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Homeless and Helpless: How the United States has Failed Those With Severe and Persistent Mental Illness

Ashley Gorfido
Cleveland-Marshall College of Law

HOMELESS AND HELPLESS: HOW THE UNITED STATES HAS FAILED THOSE WITH SEVERE AND PERSISTENT MENTAL ILLNESS

ASHLEY GORFIDO*, CLEVELAND-MARSHALL COLLEGE OF LAW, J.D. 2021

*J.D., May 2021, Cleveland-Marshall College of Law. To all of those I have had the privilege of serving as a social worker, thank you for letting me into your lives, for teaching me, for sharing your stories and experiences so candidly. Your strength and resilience are unmatched and have inspired and motivated me to do better. To be better. To my mentors and educators David Schweighoefer, Ric Kruszynski, and Ashley Hovancsek, thank you for teaching me and supporting me in using my voice to advocate for a better world. The respect and admiration I have for you all is endless. This is for all of you.

I. INTRODUCTION

The United States has failed its citizens who suffer from severe and persistent mental illness (SPMI). Homelessness is one of the most obvious manifestations of this failure. The combination of a lack of effective treatment, inadequate entitlement programs, such as Social Security Disability Insurance, and subpar housing options form systemic barriers that prevent people suffering from mental illness from being able to obtain adequate housing. Cultural beliefs within the United States regarding who is homeless and what homelessness means also play a significant role in the development of positively impactful social welfare programs.

SPMI refers to mental disorders that affect people in early adulthood and have significant effects on family relations, educational attainment, occupational productivity, and social role functioning over the individual's life span.[1] Mental health disorders that fall into this category include schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, autism, and obsessive-compulsive disorder.[2] These disorders affect roughly five million people and represent a significant percentage of the clients of mental health services.[3] It has been estimated that the economic impact of SPMI in the United States is $148 billion per year and 10% of the annual direct health care costs.[4]

Current models of care for mental health treatment do not adequately address mental illness.[5] "Mental illness accounts for about one-third of the world's disability caused by all adult health problems, resulting in enormous personal suffering and socioeconomic costs."[6] Mental illness is closely associated with poverty which can lead to homelessness.[7] People suffering from SPMI often receive no treatment or inadequate treatment for their mental illness.[8] There is also a growing gap between mental health care needs and available services.[9] Social stigma associated with seeking mental health services often deters people with

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[1] Michael P. Carey & Kate B. Carey, *Behavioral Research on Severe and Persistent Mental Illnesses*, 30 BEHAVIOR THERAPY 345, 345 (1999), https://doi.org/10.1016/S0005-7894(99)80014-8.

[2] *Id.*

[3] *Id.*

[4] *Id.*

[5] James Lake & Mason Spain Turner, *Urgent Need for Improved Mental Health Care and a More Collaborative Model of Care*, 21 THE PERMANENTE J. (Aug. 11, 2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5593510/.

[6] *Id.*

[7] *Id.*

[8] *Id.*

[9] *Id.*

SPMI from seeking serves, and people suffering from SPMI often have complex needs that are difficult to address within the current treatment models.[10]

"Homelessness among persons with severe and persistent mental illness is the most visible manifestation of failures in mental health policy and in other areas of public policy."[11] The average age of onset of SPMI ranges from late teens through early 20s.[12] "Working-age Americans with disabilities are much more likely to live in poverty than other Americans are."[13] People suffering from SPMI rely on Social Security Insurance (SSI) and/or Social Security Disability Insurance (SSDI) for income.[14] In the best case scenario, the income received will put the individual at the poverty line.[15] In 2008, the average SSI payment was $439 per month and the average SSDI payment was $1,063 per month.[16] Poverty-level income does not support decent housing. "The average rent on a modest efficient apartment [is] equal to 96% of the monthly Social Security Insurance payment."[17]

People suffering from SPMI represent roughly 45% of the homeless population in the United States.[18]

> Loss of housing represents a profound breach in the fabric of normative expectations and social structures that bind individuals to any society. Few situational changes connote so many interrelated losses—in physical security, personal identity, social status, and community connections—particularly among persons with a history of severe mental illness.[19]

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[10] *Id.*

[11] Sandra Newman & Howard Goldman, *Putting Housing First, Making Housing Last: Housing Policy for Persons With Severe Mental Illness*, 165 AM. J. PSYCHIATRY 1242, 1242 (2008).

[12] Ronald Kessler et al., *Age of Onset of Mental Disorders: A Review of Recent Literature*, 20 CURRENT OPINION IN PSYCHIATRY 359, 359 (2007).

[13] David C. Stapleton et al., *Dismantling the Poverty Trap: Disability Policy for the Twenty-First Century*, 84 THE MILBANK Q.: MULTIDISCIPLINARY J. OF POPULATION HEALTH & HEALTH POL'Y 701, 701 (2006), https://doi.org/10.1111/j.1468-0009.2006.00465.x.

[14] Newman & Goldman, *supra* note 11, at 1243.

[15] *Id.*

[16] *The Average Disability Benefit*, DISABILITY BENEFITS CTR., https://www.disabilitybenefitscenter.org/how-to/how-to-determine-how-much-money-you-will-receive-from-social-security-disability (last visited Nov. 18, 2019).

[17] Newman & Goldman, *supra* note 11, at 1243.

[18] *Id.*; Angela Parcesepe & Leopold Cabassa, *Public Stigma of Mental Illness in the United States: A Systematic Literature Review*, 40 ADMIN. & POL'Y IN MENTAL HEALTH & MENTAL HEALTH SERVS. RES. 384, 390 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3835659/.

[19] Russell K. Schutt & Stephen M. Goldfinger, *Fundamental Causes of Housing Loss among Persons Diagnosed with Serious and Persistent Mental Illness: A Theoretically Guided Test*, 2 ASIAN J. OF PSYCHIATRY 132, 132 (2009), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2818505/pdf/nihms159889.pdf.

Without adequate income to support stable housing, people with SPMI have to rely on public housing programs for housing services. "The U.S. Department of Housing and Urban Development (HUD) administers Federal aid to local housing agencies (HAs) that manage the housing for low-income residents at rents they can afford."[20] Placement in subsidized housing reduces, but does not eliminate, the risk of housing loss for people suffering from homelessness and SPMI.[21] Studies show 16% to 25% of people suffering from homelessness and SPMI lose their housing one year after obtaining it, and 50% after five years of having housing.[22]

Arguably, the biggest problem for people with SPMI who are also experiencing homelessness is that America does not like them. The demographics of this population encompass those who have not been seen in a favorable light throughout the history of the United States, and those who have been subject to significant discrimination. Society tends to understand homelessness as the result of personal deficiencies like SPMI.[23] Homelessness has been an issue of national concern among the media, academia, and policy makers since the 1960s, and is a historical social issue that has existed since the 1700s.[24] The focus in remedying homelessness has been on explaining the causes and developing more effective prevention and intervention strategies.[25] "A critical point in the debate is whether homelessness results from individual or structure-level factors. For instance, is homelessness the result of personal disabilities such as substance abuse and poor decisions or is it the result of larger systemic factors such as insufficient affordable housing and employment opportunities?"[26] Policy makers attribute the causes of homelessness to individual factors. This blame-shift has resulted in a failure to address the glaring issues that exist within the United States' social welfare programs, e.g. housing and SSI and SSDI.[27]

Part II of this Note will review the history of treatment for persons with SPMI, specifically how that treatment has evolved, the history of federal policies regarding SSI, SSDI and housing, and societal beliefs regarding homelessness and mental illness that have impacted policy making decisions. Part III of this Note will look at these same areas from a current perspective and will address the current issues and some possible solutions. Part IV of this Note will discuss how lack of

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[20] *What is Public Housing?*, HUD'S PUBLIC HOUSING PROGRAM, https://www.hud.gov/topics/rental_assistance/phprog (last visited Nov. 18, 2019).

[21] Schutt & Goldfinger, *supra* note 19, at 133.

[22] *Id.*

[23] Courtney Cronley, *Unraveling the Social Construct of Homelessness*, 20 J. HUM. BEHAV. SOC. ENV'T 319, 324 (2010).

[24] *Id.*

[25] *Id.* at 319-20.

[26] *Id.* at 320.

[27] *Id.*

effective treatment, poor disability programs, and the need for better housing options work together to form systemic barriers for people with SPMI. Part IV will also address how the cultural beliefs in the United States regarding people who have SPMI and are homeless serve as an independent barrier to policy change. Ultimately, this Note argues that homelessness is a product of system failures rather than individual factors.

II. BACKGROUND

A. The History of State Hospital Care

Mental illness is not a new problem, and the methods for caring for people suffering from SPMI have had advances and setbacks.[28]

> The history of psychiatric hospitals was once tied tightly to that of all-American hospitals. Those who supported the creation of the first early-eighteenth-century public and private hospitals recognized that one important mission would be the care and treatment of those with severe symptoms of mental illnesses.[29]

Most people suffering from SPMI during this time remained with their families and received treatment at home.[30] Communities showed significant tolerance for what would be considered strange thoughts and behaviors; however, some people suffering from SPMI seemed too violent or disruptive to remain at home or in the community.[31] Public almshouses and private hospitals created separate wards for people suffering from SPMI.[32]

The nineteenth-century brought European ideas regarding treatment and care for SPMI to the United States.[33] "'Moral treatment' promised a cure for mental illnesses to those who sought treatment in a very new kind of institution – an 'asylum.'"[34] Moral treatment originated in the late eighteenth century, and was based on the assumption that mental illness could be alleviated if patients were treated in a considerate and friendly manner, if they had opportunities to discuss their troubles, if they actively engaged in some form of communal life, and if their

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[28] DAVID MECHANIC ET AL., MENTAL HEALTH AND SOCIAL POLICY: BEYOND MANAGED CARE 46 (Craig Campanella et al. eds., 6th ed. 2014).

[29] Patricia D'Antonio, *History of Psychiatric Hospitals*, PENN NURSING, https://www.nursing.upenn.edu/nhhc/nurses-institutions-caring/history-of-psychiatric-hospitals/ (last visited Nov. 25, 2019).

[30] *Id.*

[31] *Id.*

[32] *Id.*

[33] *Id.*

[34] *Id.*

interests were stimulated.[35] Moral treatment rejected the use of harsh restraints and long periods of isolation that were used as treatment methods to manage destructive behaviors of mentally ill individuals.[36]

Moral treatment was established at some institutions, but "the general sense of social responsibility toward the unfortunate was not very strong during this era."[37] People suffering from SPMI often ended up in jail or local poorhouses, "undifferentiated from offenders and the destitute poor."[38] Dorothea Dix brought attention to the awful treatment of this population and was a key figure in the building and expanding of specialized mental hospital facilities.[39] "The mental hospital system marked a real advance from the indiscriminate practices that preceded it. The evidence is that the conditions mental hospitals provided were relatively humane and therapeutic."[40] By the 1870's nearly every state had one or more such treatment facilities funded by state tax dollars.[41]

The industrial revolution brought social conditions that increased the tendency to hospitalize those who could not adapt to the new demands of the time.[42] Family structures changed during this time due to changes in the nature of work, family life, and community tolerance for bizarre behavior or incapacity.[43] These changes made it difficult to maintain old and disabled members within the family.[44] As the number of older people increased due to an increase in life expectancy, the mental hospital became a refuge for the elderly.[45] This resulted in mental hospitals being confronted with many more patients than it could handle effectively, and the burden of these numbers made it difficult to maintain moral treatment.[46]

> By the 1890s, however, these institutions were all under siege. Economic considerations played a substantial role in this assault. Local governments could avoid the costs of caring for the elderly residents in almshouses or public hospitals by redefining what was then termed "senility" as a psychiatric problem and sending these

[35] MECHANIC, *supra* note 28, at 46.

[36] D'Antonio, *supra* note 29.

[37] MECHANIC, *supra* note 28, at 46.

[38] *Id.*

[39] *Id.*

[40] *Id.*

[41] D'Antonio, *supra* note 29.

[42] MECHANIC, *supra* note 28, at 47.

[43] *Id.*

[44] *Id.*

[45] *Id.*

[46] *Id.*

> men and women to state-supported asylums. Not surprisingly, the numbers of patients in the asylums grew exponentially, well beyond both available capacity and the willingness of states to provide the financial resources necessary to provide acceptable care.[47]

"In 1920, 18 percent of all first admissions to mental hospitals in New York State were diagnosed with senility or cerebral arteriosclerosis. By 1940, this patient group accounted for 31 percent of all admissions. What was true for New York State describes other states as well."[48]

What was supposed to be a place of healing for those suffering from SPMI had become a dumping ground for America's unwanted. Moral treatment was replaced by the former "regimentation of patients and rigid bureaucratic procedures to facilitate the handling of an overwhelming inpatient census."[49] Economic and social instability left a large number of people in need of care, and with no alternative, the mental hospital assumed this responsibility.[50]

> By the 1950s, the death knell for psychiatric asylums had sounded. A new system of nursing homes would meet the needs of vulnerable elders. A new medication, chlorpromazine, offered hopes of curing the most persistent and severe psychiatric symptoms. And a new system of mental health care, the community mental health system, would return those suffering from mental illnesses to their families and their communities.[51]

B. A Shift into the Community

World War II brought much needed attention to the mental health needs in the United States, giving psychiatry the opportunity to develop programs for psychiatrically disabled soldiers.[52]

> The publicity given to psychiatric causalities among veterans, combined with large loss of personnel due to psychiatric reasons during induction, galvanized new public policies in relation to mental health. Government officials and informed laypersons alike felt the need to learn more about the causes and prevention of mental illness, to assist the individual states in strengthening their mental health programs, and to build a satisfactory personnel pool in the mental health arena. In 1946, Congress passed the National Mental Health Act, creating grant programs for research into etiology and

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[47] D'Antonio, *supra* note 29.

[48] MECHANIC, *supra* note 28, at 47.

[49] *Id.*

[50] *Id.*

[51] D'Antonio, *supra* note 29.

[52] MECHANIC, *supra* note 28, at 49.

> treatment of neuropsychiatric problems, professional training, and community clinics as pilot and demonstration efforts. The law also established the National Institute of Mental Health (NIMH) to administer the system grants and to serve as a new focal point within the federal government for addressing mental illness as a major public health concern.[53]

However, the public gained very little from all of these progressive changes. Direct federal aid to the states actually decreased.[54]

Innovations, like psychotropic medications, were being developed, but the states did not have the facilities, financial resources, or personnel to implement these new treatment options.[55] An increase in federal funding of research and a decrease in state aid created an imbalance.[56] The research produced promising outcomes of accelerated release of long-term patients after receiving intensive care and drug therapies, but the states had no way of providing the same treatment options to its citizens.[57]

Work being done by the Council of State Governments and the conferences sponsored by the Milbank Memorial Fund fueled concepts of community care.[58] In response to individual state success in funding community care and the advocacy of the American Psychiatric Association and the American Medical Association, Congress passed the Mental Health Study Act of 1955, establishing a Joint Commission on Mental Illness and Health.[59] The emphasis was on community based mental health treatment motivated by a desire to decrease hospital populations and improve efficiency.[60]

> The Mental Health Study Act appropriated funds for the Joint Commission to study and make recommendations concerning various aspects of mental health policy. In 1961, the commission published its highly visible report, *Action for Mental Health*, which argued strongly for an increased program of services and more funds for basic, long-term mental health research. It recommended that expenditures in the mental health field be doubled in five years and tripled in 10 years. It argued for better recruitment and training programs for mental health workers. It called for expansion of treatment programs for acutely ill patients in all facilities, including

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[53] *Id.*

[54] *Id.*

[55] *Id.*

[56] *Id.*

[57] *Id.*

[58] *Id.*

[59] *Id.* at 49-50.

[60] *Id.* at 50.

> general hospitals and mental hospitals. It argued for establishment of mental health clinics, suggesting one for every 50,000 persons in the population. It attacked the large state mental hospitals, proposing their transformation into a regional system of smaller intensive treatment centers with no more than 1,000 beds. And it recommended new programs for the care of chronic patients as well as aftercare and other rehabilitation services. Here was a wide-ranging and ambitious agenda for change that fell on receptive ears in Washington. Many recommendations quickly began to be converted to action because of financial and moral support from the federal government. The most far-reaching initiative was a new community mental health centers program.[61]

Ultimately, the decision was made to establish "a nationwide network of compressive community mental health centers" which would be independent of mental health hospitals.[62]

Community Mental Health Centers (CMHCs) were required to offer the following services: (1) inpatient care, (2) emergency care, (3) partial hospitalization, (4) outpatient care, and (5) education and consultation.[63] The number of mandated services eventually expanded to 12, including alcohol and drug abuse services, services for children and the elderly, and follow-up care and transitional services for the chronically ill.[64] The funding level was set at $150 million with a matching provision to be supplied by states.[65] By 1981, 796 CMHCs had been funded and were serving more than 3.3 million patients, and the number of patients in state and county hospitals declined significantly.[66] However, only half the number of needed CHMCs came into existence, and they did not establish strong operational linkages with state hospitals.[67]

Without a strong link between state hospitals and CMHCs, discharged patients were not being focused on as a population of concern.[68] Hospitals experienced the "revolving door" door problem, where recently discharged patients returned for repeated hospitalizations only after brief periods in the community.[69] A report by the U.S. Inspector General stated that CMHCs failed to provide

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[61] *Id.*

[62] *Id.*

[63] *Id.* at 51.

[64] *Id.* at 51-52.

[65] *Id.* at 52.

[66] *Id.*

[67] *Id.*

[68] *Id.*

[69] *Id.*

adequate services to people suffering from SPMI, and it identified this failure as a significant factor in the growth of the number of homeless people in the United States.[70]

C. The Role of Social Security

The Social Security Amendments of 1972, which created Supplemental Security Income (SSI), not legislation on mental health, had the most positive impact for persons suffering from SPMI.[71]

> These amendments brought previously existing aid programs for the aged, blind, and disabled under stronger federal regulation by requiring states to comply with a standard definition of disability, although states could also provide assistance beyond the federal minimum. Social Security Disability Insurance (SSDI) had existed as a federal benefits program for at least some disabled workers since the late 1950s, but it required that applicants possess a minimum work history to qualify. SSI, in contrast, provided benefits to disabled persons in poverty regardless of their work history, and it extended disability benefits to children. The 1972 amendments defined disability status in this way: "Any person unable to engage in any substantial gainful activity (SGA) by any medically determinable physical or mental impairment expected to result in death or that has lasted or can be expected to last for a continuous period of 12 months.[72]

Although this offered a source of income to people with SPMI, the amount was insulative and far below a livable wage. The guaranteed income was $130 per month or $800 per month in 2019.[73]

D. Modern Homelessness

The modern era of homelessness began in the early 1980s.[74] Gentrification of the inner city, deinstitutionalization of people suffering from SPMI, and other major forces contributed to the complexity of homelessness in the modern era.[75]

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[70] *Id.*

[71] *Id.* at 53.

[72] *Id.*

[73] *Id.*; *Value of $130 from 1972 to 2020*, CPI INFLATION CALCULATOR, https://www.in2013dollars.com/us/inflation/1972?amount=130 (last visited Nov. 4, 2020).

[74] COMM. ON AN EVALUATION OF PERMANENT SUPPORTIVE HOUSING PROGRAMS FOR HOMELESS INDIVIDUALS ET AL., PERMANENT SUPPORTIVE HOUSING: EVALUATING THE EVIDENCE FOR IMPROVING HEALTH OUTCOMES AMONG PEOPLE EXPERIENCING CHRONIC HOMELESSNESS 176 (The National Academies Press eds., 2018), https://www.ncbi.nlm.nih.gov/books/NBK519584/.

[75] *Id.*

"An inadequate supply of affordable housing options, and deep budget cuts to the U.S. Department of Housing and Urban Development (HUD) and social service agencies in response to what was then the country's worst recession since the Great Depression" were also significant factors.[76]

> Deinstitutionalization of the mentally ill has roots in the civil rights and civil liberties movements of the 1960s, which envisioned more fulfilling lives for those who had been languishing in understaffed psychiatric hospitals through new medications and robust community-based services. The number of patients living in state hospitals dropped from 535,000 in 1960 to 137,000 in 1980. California saw a dramatic reduction in state hospital beds from 37,000 in 1955 to 2,500 in 1983 []. Funding for the needed housing and community-based services proved inadequate, and, as cheap housing disappeared, vast numbers of previously institutionalized individuals with severe and persistent mental illness or those who might have gone to institutions in earlier eras drifted onto the streets and into temporary shelters.
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> The recession of the 1980s resulted in deep cuts to the HUD budget, which decreased from approximately $29 billion in 1976 to approximately $17 billion in 1990, and led directly to reductions in the budget authority for housing assistance (from almost $19 billion in 1976 to about $11 billion in 1990) and in subsidized housing for poor Americans (OMB, 2001). Two changes in policy particularly contributed to the rise in homelessness during that period. First, cuts in Supplemental Security Income (SSI) in the late 1980s, accompanied by a tightening of the disability eligibility process (Social Security Act of 1980), adversely affected mentally ill persons living in rooming houses. The subsequent loss of personal income contributed to homelessness for many of these individuals []. The Social Security Disability Benefits Reform Act of 1984 was later enacted to pull back on some of the aspects of the 1980 Social Security Act, which impeded the efforts of some individuals experiencing illness and homelessness to pursue benefits.[77]

E. Society's Understanding of Homelessness and Mental Illness

Themes of the United States' culture, such as individualism and self-reliance, affect perceptions and interpretations of homelessness.[78] In American culture, success and failure are matters of individual responsibility.[79] This

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[76] *Id.*

[77] *Id*. at 176-77.

[78] Cronley, *supra* note 23, at 324.

[79] *Id.*

perpetuates the belief that an individual's ability to find and maintain housing is a matter of individual-level factors and personal choice, and those who are not able to do this are seen as deviate or dysfunctional.[80] These beliefs can be seen within the treatment settings for individuals who are homeless with SPMI through the use of treatment models that place emphasis on correction and rehabilitation.[81]

Books such as *A Nation in Denial* support these American cultural themes and beliefs by maintaining that homelessness is a function of personal problems, like SPMI or substance use disorders, meaning that public policy should focus on rehabilitating the homeless and place less emphasis on housing.[82] "One public opinion poll concluded that Americans are inclined to the idea that opportunity is present to those who avail themselves of it.' According to the individual argument, people become homeless in the United States not because of a dysfunctional system but because of a dysfunctional self."[83]

American politics support notions of homelessness that are based on individualism and self-reliance. The Nixon Administration introduced the neoconservative perspective, a political ideology that combines traditional conservatism with political individualism, which emphasized privatization and devolution.[84] This perspective gained popularity among politicians and policy makers into the Reagan years resulting in significant reductions to the HUD budget and the decentralization of federal responsibility for homelessness.[85] "These activities helped to build strength for the individual perspective of homelessness by transforming the experience into a distinctly personal and isolated problem."[86] The 1994 *Contract with America* and subsequent welfare reform legislation focused on the recipients of public assistance, rather than the social conditions that make public assistance necessary, furthering the overall American belief that homelessness is a personal problem.[87] "Newt Gingrich, Republican Speaker of the House at the time, praised *Contract with America* and resultant welfare reform legislation for 'requiring welfare recipients to take personal responsibility for decisions they make.'"[88]

The Clinton Administration marginally increased funding for housing programs, but it placed the responsibility of designing and implementing housing

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[80] *Id.*

[81] *Id.* at 325.

[82] *Id.*

[83] *Id.*

[84] *Id.*; Richard Dagger & Terence Ball, *Neoconservatism: Political Philosophy*, ENCYCLOPEDIA BRITANNICA, https://www.britannica.com/topic/neoconservatism (last visited Apr. 3, 2020).

[85] Cronley, *supra* note 23, at 326.

[86] *Id.*

[87] *Id.*

[88] *Id.*

programs on individual local communities, typically by providing community block grants.[89] This revitalized older perspectives of kinship care where local communities, and not the federal government, organized and provided social welfare programs.[90]

> Policy groups and scholars are divided over the effectiveness of this neoliberal privatization. Groups such as the Cato Institute[91] contend that local responses to housing will result in more efficient and effective prevention and intervention strategies, because they rely on community and market preferences. The Cato Handbook for Policymakers [citation omitted] states that overregulation of land use leads to land shortages and increased housing costs. To ensure affordable housing, a government must allow the market economy to determine development and thus costs. Other policy groups and advocates, such as the Urban Institute[92] and the National Coalition for the Homeless, disagree with this view, arguing that the private sector cannot address housing shortages adequately and thus privatization actually exacerbates housing needs.[93]

Regardless of whether the private or public sector is responsible for the development and implementation of housing programs, the lack of available low-income housing is a social and structural level factor that contributes to high levels of homelessness, especially for those with personal risk factors like SPMI.[94]

The Stewart B. McKinney Homeless Assistance Act of 1987 has a stated mission of coordinating a "federal" response to homelessness; however, the Council's recent activities show a greater effort to coordinate local responses to homelessness.[95] The Council encourages local communities to develop "Ten-Year Plans to End Chronic Homelessness" which require communities to develop individualized local solutions to the problem of chronic homelessness.[96] "The federal government continues to exercise influence through funding and requirements such as using an information management system or adopting a housing-first approach, but it is devolving responsibility for program planning and

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[89] *Id.*

[90] *Id.*

[91] The Cato Institute is a public policy research organization which conducts independent, nonpartisan research on varying policy issues.

[92] The Urban Institute is a nonprofit research organization which conducts research on public policy.

[93] Cronley, *supra* note 23, at 326.

[94] Greg Greenberg & Robert Rosenheck, *Mental Health Correlates of Past Homelessness in the National Comorbidity Study Replication*, 21 J. HEALTH CARE FOR POOR & UNDERSERVED 1234, 1234-49 (2010), https://muse.jhu.edu/article/400765/pdf.

[95] Cronley, *supra* note 23, at 326.

[96] *Id.*

implementation to the local community."[97] The political trend of privatized social services is a response to a lack of public support for federal intervention in social welfare.[98] "The public encourages a free-market approach to social welfare, believing that laissez faire trade results in the most equitable and efficient distribution of resources."[99]

For most Americans, knowledge of homelessness does not come from proximate sources such as exposure to the homeless community, but comes from media sources.[100] The media coverage of homelessness has been generalized following annual cycles "cresting during the holiday season as an expression of ritualized concern for the unfortunate."[101] The content of media coverage of homelessness has shifted over time.[102] In the 1980s, coverage of homelessness showed the diversity of this group and the challenges they face that are beyond their control, and "hence deserving of aid."[103] Over the past two decades this coverage has been pushed aside for harsh headlines.[104] Maintaining that homeless persons are deviant in media coverage creates and supports beliefs that this population is deviant and dysfunctional within a culture of individualism and self-reliance.

In 2018, the United States' homeless population was 70% male, 67% single individuals, 40% African American/Black, 6% Multiracial, 3% American Indian/Alaska Native, and 1% Asian.[105] It is no secret that the United States has a long and ugly history of racism. There is a synonymy of blackness with criminality in America.[106] There are documented historical accounts that demonstrate how myths, stereotypes, and racist ideologies have led to discriminatory policies, with policies regarding homelessness as arguably representative of these such theories.

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[97] *Id.* at 326-27.

[98] *Id.* at 327.

[99] *Id.*

[100] Barrett Lee, Kimberly Tyler, & James Wright, *The New Homelessness Revisited*, 36 THE ANN. REV. OF SOC. 511, 511-21 (2010), https://www.annualreviews.org/doi/pdf/10.1146/annurev-soc-070308-115940.

[101] *Id.*

[102] *Id.*

[103] *Id.*

[104] *Id.*

[105] *Facts About Homelessness 2020*, BACKPACK BED FOR HOMELESS, https://backpackbed.org/us/facts-about-homelessness?gclid=CjwKCAjwpqv0BRABEiwA-TySwT8NdqOwVwNKCUxW7dVIjcnKy-4cGkBaTOAQBU8tNwgnMg9QeE35cRoCsnoQAvD_BwE (last visited Apr. 3, 2020).

[106] Calvin Smiley & David Fakunle, *From "Brute" to "Thug:" The Demonization and Criminalization of Unarmed Black Male Victims in America*, 26 J. HUM. BEHAV. SOC. ENVIRON 350, 350-66 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5004736/.

.[107] "Misconceptions and prejudices manufactured and disseminated through various channels such as the media included references to a '*brute*' image of Black males. In the 21st century, this negative imagery of Black males has frequently utilized the negative connotation of the terminology '*thug*.'"[108] With 70% of the homeless population being male and 40% being Black, it would logically follow that these racist beliefs are held against homeless persons as well.

In 2015, the U.S. Department of Housing and Urban Development conducted the most extensive survey ever undertaken regarding homelessness, and found that at a minimum, 25% of Americans are homeless.[109] Of homeless Americans, 45% are mentally ill.[110] Americans endorse holding stigmatizing beliefs regarding people who have mental illness.[111] Specifically, beliefs that mentally ill people are dangerous, incompetent, punishable, commit crimes, and that they are shameful and blameworthy.[112] With these beliefs in combination with the overall American perception of homeless people being deviant, dysfunctional, "brute", and "thug," it is no surprise that the United States does not have or has not chosen to implement better policies to help this population.

III. ANALYSIS

Not being able to receive treatment in your community, income to meet your basic needs, or housing which you can afford are great hardships independent of one another. These hardships are compounded when policymakers in positions to change social welfare programs that provide assistance in these areas hold beliefs that those in need created their own suffering and should employ self-reliance to get out of the situation. When these factors come together, they form a vicious, cyclical barrier that prevents people suffering from SPMI from living productive lives and contributing to society. This is a systemic problem and a failure of our society. Each of these factors will be looked at independently as well as a conclusion that addresses how each affects the other.

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[107] *Id.*

[108] *Id.*

[109] *250,000 Mentally Ill are Homeless. 140,000 Seriously Mentally Ill are Homeless*, MENTAL ILLNESS POLICY ORG., https://mentalillnesspolicy.org/consequences/homeless-mentally-ill.html (last visited Apr. 3, 2020).

[110] *Id.*

[111] Parcesepe & Cabassa, *supra* note 18, at 390.

[112] *Id.*

A. Lack of Effective Treatment

Mental illness is the leading cause of disability in the United States for people aged 15 to 44 with annual productivity loss at over $31 billion.[113]

> Mental illness is the pandemic of the 21st century and will be the next major global health challenge. Despite the increased availability of [psychotropic medications] during the past few decades, limited efficacy, safety issues, and high treatment costs have resulted in an enormous unmet need for treatment… Poverty is linked to a higher burden of mental illness, with variables such as education, food insecurity, housing, social class, socioeconomic status, and financial stress exhibiting a strong association.[114]

Psychiatric disorders have been found to be the largest "to the all-cause morbidity burden as measured by disability-adjusted life years."[115]

Approximately 50 percent of all medical visits are to primary care providers.[116] This means that a significant amount of mental health care is taking place under primary care.[117] This would seem like a natural starting point for improvement of mental health care, but there have been significant barriers to providing quality mental health care in this setting.[118] "Primary care physicians (PCPs) are often ambivalent or uncertain about treatment and referrals for mental health problems, and they are commonly insecure about making mental health diagnoses and ordering psychotropic medication." [119]

Of the patients with SPMI that are seen by a PCP, very few ever receive a referral for specialized care.[120] Of the PCPs who have reported that a referral for specialized care was necessary, two-thirds have reported that they were unable to get the necessary care for their patient.[121]

> Any attempt to define precisely the gap between need for treatment for mental health problems and use of services is futile. Estimates of need rest on varying assumptions about how to define mental disorders, while utilization figures depend on which sources of help are included. However, the fact that most people who have mental

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[113] Lake & Turner *supra* note 5.

[114] *Id.*

[115] *Id*.

[116] MECHANIC, *supra* note 28, at 161.

[117] *Id.*

[118] *Id.*

[119] *Id.*

[120] *Id.* at 162.

[121] *Id.*

> health problems, even the most severe, do not receive treatment – and if they do, the treatment does not meet accepted standards of quality – should be of great concern.[122]

i. Solutions

As the frontline of treatment, it is appalling that primary care doctors do not feel competent in diagnosing or treating mental illness. Medical doctors must complete Continuing Medical Education (CME) hours to maintain their medical license.[123] With approximately 50 percent of people suffering from mental illness presenting initially in the primary care physician's office, the requirements for what type of CMEs are completed should be revised to require doctors to complete a certain number of hours on mental health education. In addition, doctors should be required to complete a course on the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Addition* (DSM-5), to support confidence and competency in diagnosing mental illness. Greater confidence and competency in treating SPMI would lead to better treatment outcomes and help close the gap between initial PCP appointments with attempted referrals to actually seeing another treatment provider.

B. SSDI and SSI

SSDI and SSI provide cash assistance to millions of American with disabilities that keep them in poverty.[124] The maximum SSI benefit is only 75 percent of the federal poverty standard for an individual.[125]

> SSI is a means-tested poverty program for elderly and disabled people, and its benefit levels are much lower. The federal program replaced the existing state programs in 1974. To determine disability, the federal program uses SSDI medical eligibility criteria. What distinguishes SSI from SSDI is that it is targeted to people with low incomes and limited resources. In 2005, unmarried SSI beneficiaries with no other income received a maximum of $564 in monthly benefits, or 72.6 percent of the federal poverty guideline for a one-person household; married couples with both individuals eligible and no other income received $846, or 81.3 percent of the federal poverty guideline for a two-person household. In December 2004, 8.5 percent of individual working-age recipients with

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[122] *Id.* at 163.

[123] *Doctor of Medicine Renewal*, STATE MED. BD. OF OHIO, https://med.ohio.gov/Renew/Physician/Physician-MD-DO-DPM (last visited Nov. 14, 2020) ("Physicians renewing their license must complete 50 hours of CME designated by the AMA as category 1.").

[124] Stapleton et al., *supra* note 13.

[125] *Id*.

> disabilities received less than $50, and 55.4 percent received the individual maximum, $564.[126]

"Socioeconomic status, which is typically operationalized as income, occupation, and education, reflects not only access to material resources but also differences in power, prestige, social and human capital, and the resources that help people cope with stressful events and strains."[127] A persistent finding in epidemiological literature is the inverse relationships between socioeconomic status and the prevalence of mental disorders, specifically schizophrenia.[128] In effect, the United States keeps people with SPMI sick and unproductive.

The Technical Assistance Collaborative and the Consortium for Citizens with Disabilities Housing Task Force released a report showing the difficulties faced by people with SPMI receiving SSI in trying to obtain affordable rental housing.[129] The most obvious issue identified by the report was that "nowhere in America are SSI benefits enough to rent your own apartment."[130] The key findings in the report included:

- The average annual income of a single individual receiving SSI payments was $8,995 — equal to only 20.1% of the national median income for a one-person household and about 23% below the 2014 federal poverty level.
- The national average rent for a modest one-bedroom rental unit was $780, equal to 104% of the national average monthly income of a one-person SSI household. This finding confirms that, in 2014, it was virtually impossible for a single adult receiving SSI to obtain decent and safe housing in the community without some type of rental assistance.
- The national average rent for a studio/efficiency unit in 2014 was $674, equal to 90% of monthly SSI. In eight states and in the District of Columbia, areas with the highest housing costs in the nation, the average studio/efficiency rent exceeded 100% of the income of an SSI recipient.
- In 17 states and the District of Columbia, statewide average one-bedroom rents were higher than monthly SSI payments, including: Hawaii (173%), District of Columbia (171%), Maryland (146%), New Jersey (144%), New York (133%),

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[126] Stapleton et al., *supra* note 13 at 707-08.

[127] MECHANIC, *supra* note 28, at 116.

[128] *Id.*

[129] Andrew Sperling, *New Report Shows Challenges Facing People with Serious Mental Illness Living on SSI*, NAT'L ALLIANCE ON MENTAL ILLNESS (June 12, 2015), https://www.nami.org/Blogs/NAMI-Blog/June-2015/New-Report-Shows-Challenges-Facing-People-With-Ser.

[130] *Id.*

Virginia (126%), Delaware (123%), California (121%), Massachusetts (121%), New Hampshire (113%), Connecticut (113%), Florida (111%), Illinois (111%), Vermont (107%), Colorado (106%), Nevada (105%), Washington (104%), and Rhode Island (103%).[131]

- In four states — Delaware, Hawaii, New Hampshire, and New Jersey — and the District of Columbia, one-bedroom rents exceeded 100% of SSI in every single housing market area. Over 156,000 people with disabilities receiving SSI lived in these areas in 2014.
- In 162 housing market areas across 33 states, one-bedroom rents exceeded 100% of monthly SSI. Rents for modest rental units in 15 of these areas exceeded 150% of SSI.[132]

i. Solutions

The Netherlands is known for having one of the best disability insurance programs in the world.[133]

> At its peak in 1990, Dutch spending on disability pensions had climbed above 4 percent of gross domestic product (GDP), or more than four times the current U.S. DI rate. By 2010 the Dutch had reversed this expansion through a wide variety of program changes. In the early to mid-1980s, they reduced benefits modestly and restricted eligibility. When expenditures started to rise again, the Dutch shifted the costs of sickness benefits to employers and extended benefit duration (1996). Subsequently (1998), the government shifted a portion of the costs of disability benefits to individual employers and introduced experience rating of employer DI contributions to reflect rates of disability in individual firms. In a new round of program restructuring (2002), the Dutch required employers to rehabilitate and accommodate their sick workers (the Gatekeeper Protocol). In 2004, they extended the duration of employer-provided sick pay (from one to two years) and applied employer mandates for rehabilitation and accommodation to this full period. Only at the conclusion of this two-year period do employees become eligible to apply for DI benefits. In 2006, the Dutch government enacted new incentives and penalties for workers with

[131] *Id*.

[132] *Id.*

[133] Ilene R. Zeitzer, *Recent European Trends in Disability and Related Programs*, 57 SOC. SEC. BULL. 21, 22 (Summer 1994), https://www.ssa.gov/policy/docs/ssb/v57n2/v57n2p21.pdf.

> partial disabilities, aimed at inducing them to remain in, or return to, employment.[134]

Using this as a model, the United States could adopt "more adequate benefits and stronger support for rehabilitation provided sooner with respect to the onset of illness or disability than [what] typically occurs."[135]

The United States could also reform SSI and SSDI to provide for a living wage. Doing so would allow people to move out of poverty which would decrease the affects poverty has on symptoms of SPMI. Additionally, adopting a grading system for SSI and SSDI which would allow people to work and still receive some sort of subsidy income would encourage people to seek employment as their symptoms decreased allowing them to participate in society.

C. The Challenge of Housing

The lack of a stable residence has a direct and deleterious impact on mental health.[136] More than 550,000 people in the United States were staying in shelters or places not intended for human habitation on a single night in 2017.[137]

> Given the importance of housing as a social determinant of health, it is critical to find, create, and implement housing for individuals experiencing chronic homelessness. The World Health Organization (WHO) defines social determinant of health as "the circumstances, in which people are born, grow up, live, work and age, and the systems put in place to deal with illness." People experiencing homelessness have been significantly impacted by a social determinant of health, leading to chronic health conditions, substance use, mental illness, and increased mortality.[138]

i. Solutions

Housing first is an approach to address homelessness that prioritizes providing housing to people experiencing homelessness prior to other services.[139]

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[134] Elaine Fultz, *Disability Insurance in the Netherlands: A Blueprint for U.S. Reform?* CTR. ON BUDGET & POLICY PRIORITIES (Sept. 16, 2015), https://www.cbpp.org/research/retirement-security/disability-insurance-in-the-netherlands-a-blueprint-for-us-reform.

[135] *Id.*

[136] COMM. ON AN EVALUATION OF PERMANENT SUPPORTIVE HOUSING PROGRAMS FOR HOMELESS INDIVIDUALS, *supra* note 74, at vii.

[137] *Id.* at 14.

[138] *Id.* at 34.

[139] *Housing First*, NAT'L ALLIANCE TO END HOMELESSNESS (Apr. 20, 2016), https://endhomelessness.org/resource/housing-first/.

> HUD defines permanent housing approaches to addressing homelessness "as community-based housing without a designated length of stay in which formerly homeless individuals and families live as independently as possible." There are two types of permanent housing: permanent supportive housing (PSH) for persons with disabilities and rapid re-housing. These program models follow the Housing First approach. In some communities, people experiencing homelessness also get priority access to long-term rental assistance in public housing or the private market, with the latter provided primarily by Housing Choice Vouchers. However, these programs typically have waiting lists, so are rarely available to people at the time they experience homelessness. These subsidies do not generally have any associated services.[140]

A creation of more PSH sites that also offer therapeutic services, therefore opening them up to Medicaid funding, would be a long-term solution for people with SPMI.[141]

D. What America Sees

"People with mental health disabilities often fall victim to harmful misrepresentation and discrimination, including having their diagnoses and symptoms used to publicly mock and insult others. Similarly, homelessness is widely misunderstood, and people who experience homelessness are frequently exploited, objectified, and violently victimized."[142] Because of society's beliefs and views of the homeless population, attempts to change a community's response to homelessness can ignite intense opposition which can been seen through research on shelter locations.[143] "Decentralization proposals are endorsed by residents of poor neighborhoods, who argue that their areas constitute dumping grounds already saturated with undesirable service sites. In contrast, inhabitants of outlying urban and suburban neighborhoods tend to object vigorously to shelter

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[140] COMM. ON AN EVALUATION OF PERMANENT SUPPORTIVE HOUSING PROGRAMS FOR HOMELESS INDIVIDUALS, *supra* note 74, at 30.

[141] COMM. ON AN EVALUATION OF PERMANENT SUPPORTIVE HOUSING PROGRAMS FOR HOMELESS INDIVIDUALS, *supra* note 74, at 9 ("The Centers for Medicare & Medicaid Services should clarify the policies and procedures for states to use to request reimbursement for allowable housing-related services, and states should pursue opportunities to expand the use of Medicaid reimbursement for housing-related services to beneficiaries whose medical care cannot be well provided without safe, secure, and stable housing.").

[142] Heidi Schultheis, *Lack of Housing and Mental Health Disabilities Exacerbate One Another*, CTR. FOR AM. PROGRESS (Nov. 20, 2018), https://www.americanprogress.org/issues/poverty/news/2018/11/20/461294/lack-housing-mental-health-disabilities-exacerbate-one-another/.

[143] Lee, Tyler & Wright, *supra* note 98, at 512.

relocation plans."[144] Middle-class residents have been quite successful in keeping shelters out of their communities through litigation, zoning regulations, and other measures.[145]

Negative societal reactions to the homeless population have resulted in the criminalization of normal behaviors.[146] The presence of homeless people in downtown public spaces has resulted in many cities criminalizing eating, drinking, resting, sleeping, and performing bodily functions because of where they occur.[147] "Criminalization entails aggressive police enforcement of quality of life ordinances that prohibit activities such as loitering or camping. Some ordinances target those who seek to help the homeless, cracking down on feeding programs and similar forms of assistance pursued out in the open."[148]

So, what are you supposed to do if you are homeless and have an SPMI? Society has framed you as deviant, dysfunctional, and being overall "undesirable," and policymakers share these beliefs. This results in in outrageously deficient social welfare programs leaving one without an income to change the situation, nor an adequate housing option, and further, your attempts to meet your basic needs are criminalized.

i. Solutions

Media coverage needs to show the homeless population for what it actually is: a diverse group of individuals who, due to many factors outside of their control including a lack of adequate resources, have become homeless. This would help the general public develop more empathetic notions of homelessness and help to form a storyline that does not encompass deviance or dysfunctionality. Society developing empathy for this population would put pressure on policymakers to do something more than tell local communities to come up with a plan to solve homelessness.

Normal, basic, need meeting behaviors, e.g. eating, resting, etc. need to be decriminalized. Criminalizing these behaviors fuels beliefs that the homeless are deserving of their circumstances and have created their homelessness. It supports the already existing narrative that homeless people and people with SPMI are punishable criminals. It also supports irrational fears people have about interacting with people who have SPMI and are homeless.

Advocacy organizations can seek federal intervention via housing discrimination laws to address local officials shielding communities from homeless

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[144] *Id.* at 512-13.

[145] *Id*. at 513.

[146] *Id.*

[147] *Id*.

[148] *Id*.

facilities.[149] This would help to address an overall lack of housing, including transitional housing, and would force a greater exposure to the homeless population. Having proximate exposure to the homeless population could help remove some of the stigma associated with this population and help the general population to see homeless people as people.

IV. CONCLUSION

Lack of effective treatment, poverty-level income, and lack of housing options creates a systemic barrier that prevents people suffering from SPMI from recovering. Without effective treatment, people with SPMI are not able to control their symptoms and are therefore not able to engage in employment further relying on SSI and SSDI for income. With poverty-level income, homeless individuals are not able to afford housing, so they are forced to rely on government housing options which are limited and have waitlists. The end result is continued illness and homelessness.

Simply providing better treatment would allow someone with SPMI to manage their mental health more effectively and potentially eliminate severe symptoms of SPMI. This would support the individual in obtaining employment eliminating their need for SSI or SSDI altogether. With their mental health symptoms under control and access to stable employment, these individuals would have income to support their own housing. Homelessness *does not* have to be a problem.

However, better, more effective social welfare policies and programs will never exist within the current cultural and societal beliefs held by Americans. Stigmas associated with mental illness, racism, and the notion of "I" before "we" does not support real change. Shunning and criminalizing those who have the highest level of need is despicable, and until we see this population as being in need rather than as criminals, the policies will not change.

[149] *Id.*