermined program having little flexibility to meet individual needs; progress made in one setting is often lost when the individual is moved to the next higher level of care; an essential element of the range of residential

settings, long-term supported housing, is rarely available; and finally, treatment-oriented systems often do not provide enough assistance in helping the individual to secure permanent community housing (Allard, Carling, Bradley, Spencer, Randolph, & Ridgway, 1986).

In addition, by advocating for this continuum of residential service programs, the mental health community has in many cases confused the need for housing with the need for services (Carling & Ridgway, *in press*). Under this system, persons seeking housing must be willing to participate in the service program operated by the facility. Failure to comply with the service program usually means dismissal from the program and the resulting loss of housing. Many persons are unwilling to comply with the structure defined in each of the residential settings, or, because of past disruptive behavior, they are not accepted into most programs within the continuum. As a result, this group, which to a large extent is composed of the young adult chronic client, is at high risk of becoming homeless (Arce, Tadlock, Vergare, & Shapiro, 1983; Bachrach, 1984; Gardner & O'Hara, 1984; Levine and Stockdill, 1986).

From this group of people whose behavior is often inappropriate and disruptive or for those unwilling to give up their freedom and comply with the structure of the residential center, there is a definite lack of residential placements (Arce, Tadlock, Vergare, and Shapiro, 1983; Gardner & O'Hara, 1984). A choice is often made between two poor options: giving up one's freedom or living on the streets. From one perspective, the act of choosing to live on the streets rather than conforming to a structured residential program does not have to be viewed as a bizarre act but can be seen as a positive move towards health, an attempt not to be identified as a patient (Gardner & O'Hara, 1984). Unfortunately, a serious mismatch developed between the structured services offered through the mental health system and the needs of this group (Ball & Havassy, 1984). This condition continues to exist in spite of evidence that not all homeless mentally ill persons are in need of structured treatment settings (Bachrach, 1984).

*An Alternative View of Homelessness Among
Persons with a Chronic Mental Illness*

From one perspective deinstitutionalization has contributed to the problem of homelessness. If this policy had not occurred, many of people who are homeless and have a mental illness would still be hospitalized and therefore off the streets. For example, in Israel, where deinstitutionalization has not been implemented, homelessness among the mentally ill is not a problem (Lamb, 1984). But this approach does not explain why, when deinstitutionalization was implemented twenty years ago, the number of persons both homeless and mentally ill has increased only recently, coinciding with the rise in "the new homeless" which, unlike the stereotypical older, white, skidrow alcoholic, now includes former mental patients, minorities, women, children, and intact families (Hopper & Hamberg, 1984; Swanstrom, 1988).

Rather than deinstitutionalization being the significant variable in recent growth of the homeless mentally ill, the decline in low income housing is a primary cause. A number of reports emphasize the lack of housing options as a critical factor in the homelessness of persons with a mental illness (Baxter & Hopper, 1984; Hopper & Hamberg, 1984; Levine, Lezak & Goldman, 1986; Mowbray, 1985; NASMHPD, 1985; Wright & Lam, 1987).

From a policy perspective, this definition of the problem of homelessness among the chronically mentally ill is significant for two reasons. First, it identifies the greatest need of the homeless mentally ill as being affordable housing, not mental health services. There is considerable evidence indicating that until persons with a mental illness have a stable living situation that offers them some measure of dignity, rehabilitation services are of limited value. While some services may be necessary to secure housing, services alone cannot compensate for deficiencies in living circumstances (Baxter & Hopper, 1982; Levine & Haggard, in press).

Second, because the lack of affordable housing is a need shared by most homeless individuals, and not just the homeless mentally ill, the mental health system is no longer solely responsible for the solution. Therefore, it is legitimate for the

state mental health system to join forces with other governmental bodies and with the private sector to work towards the goal of additional low cost housing units, some of which would be utilized by persons with a mental illness (Allard et al., 1986).

The question still remains as to who will coordinate these resources and incur the bulk of the costs. Ultimately, the federal government needs to take the leadership role in the development of affordable housing, although under the Reagan administration, this did not occur (Whitman, 1988). There has been a tendency for each layer of government to "pass the buck" when it comes to assuming financial responsibility (Levine & Stockdill, 1986). Historically, state mental health agencies have viewed housing as a social welfare problem and have concentrated their housing efforts on residential treatment programs which are generally expensive and serve only a small percentage of persons with a mental illness that are in need of housing (Carling, Randolph, Blanche, and Ridgeway, 1988).

Attitudes towards housing are beginning to change, and some state mental health departments are beginning to assume a leadership role in the coordination and development of low income housing, because in many instances, they have the legal responsibility to see that persons with a chronic mental illness have appropriate housing options (Ridgeway & Carling, 1987). The Position Statement of the National Association of State Mental Health Program Directors (1988) reflects this stance, calling for public mental health systems to exercise leadership in the development of housing and emphasizing the need to coordinate and negotiate roles played by the mental health authorities, public assistance and housing authorities, the private sector, and consumers themselves.

An example of this mandate is found in Rhode Island. The Rhode Island Division of Mental Health, in its Housing Policy Statement (1988), outlines its roles and responsibilities:

- (a) It should assess the housing needs of severely mentally disabled adults and develop an implementation plan for meeting those needs.
- (b) It should serve as the advocate for the development of housing stock for severely mentally disabled adults.

- (c) It should raise capital through bond monies for housing development and determine priorities for use.
- (d) It should ensure that sufficient and suitable housing stock is secured to permit severely mentally disabled adults who require residential support services to live in the community.

Utilization of Housing Opportunities

Even if adequate low-cost housing options could be made available, there are some people who are uncertain if the homeless mentally ill would utilize them, the implication being they are homeless by choice (Mowbray, 1985; Bachrach, 1984). This assumption has been refuted by a number of studies which indicated when decent, humane shelter is provided, it will be utilized (Baxter & Hopper, 1981; Baxter & Hopper, 1982; Lipton, Nutt, and Sabatini, 1988; Morrissey & Dennis, 1986).

Although the homeless mentally ill are willing to accept some housing options, the perception of their needs by the mental health community and by the homeless persons themselves often do not coincide (Ball & Havassy, 1984; Carling et al., 1988). Mental health professionals usually focus on the need for structure and supervision (Lamb, 1984), while the mentally ill homeless look at such things as the neighborhood they may be moving in to, the safety it affords, and the amount of the space available, which are the same factors which most people, whether having a mental illness or not, consider when selecting a new residence (Morrissey & Dennis, 1986).

An approach to housing, referred to as supported housing or community residential rehabilitation (CRR), attempts to overcome some of the problems associated with the residential continuum model and to more adequately meet the individual housing needs of persons having a chronic mental illness (Carling & Ridgway, in press; Carling & Wilson, 1988). This housing approach concentrates on the community integration of persons with a mental illness. This emphasis on community integration is especially relevant to the discussion of homelessness, which was defined as having three components: the lack of shelter, of resources, and of community ties.

The essential components of supported housing include a shift away from treatment based housing facilities to the use

of normal housing, clearly separating housing from services. It also emphasizes the choice of an individual as to where and how he or she will live. Finally, rehabilitative and supportive services are to be provided on a flexible basis determined by the needs of the individual and are to be available on a long-term basis (Carling & Wilson, 1988).

Conclusion

The improper implementation of deinstitutionalization is often suggested as being a primary cause of homelessness among persons with a chronic mental illness. Upon closer examination of the perspective, it was not until a severe housing shortage occurred that homelessness appeared among this group, as well as others. While the improvement of the implementation of deinstitutionalization is clearly needed, this will not alleviate the problem of homelessness among persons with a mental illness. Levine and Haggard (in press) emphasize the extent of this position: "Ultimately, the fate of homeless mentally ill persons depends upon the accessibility of both specialized and nonspecialized residential alternative."

By focusing on the need for housing, the mental health system can legitimately work with other organizations to improve the housing stock for all people. This emphasis on housing is critical, because while people with a chronic mental illness need long-term supportive and rehabilitative services, these services are most beneficial when provided to someone in a stable living environment and administered on a flexible, individualized basis.

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