

Searching for Home: Mentally Ill Homeless People in America

God, if you look upon me
From your whitened dome,

Let this blue earth hold me
While searching, I come home.

—Aviva Schwager
Patient, The Bridge

On any given night in the United States, an estimated 600,000 people are homeless.¹ Of those, approximately 200,000 suffer from serious mental illness. Unfortunately, these are facts that no longer hold surprise for most Americans. We have grown accustomed to the sight of the wild eyed, dirt-covered man on the corner. We have become used to averting our gaze from the toothless old woman who mutters to herself at the bus stop and wears many layers of clothes even in warm weather. We are no longer as shocked as we were a decade ago at the sight of small children crouched beside their parents, panhandling on some of our busiest streets.

A Gallup poll reported last year that although most Americans feel compassion for homeless men and women they encounter on the street, many are puzzled, not knowing how to react to this growing problem that seemed to emerge out of nowhere. Some cities have dealt with their homeless populations by jailing individuals for sitting on the streets or sleeping in parks. Other cities, citing public health concerns, have bulldozed encampments and shantytowns built under city bridges. Unable to find a simple, inexpensive solution to the problem, many individuals and communities prefer to pretend that it does not exist. While there is no single solution for this problem, some responses have been more successful than others. When combined, these responses have, in the past 3 years, made a tremendous difference in the lives of homeless Americans.

Because homeless men and women are still so visible in our communities, few people realize that over the past 3 years the number of homeless people helped by the government has increased by more than 1,000 percent. Few seem to know that

a major shift in thinking about and creating programs to address homelessness has occurred on the national and local levels, resulting in unprecedented success in dealing with the problems faced by this population. Few people realize that this approach, which we call the *Continuum of Care*, has resulted in a major shift of national priorities away from emergency shelter services toward long-term solutions such as transitional and permanent housing, job training, and medical and mental health services.

In this essay I will describe the current situation faced by homeless people with serious mental illness and explore the origins of the problem of homelessness, recent efforts that are working, and what is needed to remedy what has become a serious national problem.

The Present: A Snapshot of Mentally Ill Homeless People in America

It is difficult to imagine a more dangerous or more distressing combination of problems to befall any one person than to be homeless and to suffer from a severe mental illness. Yet those who are homeless and mentally ill are often diagnosed with many accompanying disabilities—such as drug addiction, alcoholism, HIV/AIDS, diabetes, and tuberculosis. Mentally ill homeless people tend to be the sickest, the most ragged, and the most difficult people for society to accept. In addition, because rationality itself is compromised by mental illness, they are often the least able to help themselves, either economically or medically, and thus they slide more deeply into danger.

Who are mentally ill homeless persons, and how do they survive? They are among the poorest people in our Nation, earning or receiving in Supplemental Security Income (SSI) and other benefits an average annual income of \$4,200. While most would like to work, this population faces some of the highest barriers to employment. It is estimated that one-half of the mentally ill homeless people suffer from drug and alcohol abuse, and many use substances as a method of self-medication. An estimated 4 percent to 14 percent of adults in family shelters have been in a mental hospital.

Because mentally ill homeless men and women are vulnerable to attack, they are often victims of violent crime. Some of the crimes against them are examples of the worst behavior imaginable. But many mentally ill homeless also come into contact with the criminal justice system as offenders, arrested as they engage in such illegal activities as trespassing, petty theft, shoplifting, and prostitution—often crimes of survival under the most desperate of conditions, and a direct result of their mental illness.

While some individuals are a threat to others, the greatest threat many mentally ill homeless people pose is to themselves. More than once, I have had conversations with men and women in obvious misery and pleaded with them to get a broken leg set or to come in out of the cold, only to have my offers rejected. Unable to comprehend the origin of their pain, and always suspicious of offers of help, these people become vulnerable to freezing to death in winter, having limbs amputated, or dying prematurely from a range of illnesses.

Figure 1

Profile of the homeless persons reported to be using community mental health centers

- 75 percent are between 20 and 44 years old.
- 71 percent are male.
- 47 percent have no insurance. In addition, 33 percent receive Medicaid; 15 percent have either Medicare, veterans benefits, or other; 4.5 percent are self-pay clients; and 0.5 percent are privately insured.
- 32 percent live at shelters; 27 percent live on the streets; 17 percent live with family or friends; 10 percent live in transitional housing; 7 percent other; and 7 percent unknown.

Source: Brown, 1996; Ion and Cordray.

The median age of the homeless has decreased. The average homeless person today is in his or her early to mid-30s. Although 21 percent of homeless persons with mental illnesses at community mental health centers are self-referrals (see figure 1), the majority of homeless clients are referred to the centers by emergency shelters, hospital emergency rooms, police, State psychiatric hospitals, and the criminal justice system.

These individuals suffer from severe mental illnesses such as schizophrenia, mood disorders, severe depression, and personality disorders. Given consistent medical and psychosocial treatment along with stable housing, many of them could again function at a high level. But such stability and consistent care are impossible to achieve when one is homeless. Thus homelessness and mental illness become a vicious circle, one compounding the other in a vortex of suffering for the individual. Unfortunately, without mental health treatment and related support services, it is difficult for mentally ill homeless persons to gain access to, and remain in, permanent housing. Often they face stigma associated with their illness and discrimination by potential landlords or neighbors. All of these factors make individuals with serious mental illnesses extremely vulnerable to homelessness and difficult to help once they become homeless.²

History of the Problem: How Did We Get Here?

Contemporary homelessness came to the general public's attention in the late 1970s and early 1980s.³ Since the most visible members of the "new" homeless population were often disheveled and disoriented, and since it was common knowledge that State mental hospitals had been returning their chronic patients to the community, many people assumed that the rise in homelessness was a result of State deinstitutionalization policies. The true reasons for the rise in homelessness are far more complex. Deinstitutionalization and the inability of some community mental health programs to serve the most severely disabled did play a significant part in creating the problem, but other factors played important roles as well.

Deinstitutionalization

Until the late 1950s and early 1960s, most Americans suffering from serious mental illness were long-term residents of State mental hospitals, where all their care was administered under one roof. Then, because of changes in the technology of mental health treatment (in particular, the advent of psychotropic medications), the process of deinstitutionalization began. Along with the depopulation of State hospitals, stricter criteria were implemented for new admissions, and authority for the planning and provision of mental health services was decentralized from the State to local communities.⁴

Advocates of deinstitutionalization knew that the asylum was not the best place for the mentally ill. However, deinstitutionalization was intended to be only the first step in a careful shifting of money and responsibility to community mental health centers. What actually happened was the worst possible combination of events: Deinstitutionalization began, but funds for the planning and implementation that were supposed to create responsive community care were cut.

The population shift was sudden and dramatic. Nationally, the census of State mental hospitals was reduced from 560,000 in 1955 to 216,000 in 1974 and to 100,000 in 1989. Many formerly institutionalized patients either died, were eventually moved to nursing homes, or moved in with their families. Others were denied admission to State hospitals because of the stricter admission policies or were admitted for shorter stays. Upon release, they went home to live with their families; were placed in group homes or supervised apartments run by mental health centers; or resided in board-and-care homes, single-room occupancy (SRO) hotels, and other forms of marginal housing. Many mentally ill people were released from institutions without a safety net of assured treatment, supportive services, or appropriate housing.

Because mental health systems are run by States, the rate and timing of deinstitutionalization varied by State. In New York, for example, the depopulation of State hospitals was largely completed by 1978, before the rise in homelessness there became pronounced. In Illinois, the State hospital population dropped from 23,000 in 1971 to 10,000 in 1980.⁵

Patients who were deinstitutionalized or discharged from short-term hospitalization without adequate housing and supportive services were not the only persons to suffer from the lack of community-based resources. The National Institute of Mental Health (NIMH) funded 10 studies to determine the socioeconomic and mental health status and the service needs of homeless people. By 1989 this body of research had established that approximately one-third of the single adult homeless population had a serious mental illness and about one-half of this subgroup had a co-occurring substance-use disorder. NIMH also found that only about one-half of this group had ever been hospitalized for a psychiatric disorder. The lack of an accessible, comprehensive system of community care meant that many who in an earlier era would probably have been institutionalized fell through the social safety net and ended up on the streets.⁶

Federal Mental Health Legislation

In the mid-1960s, deinstitutionalization and efforts to promote alternatives to hospitalization were powerfully reinforced by Federal legislation. The Community Mental Health Centers Act of 1963 authorized Federal funding for the construction and operation of comprehensive community mental health centers (CMHCs) to provide outpatient, inpatient, emergency, consultation, and partial hospitalization services for the deinstitutionalized population.

However, fewer than one-half of the number of CMHCs originally proposed were funded, and little coordination developed between CMHCs and State hospitals. Additionally, CMHCs were frequently criticized for delivering insufficient care to discharged hospital patients. By 1977 the U.S. General Accounting Office had found fragmentation and lack of coordination among service providers to be the prime causes of inadequate care for people with serious mental illnesses.⁷

In 1980 Congress passed the Mental Health Systems Act—based on the Carter Commission’s National Plan for the Chronically Mentally Ill—to renew Federal commitment to community mental health systems. In 1981, however, the Act was repealed, which reversed the momentum of 17 years of Federal efforts to improve community-based systems. In its place, President Reagan signed a bill that cut Federal funds for mental health and created the Alcohol, Drug Abuse, and Mental Health Services Block Grant, to be administered by the States. With this change, the problems faced by mentally ill people grew much greater.

Medicaid and Other Fiscal Incentives

The creation of Medicaid in the mid-1960s further promoted the shift in the locus of care from State hospitals to community-based treatment programs, particularly nursing homes and general hospitals, because Medicaid does not reimburse for care in State hospitals. In addition, SSI and the Supplemental Security Disability Insurance (SSDI) program provided direct entitlements to mentally disabled individuals living in the community. SSI also subsidized the cost of living in special housing settings such as board-and-care homes and other types of community residential facilities.

The Supply and Cost of Housing for People With Serious Mental Illnesses

Despite the lack of program help, most deinstitutionalized mentally ill men and women avoided homelessness until the late 1970s. What caused this change? In the 1960s and early 1970s, housing was generally plentiful and affordable. However, the overall supply of low-cost rental units declined radically between the mid-1970s and mid-1980s. During this period, the Nation lost 780,000 units with rents less than \$250, mostly due to urban renewal, inflation, and gentrification. At the same time, Federal expenditures on public housing were cut by 80 percent between 1980 and 1987. For people with low incomes, the impact was severe.

The mentally ill population was especially hard-hit by the decline in the supply of SRO units in low-cost hotels. It was in this type of unit that many former State hospital patients lived. Between 1970 and 1982, more than one million SRO units were lost to urban renewal and gentrification. The number of people living in hotels and rooming houses who had no other permanent addresses dropped from 640,000 in 1960 to 204,000 in 1980, and to 137,000 in 1990.⁸

The number of low-rent SRO units in Atlanta decreased from approximately 2,000 to 233 between 1970 and 1983; Chicago lost 18,000 units between 1973 and 1984; in New York City, units declined from 127,000 to 14,000 between 1970 and 1980; Portland went from 4,128 to 1,782 units between 1970 and 1987; San Diego lost 1,247 units in 30 hotels between 1976 and 1984, and by 1990 had only about 3,500 units left; San Francisco lost 5,723 of its 32,214 units between 1975 and 1979; and Seattle lost some 15,000 units between 1960 and 1981.⁹ Not only was housing stock lost, but the cost of housing rose dramatically—often exceeding the SSI payments that are the bulk of income for many mentally ill Americans.

In 1984 the average annual income for a national sample of persons with serious mental illness was \$4,200.¹⁰ The monthly fair market rent (FMR) for a one-bedroom unit in Philadelphia was \$471, while the maximum monthly SSI benefit was \$418. This same situation—low SSI payments and high rents—was occurring across the Nation. In Minneapolis-St. Paul the FMR was \$455, while the monthly SSI benefit was \$461; in New York City the FMR was \$504, but the SSI was \$472; and in San Francisco the FMR was \$748, while the monthly SSI benefit was only \$630.¹¹ For people receiving SSI, finding a place to live became nearly impossible. In 1990, in at least 12 cities around the country, a person receiving SSI would have to spend his or her entire benefit to cover the cost of an average one-bedroom unit.

SSI Disability Reviews and Related Policies

To make matters worse, in the early 1980s under the Reagan administration the Social Security Administration instituted a policy of aggressively reviewing claims for disability benefits. As a result of these new Federal guidelines, an estimated 491,000 people were dropped from the disability rolls of Social Security, and persons with serious mental illnesses were disproportionately represented. Although benefits for more than 200,000 were reinstated following appeal, so many people became homeless as a result of this policy that a class action suit was filed on their behalf. When the case was won, back payments of SSI were placed in trust to develop permanent housing for many of the individuals who could be located. Unfortunately, many were already homeless and were never found.¹²

The Role of Housing in Mental Health Policy

Although State policies of deinstitutionalization contributed to homelessness among people with serious mental illnesses, few experts in the field have advocated a return to the asylum. Instead, experts agree that improving the accessibility and availability of housing and community mental health services was, and is, far more appropriate than advocating reinstitutionalization.

Prior to the emergence of homelessness among people with serious mental illness, the role of housing in State mental health policy was one of transition. It was expected that some of those who had been institutionalized for many years would need a period of adjustment before returning to the community, living in what were typically called halfway houses, group homes, or community residences. It was assumed that nearly everyone could eventually—after a period of 6 months to 2 years—make the transition to independent living.

But it was not until 1978, when Federal legislation established the NIMH Community Support Program (CSP), that housing was considered a part of the range of needs of persons with serious mental illness. This modestly funded demonstration program (\$3 million to \$4 million per year distributed across 19 States) was designed to test alternatives to long-term institutionalization for persons with serious mental illnesses. The CSP model recognized that mental health treatment was not enough for many of the people with serious mental illnesses and that a community support system should include a comprehensive array of services, such as client identification and outreach, case management, mental health treatment, income maintenance, rehabilitation, medical care, and housing. Philosophically, most States and communities have adopted the CSP model, but financial constraints have limited the capacity to establish all the components of a comprehensive service system or to serve everyone in need.¹³

During the past 10 years, the rise in homelessness among people with serious mental illnesses has prompted State mental health agencies to take a more active role in developing housing and collaborating with public housing agencies and private housing developers. In 1987 the National Association of State Mental Health Program Directors published a position paper on housing for persons with serious mental illnesses. Today more than one-half of the State mental health agencies in the United States have designated staff assigned to address housing and homelessness issues.

Solutions

Homelessness, especially among people with severe mental illness, is a problem for all of American society. Most importantly, it is a problem for those individuals experiencing severe mental illness. It is a problem for the majority of Americans who feel compassion but are frustrated with the slow pace of progress. It is a problem for parents, who no longer feel comfortable walking with their small children through neighborhood parks and for business owners, who see their customers turn away because of the ragged homeless person camped near the front door. It is a problem for those of us in the Federal Government who know that the health of our country is only as strong as the compassion shown to our poorest citizens. It is a problem faced increasingly by local governments, community organizations, and police forces—all of which have been the sometimes reluctant beneficiaries of decentralization policies that place the responsibility for coping with homelessness squarely on their shoulders.

The good news is that although homelessness among people with mental illness is a significant challenge for the country, increasingly it is a challenge we are finding ways to meet. In 1996 the U.S. Department of Housing and Urban Development

(HUD) spent 37 percent of its homeless assistance funds to serve the mentally ill homeless population. It is estimated that from 1993 to 1995 HUD's homeless assistance programs helped as many as 400,000 homeless people—many of them mentally ill—attain permanent housing and self-sufficiency. But because homeless persons with severe mental illnesses are often the most visible, the most difficult to reach, and the most difficult to ignore on our streets, it appears to the uninformed American that the problem continues unabated.

As with so many of society's problems, we do a disservice to this issue by looking for one ultimate solution. Through decades of trial and error, we have come to understand that although there is no one solution to the problem of homelessness, solutions can be crafted as a series of steps that, when taken together, provide real help.

Until the last few years, the social service delivery system for homeless persons was a loose association rather than a structured system. One of our greatest efforts has been to change the overall structure of the social service delivery system by integrating services for the homeless population. According to studies on the subject, programs with adequate integration should:

- Assertively address mental health, substance abuse, and other problems through active outreach and services.
- Closely monitor the need for services.
- Integrate mental health and substance abuse interventions.
- Involve a comprehensive set of services for developing living, interpersonal, vocational, and social skills.
- Ensure a stable residential situation with a continuum of housing options that are safe and free of illegal drugs and alcohol.
- Understand that chronic mental health and substance abuse problems need long-term treatment.
- Commit to the belief that improved quality of life is possible for an individual, regardless of the nature and severity of his or her problems.

In my years as Mayor of San Antonio and as Secretary of Housing and Urban Development, I have seen sensitive, well-conceived policies make a dramatic difference in the number of homeless persons on the street and the quality of life of those who remain homeless. Over the past 3 years, the Clinton administration has initiated an entirely new Federal approach to the problem of homelessness that functions by combining these solutions into a new approach, the *Continuum of Care*.

The Continuum of Care

In 1993 President Clinton directed the Interagency Council on the Homeless to develop a Federal plan to address homelessness. The Federal plan to break the cycle of homelessness—*Priority: Home!*—was developed, and the Clinton administration's Continuum of Care concept was put forth. This concept combines prevention, outreach, assessment, emergency shelter, and transitional and perma-

ment housing with necessary services such as job training, child care, substance abuse treatment, and mental health services.

HUD's implementation of the Continuum of Care is designed to encourage localities to develop a coordinated, comprehensive, long-term approach to homelessness. We have structured a comprehensive approach of program and service delivery for homeless individuals and families that builds partnerships among States, localities, not-for-profit organizations, and the Federal Government.

The Continuum of Care approach has one main goal: to help homeless individuals and families move to self-sufficiency (to the extent possible) and to permanent housing. It operates simultaneously on the individual level and the community level. For homeless individuals, the Continuum of Care ensures a variety of options ranging from outreach, assessment, and emergency and transitional services to temporary and permanent housing. At the community level, HUD encourages localities to design and implement a coordinated process through which various sectors act in concert to provide services and housing.

HUD has identified several components that are basic to its Continuum of Care approach. While not all will be needed by every homeless person, the following components must be in place in order for the continuum to be viable in a community:

- Outreach and assessment, to identify the needs of individuals or families and to link participants to appropriate facilities and services.
- Emergency shelter, to provide safe alternatives to the streets and referrals to service providers and housing opportunities.
- Transitional housing, with supportive services appropriate to the problems faced by individuals or families not prepared to live on their own. Such services may involve job training, job placement, substance abuse treatment, short-term mental health services, or training in independent living skills.
- Permanent housing, with or without supportive services.

A strong prevention strategy is also a key element of the Continuum of Care.

While the Continuum of Care is intended to be a system of services and housing to meet the needs of the entire homeless population of any community, it must include a component that specifically addresses the needs of mentally ill homeless persons. Since the Continuum of Care approach has been implemented, more homeless people are being helped by federally funded programs.

An independent study recently completed by the Barnard-Columbia Center for Urban Policy reports that the Continuum of Care is working. The study (with site visits to nine American cities) includes an analysis of the effectiveness of the Continuum of Care and reflects significant progress during the Clinton administration. The study found that:

- Significantly more persons appear to have been served as a result of HUD's new policies.

- HUD's homeless assistance funding has shifted from emergency measures to programs that provide transitional and permanent housing. Funding for transitional and permanent housing programs increased from \$331.2 million to \$931 million (a 181.1-percent increase), while emergency funding for shelter and services increased from \$72.4 million to \$156.8 million (a 116.5-percent increase).
- The Continuum of Care approach has resulted in significantly more assistance for homeless persons with disabilities (including those with severe mental illnesses, substance abuse problems, HIV/AIDS, and physical disabilities).

In addition, the study found that, due at least in part to the Continuum of Care process, the concept of community participation has expanded, bringing together a broad-based group of public and private stakeholders: business and civic leaders, service providers, local and State government representatives, elected officials, advocates, and people who are or have been homeless. In the past, those stakeholders did not have the incentive to plan together.

Community stakeholders have realized that they can accomplish together what no single group could accomplish alone, and they are building on existing strengths and resources to avoid duplication of efforts and create opportunities to move beyond long-standing concerns about preserving "turf." The Continuum of Care promotes a process of compromise and consensus-building in order to resolve problems and address differences of opinion and philosophy. Local autonomy is encouraged through sufficient flexibility for communities to identify particular local resources and needs and to implement policy and program priorities appropriate to the needs of local homeless populations.

There are two primary ways the Continuum of Care concept can work on behalf of persons with mental illness. First, various providers in a community come together to provide a highly coordinated range of services and housing for people with severe mental illness. Second, community organizations provide a full range of services and care under the auspices of one organization, in effect a multiservice program for mentally ill homeless persons within the larger Continuum of Care. Following are descriptions of two of the best examples of the Continuum of Care concept, The Bridge, Inc., in New York City and Christ House in Washington, D.C.

The Bridge

"One of the hallmarks of our program is that each person is treated as someone quite precious," says Murray Itzkowitz, executive director of The Bridge, Inc., a nonprofit, nonsectarian organization that was founded in 1954 in New York City. "Our philosophy is to look at the successes in our clients' lives. We incorporate people into a kind of family. It's a much more compassionate approach."

Serving more than 600 men and women a year, The Bridge provides a range of services to men and women with mental illnesses: temporary and permanent housing, mental health treatment, vocational training and job placement, health care, education, and opportunities to learn independent living skills. HUD has provided funding to The Bridge through its Supportive Housing program, which supports New York City's Continuum of Care system.

Organizations such as The Bridge offer total assistance to the client to help that person build a life and a support system that will be there during tough times. That means creating a second family at The Bridge, as well as helping to reunite primary families, many of which have been estranged for years or even decades.

At The Bridge, the Continuum of Care begins with the street outreach and intake process. When someone agrees to leave the streets, counselors devise a personalized treatment plan that will provide the care and services the individual needs to become stabilized and able to move toward increased functioning and self-sufficiency. “The continuum process can take a long time,” says Itzkowitz. “It usually takes years to see a person through to the point where they’re stabilized, able to communicate, and derive satisfaction in life. It’s expensive and it takes a long time. There is no way around it.”

With a staff of more than 160 mental health and allied professionals and paraprofessionals, these are the kinds of services The Bridge can offer:

Continuing day treatment. This program offers structured activities to help stabilize patients and prevent relapse.

Extensive outreach and programming for the homeless. From a lightly structured, low-commitment drop-in center for homeless people living in encampments and on the streets to more intensive case management and treatment services for mentally ill persons suffering with HIV and AIDS, The Bridge makes it easier for homeless individuals to receive help.

Housing. Two residences now under construction will add 51 beds for homeless mentally ill adults to the housing already offered by The Bridge. Existing housing includes an 8-bed residence for homeless encampment occupants and a 24-bed residence for psychiatrically and physically frail individuals. A 67-bed scattered-site apartment program, now in its 17th year, offers mentally ill and homeless adults the opportunity to move from supervised to independent graduate housing. Many homeless adults who start out in The Bridge’s supervised, single-site, transitional residences move to less-supervised, scattered-site permanent housing, and ultimately to graduate housing. By the late 1990s, The Bridge will help provide 313 mentally ill persons with permanent housing.

Health care. Few services are needed more sorely by the homeless than medical attention. The Bridge employs two full-time nurses and offers the onsite part-time services of a physician and nurse team.

Vocational training and job placement. Clients are trained in food services, building maintenance, mailroom and messenger service, clerical service, and as coatroom attendants. A full-time job placement service is also available.

Mental health clinic and intensive psychiatric rehabilitation treatments. Under these two programs, The Bridge provides individualized psychiatric services to its patients. According to Itzkowitz:

If it [weren’t] for Federal support, none of these things would be available. Housing is key. Once you stabilize housing, you can do rehabilitative work.

Without housing, it's a no-win situation. Whatever you gain in the day through therapy and other services, you lose at night on the streets.

The Bridge is an excellent example of a highly specialized continuum of services and housing for persons with mental illnesses. Project Return Foundation and BRC Human Services, located in New York City, also offer a continuum of services for homeless, mentally ill adults.

Christ House

Just Wondering

If I fell would you help me up?
If you had a cup of coffee, would you share a cup?

If I were hungry and had no place to stay,
would you lend a hand and help me on the way?

Would you help me get back on my feet
or just pass me by and leave me on the street?

If I were poor black white Hispanic or other,
would you be willing to treat me as a brother?

If all the things above were not about me but instead about you,
sometimes I wonder just what I would do.

—Former Christ House Patient

There are few places more disturbing to see homeless people without help and without hope than in our Nation's capital. Here, in the shadows of the White House and the Washington Monument, in the city where some of the most powerful people in the world meet, an estimated 8,000 people are homeless on any given night.

On a city street about 4 miles from the Lincoln Memorial, hope and care are visible every day and every night at an example of the Continuum of Care called Christ House. Serving homeless people with disabilities, including mental illness, Christ House is a place to heal.

"This is the place where people who don't have a home go to recover," says founder and medical director Dr. Janelle Goetcheus. It is also a place that the staff calls home—literally. Determined to create a homey, comfortable atmosphere for their clients, most of the staff of Christ House—doctors, nurses, program directors—live on the building's third floor with their families.

Often an early morning call starts things rolling. The call is usually from a hospital where a homeless man has just undergone surgery, received chemotherapy, or failed to receive treatment for his illness. "They ask us if we can take one of their patients, someone who otherwise would just be [released to] the streets in very bad condition," says Goetcheus. Patients are accepted only after a detailed screening determines that the ill person is well enough to be cared for by Christ House.

If the person is too ill to benefit from its services, Christ House works with the referring agency to locate appropriate care.

All Christ House patients are homeless. Christ House provides 24-hour nursing care, psychiatric care twice a week, three full-time social workers, job placement services, and 36 sick beds. The average stay is 1 month. In addition, Christ House has opened placement and transition housing for extended care. In January 1996, 37 apartments were made available to patients who could manage a less structured environment. Section 8 housing is also available. In 1995, Christ House established the Kairos House—a permanent home for 37 mentally ill people who need supportive services. Approximately two-thirds of Christ House patients are discharged to some form of alternative housing.

Christ House also operates a daily medical van that takes its services into the streets and to the shelters where homeless men and women congregate. Late into the night, lines of homeless people are often seen waiting their turn as Christ House nurses and doctors treat maladies ranging from colds to diabetes and AIDS. “Unfortunately,” says Dr. Goetcheus, “I see younger and younger people on the streets these days. Thirty-year-olds who have given up on life. With a poor education and a drug addiction, often just out of jail, often hooked on crack cocaine, they are some of the most needy.”

But without doubt, the biggest challenge for Christ House, as with similar treatment centers, is getting patients to overcome their distrust and walk through the door to ask for help. Most afternoons find several men standing in front of Christ House. At least one of them is a recruiter or counselor who talks to the homeless men nearby, trying to get them to trust him enough to come in for medical attention, a warm meal, and perhaps a shower and some help. “[F]ormer patients are our best recruiters,” says Dr. Goetcheus. “They know how to talk to the men, and they know what a big difference we can make.”

Successful HUD-Sponsored Programs

All of the programs mentioned above have received funding from one or more of HUD’s homeless assistance programs such as the Shelter Plus Care program, the Supportive Housing Program (SHP), and the Moderate Rehabilitation SRO program made possible by the McKinney Act. Together these programs comprise HUD’s Continuum of Care funding.

The Shelter Plus Care program provides rental assistance for persons with mental and physical disabilities and requires that organizations match the rental assistance, dollar for dollar, with supportive services.

SHP is far more flexible and can be used to fund transitional housing and supportive services for homeless individuals and families, as well as permanent housing for persons with disabilities. The growing use of SHP funds to establish and support “safe havens” for street-dwelling persons with severe mental illnesses is especially important. Safe havens provide safe residences for such persons when they are unwilling or unable, because of their illness, either to accept traditional mental health services or to adapt to highly structured transitional or permanent

housing arrangements. Safe havens do not require the client's participation in services, but it is hoped that residents will in time participate in mental health programs and move to more structured transitional or other supportive housing.

The Moderate Rehabilitation SRO program provides rental assistance in connection with the moderate rehabilitation of residential properties, helping to replace some of the low-cost, SRO housing units on which very low-income individuals, including those with mental illnesses, have relied in the past for permanent housing.

These programs have proven invaluable in helping homeless persons with mental illnesses make the difficult transition from streets and shelters to permanent housing with supportive services as needed. For example, in 1996 alone, HUD provided \$261,519,777 for 374 projects nationwide designed to help homeless mentally ill persons.

Conclusion

Services for homeless people who suffer from severe mental illnesses are vastly different today from what they were just a decade ago. While we still have a long way to go on the Federal and the local levels, our outreach is more aggressive, our funding has increased significantly, our outlook is more comprehensive, and our efforts are paying off. Today, many community mental health centers and residential programs perform intensive, aggressive outreach to homeless people, visiting shelters, soup kitchens, river banks, and churches to reach those who need their help the most. Outreach, however, is only the beginning.

While present trends in Federal housing policy emphasize devolution and decentralization for program design, implementation, and funding, State mental health and affordable housing agencies around the country are confronting new challenges that will have a major impact on their provision of housing and support services to persons with serious mental illnesses. The emergence of managed care, welfare reform, and the virtual elimination of new Section 8 rental subsidies present potential pitfalls as well as opportunities for improving the social safety net and creating permanent housing for homeless and at-risk individuals with serious mental illnesses.

The Federal Government needs to do a better job of connecting its efforts with State and local governments. We must practice what we preach when it comes to the Continuum of Care and reach out across agencies to work together in a comprehensive way that helps communities design approaches to address the needs of the homeless mentally ill population. With health, mental health, and social services from the U.S. Department of Health and Human Services (HHS) and State governments, housing assistance and supportive services from HUD, and help for veterans from the Department of Veterans Affairs, the Federal Government can do a better job of helping those with the greatest needs.

Earlier this year, HUD and HHS entered into a partnership to ensure housing and supportive services for homeless individuals with multiple diagnoses of mental illness, substance abuse, and HIV/AIDS. Using monies set aside for this hard-to-serve but critically ill population, the two departments funded nine model programs across the Nation that integrate housing and health services.

This type of Federal effort will help our communities respond better to the problems we face today. Together we can create a network of services that provides solutions for this troubled population, with some that provide less-intensive psychiatric treatment and others that provide the more extensive psychiatric services needed by a part of the homeless population. What we must also do, regardless of the level of psychiatric need, is help fund the community services such as housing, counseling, job services, and medical monitoring to help homeless people more adequately.

If, as a Nation, we choose to do little while hundreds of thousands of our men, women, and children live in abject poverty and misery, we will have failed to live up to our responsibility. Recently, when talking with a group of care providers, I was told about a man who had lived under a bridge in Washington, D.C. The man was covered with filth, ate out of garbage cans, and had no ability to communicate. A case worker described him as absolutely antisocial in his behavior and utterly resistant to care. However, with persistence, the man was finally persuaded to receive care at Christ House. Today he is a different person. He lives in one of the agency's less-structured residential apartments and is an inspiration to many with whom he comes in contact.

Without the outreach, medical attention, stability, counseling, and housing provided by Christ House, this man would be either dead or still living in inhuman conditions under one of our capital city's bridges. Those of us who are able—who drive on that bridge or walk the streets and pass homeless mentally ill persons such as this man—have a responsibility to provide not only the relatively easy charity of a bed to sleep in for a single night but also the truly charitable gift of a way to live with independence and dignity. As a Nation we are on the right path to help this situation, but we need to do more. In too many cities, appropriate housing and other help are not readily available for people living in the streets. This must change, and it must change soon.

I would like to see our Nation go a step further than we have already gone in meeting the needs of mentally ill homeless persons. Decentralization and devolution are realities. The challenge before us is to continue to foster an environment in which local community groups and governments are able to provide real support for individuals to make the shift from homelessness to stable housing. The Bridge and Christ House show us that community-based efforts work, with mental health professionals and a complete system of mental health and other services leading the way toward more humane and effective treatment of the American men and women who are homeless and mentally ill.

Notes

1. The Department wishes to acknowledge the contributions of Linda Burstyn, freelance writer, for making this essay possible.
2. From an unpublished paper prepared for HUD, "HUD's Response to Homelessness Among People Who Have Serious Mental Illnesses: Analysis and Next Steps" by Deborah L. Dennis and Deirdre Oakley, Albany, New York,

- September 1996. For further discussion of the factors making housing inaccessible to persons with mental illnesses, see Technical Assistance Collaborative (1995) and Carling (1994).
3. See Baumohl and Miller (1974); Segal, Baumohl, and Johnson (1977); Reich and Siegel (1978); Baxter and Hopper (1981); Lipton, Sabati, and Katz (1983); and Bassuk, Rubin, and Lauriat (1984) for a representative sample of publications that first heralded the rise in contemporary homelessness and suggested the links among homelessness, mental illness, and deinstitutionalization.
 4. See Bachrach (1976) and Bachrach and Lamb (1989). For background on the consequences of deinstitutionalization and inadequate community mental health care, see Segal and Baumohl (1980).
 5. For a review of deinstitutionalization in New York, see Surles (1988); for deinstitutionalization in Illinois, see Appleby and Desai (1985); and for a discussion of national trends, see Bachrach (1990).
 6. For a synthesis of the 10 NIMH study findings, see Tessler and Dennis (1992); for the APA Task Force on Homeless Mentally Ill synthesis of what was then known about homeless people with serious mental illnesses, see Lamb (1984).
 7. For a review of the development of CMHCs, the closing of State hospitals, and the decline of inpatient populations, see Federal Task Force on Homelessness and Severe Mental Illness (1992:15–16); U.S. General Accounting Office (1977); Brown (1985); Rochefort (1993); and Torrey (1988).
 8. See Interagency Council on the Homeless (1994) and Dolbeare and Alker (1990).
 9. For a review of the loss of SRO units and cuts in housing nationwide, see Interagency Council on the Homeless (1994) and Dolbeare and Alker (1990). For statistics on SROs lost in various urban areas around the country, see Hoch and Slton (1989) and Hoch (1991).
 10. See Mulkern and Manderscheid (1989). Only 25 percent were employed part time or full time, and fewer than 10 percent were employed outside sheltered work environments.
 11. For a discussion of rising housing costs and shrinking low-income housing supply, see Interagency Council on the Homeless (1994); Dolbeare and Alker (1990); Hartman (1986); and Wright and Rubin (1992).
 12. Goldman and Cattozi (1988) and the National Law Center on Homelessness and Poverty (1990).

13. The CSP program initiated by the NIMH in 1977 was designed as a pilot Federal-State partnership project to explore strategies for improving the delivery of community-based services to persons with serious mental illnesses. Early findings from this demonstration indicated that the type of housing affected use of services. That is, clients living in cooperative apartments and group homes were better adjusted to the community than those living with families, in institutional settings, or board-and-care homes. For a complete review of the CSP program, see Stroul (1988) and Carling (1984).

References

- Barnard-Columbia Center for Urban Policy. September 1996. "The Continuum of Care: A Report on the New Federal Policy to Address Homelessness." New York, NY: Columbia University.
- Brown, June Gibbs. August 1996. "Community Mental Health Centers and Homeless Persons." A report from the office of the Inspector General of HHS. Washington, D.C.: U.S. Department of Health and Human Services.
- Burt, M.R., and B.E. Cohen. 1989. *America's Homeless: Numbers, Characteristics, and the Programs that Serve Them*. Washington, D.C.: Urban Institute Press.
- Christ House. Fall 1996. *Day by Day 10:4*. Washington, D.C.
- . 1995. "Christ House, A Health Care Recovery Facility for the Homeless." 1995 Annual Report. Washington, D.C.
- Dennis, D.L., and H.J. Steadman. 1991. "The Criminal Justice System and Severely Mentally Ill Homeless Persons: An Overview." Unpublished paper prepared for the Federal Task Force on Homelessness and Severe Mental Illness.
- Drake, R.E., S.J. Bartels, G.B. Teague, D.L. Noordsy, and R.E. Clark. 1993. "Treatment of Substance Abuse in Severely Mentally Ill Patients." *Journal of Nervous and Mental Diseases* 181:606–611.
- Federal Task Force on Homelessness and Severe Mental Illness. February 1992. *Outcasts on Main Street, Report of the Federal Task Force on Homelessness and Severe Mental Illness*. Washington, D.C.
- Ion, Georgine M., and David Cordray. "Meeting the Needs of Homeless Persons with Multiple Diagnoses Through Supportive Housing and Services." Nashville, TN: Vanderbilt University.
- Mulkern, V.M., and R.W. Manderscheid. 1989. "Characteristics of Community Support Program Clients in 1980 and 1984." *Hospital and Community Psychiatry* 40(2).
- Schwager, Aviva. 1996. *Bridges: Selected Poems From the Bridge Poetry Workshop*. Ed. Patricia Thackray. New York, NY: The Bridge, Inc.

Tessler, R.C., and D.L. Dennis. 1989. *A Synthesis of NIMH-Funded Research Concerning Persons Who Are Homeless and Mentally Ill*. Rockville, MD: National Institute of Mental Health.

U.S. Department of Housing and Urban Development. 1996. "Renewing Government: 1996 Consolidated Annual Report for HUD's Community Development Programs." Washington, D.C.: U.S. Department of Housing and Urban Development, Office of Community Planning and Development.