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### An Examination of Homelessness and Mental Illness: The Argument for Better Affordable Housing Policy

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An Examination of Homelessness and Mental Illness:  
The Argument for Better Affordable Housing Policy

by

Alexandra G. Tremblay-McGaw

This thesis is submitted in partial fulfillment of the requirements for the course Senior Seminar (EC 375), during the Spring Semester of 2018



Skidmore College  
Economics Department

While writing this thesis, I have not witnessed any wrongdoing, nor have I personally violated any conditions of the Skidmore College Honor Code.

### **Abstract**

What contributes to the homeless crisis in the United States? Why are some people chronically homeless? How does mental illness impact homelessness? The purpose of this paper is to summarize and critically analyze existing literature and policies regarding the topic of homelessness while specifically focusing on one of the most vulnerable subgroups of the chronically homeless population, the mentally ill. Additionally, San Francisco will be used as a case study in order to determine if the city as a whole fits within the trends explained across the literature reviewed. Policy recommendations are explained in Section 3.

## Introduction

What contributes to the homeless crisis in the United States? Why are some people chronically homeless? How does mental illness impact homelessness? What are some policies that can aid in decreasing the number of people living on the streets?

The topic of homelessness spans across many disciplines and is complicated. However, although homelessness can appear to be a social problem, it is also an economic issue (Braiterman, Jacobs, & Murray, 2017; Downs, 2011; Quigley & Raphael, 2001; Routhier, 2011). Economic factors such as the housing market, a lack of affordable housing, and a failure of local, state, and federal governments impact the homeless rate (Downs, 2011). Furthermore, increasing unemployment rates and decreasing real incomes for the lowest earners affect the prevalence of homelessness (Routhier, 2011). Additionally, more often than not, homelessness is associated with mental illness and addiction (Dennis, Levine, & Osher, 1991; Larimer, 2009; Newman & Goldman, 2009; Sinaiko & McGuire, 2006).

The purpose of this paper is to summarize and critically analyze existing literature and policies regarding the topic of homelessness while specifically focusing on one of the most vulnerable subgroups of the chronically homeless population, the mentally ill. Additionally, because San Francisco is a large city within the United States and has a large population of people living on the streets, I will examine San Francisco's homeless population as a case study in order to determine if the city as a whole fits within the trends explained across the literature reviewed.

My work contributes to the field by consolidating previous work, summarizing the definitions and causes of homelessness, as well as providing policy recommendations. Additionally, because few organizations and research groups have used a city case history to explore the homeless problem in the United States, I detail and critically analyze San Francisco's homeless crisis. Furthermore I compare and contrast San Francisco with other cities around the United States in order to provide a robustness check and verify whether or not the literature has accurately depicted what actual homeless Americans experience on a day-to-day basis.

Using data from the Department of Housing and Urban Development (HUD), I compile total year round beds available in the United States for the homeless population.

As seen in Figure 1, total year round beds available to the homeless population are decreasing. San Francisco experienced a sudden decrease right before the Great Recession (Figure 3). This decline has continued. Other cities such as Omaha and Tucson demonstrate similar trends (Figure 4, Figure 5). However, New York City did not follow any of the same trends that the other cities demonstrated (Figure 6). In line with previous literature, the lack of appropriate housing appears to be a large contributor to the homelessness epidemic in San Francisco (Braiterman et al., 2017; Dennis et al., 1991; Larimer, 2009; Newman & Goldman, 2009; Meschede, 2011; Routhier, 2011; Table 2). Additionally, various self-report databases and studies from San Francisco (Coalition on Homelessness, 2016; Connery, 2017) align with previous literature citing mental illness, addiction, and complicated policies that are too confusing as the main reasons for why homelessness is increasing (Dennis et al., 1991; Larimer, 2009; Newman & Goldman, 2009; Sinaiko & McGuire, 2006; Table 2). As a result, I conclude that the lack of housing options, complicated bureaucratic mazes, mental illness, and addiction contribute to the homeless epidemic in the United States and San Francisco.

The paper is organized as follows. *Section 1* provides the motivation, background, and literature review for this paper. *Section 2* introduces San Francisco as a case study and discusses the analysis as well as the robustness check and policy recommendations for the city specifically. *Section 3* details general policy recommendations for the United States as a whole, discusses trends in and limitations of my research, and concludes with a discussion of future research possibilities.

## *Section 1*

### **Motivation**

Homelessness is a complex problem as is mental health; studies examining the correlation or co-existence of these problems are varied but provide useful data. Although homelessness is complicated and expensive, our current national policy inadequately addresses it with a lack of affordable housing, housing programs that lack on-site services, and bureaucratic barriers to receiving help (Dennis et al., 1991; Newman & Goldman, 2009; Meschede, 2011). As a result, in this paper I will summarize and critically analyze existing literature and policies regarding homelessness, specifically focusing on one of the most vulnerable subgroups of the chronically homeless population, the mentally ill (Dennis et al., 1991; Larimer, 2009; Newman & Goldman, 2009; Sinaiko & McGuire, 2006). Additionally, because San Francisco is my hometown and has a large population of people living on the streets, I will examine San Francisco's homeless population as a case study. I conclude with making policy recommendations that could improve living conditions within the city. Additionally, throughout my analysis I will make policy recommendations that can be applied to the nation as well as San Francisco specifically. Because few have attempted to compile all of the research and information on homelessness, especially at the national level, my goal is to summarize and detail in an extensive literature review the research that has been done. As you will read, the topic of homelessness cuts across many disciplines and is complicated. However, researchers have demonstrated that various policies can provide hope for assistance to the homeless and also improve economic cost-savings.

Although homelessness can appear to be a social problem, it is also an economic issue (Braiterman, Jacobs, & Murray, 2017; Downs, 2011; Quigley & Raphael, 2001; Routhier, 2011). With a large portion of the population unemployed, including 56% of the homeless population, there is great economic inefficiency, manifested by a decreased workforce (Coalition on Homelessness, 2009). In a vicious cycle, economic factors such as the housing market, a lack of affordable housing, and a failure of local, state, and federal government impact the homeless rate (Downs, 2011). Furthermore, increasing unemployment rates and decreasing real incomes for the lowest earners affect the prevalence of homelessness (Routhier, 2011).

As a result, the overall cost of homelessness is comprised of specific costs—in healthcare, lost wages, and productivity. For example, the economic costs incurred by the government for homeless people who do not have insurance, but need access to health, legal, and social services can be up to \$150,000 per person annually (Laird, 2010). Yet, Larimer (2009) found that in a chronically mentally ill homeless population a “Housing First” policy significantly reduced costs and the benefits extended when the participants were housed longer. Even though the cost of service use was on average \$4,066 per person per month in the year prior to the study, after being housed for 6 months, costs were reduced by 53%. As a result, it is socially and economically valuable to study the intersection of homelessness and mental illness in an effort to determine effective policies for addressing homelessness and mental illness.

## **Background**

Homelessness is a problem around the globe and the number of people living on the streets has become increasingly troublesome. However, homelessness in the United States has not been studied extensively. More often than not, homelessness is associated with not only mental illness, but also addiction (Dennis et al., 1991; Larimer, 2009; Newman & Goldman, 2009; Sinaiko & McGuire, 2006). Therefore, measuring addiction and mental illness is important for understanding homelessness (Sinaiko & McGuire, 2006).

As a result of the newly effective psychotropic drugs and emphasis on psychiatry, in 1960 the mentally ill population in the United States was deinstitutionalized resulting in fewer patients in institutions. Because psychotropic drugs stabilized these people, many of the individuals released in 1960 were moved into private housing. As a result, they were able to live independently. However, because of budget cuts in 1975, many mental institutions were required to discharge the remaining patients who were labeled higher risk (Quigley, 1996). The patients released post 1975 required round-the-clock care because of their severe mental illness and thus, without that care, were at a higher risk for homelessness (Dennis et al., 1991). Although the deinstitutionalization of a certain portion of the mentally ill population may have contributed to the increase in the

homeless population, many argue that there are more important economic factors that impact homelessness (Braiterman et al., 2017; Newman & Goldman, 2009; Routhier, 2011).

## **Literature Review**

### Definitions of Homelessness

While homelessness is defined by some as not having a home, having little access to social support, and few social connections (Johnstone, Parsell, Jetten, Dingle, & Walter, 2016), others argue it manifests as a loss of complete autonomy and is characterized by the lack of support from friends and family, and a sense of endurance while struggling to survive within an ecological system (Table 1; Teo & Chiu, 2016). Homelessness might also be defined as the result of a loss of a dwelling from a natural disaster, an accident, or a combination of economic hardship, political and legal circumstances, and personal behavior (Crane & Warnes, 2000). While various aspects of homelessness have been explored, authors continue to dispute the extent to which homelessness should be defined and what the main causes are (Braiterman et al., 2017; Dennis et al., 1991; Newman & Goldman, 2009; Routhier, 2011; Teo & Chiu, 2016).

### Homelessness and Mental Illness

Multiplying the complexity of the issue, different authors variously define homelessness and mental illness, and disparately sample the homeless population; in addition, there is a great deal of variety in how mental health is reported and the methods researchers use to analyze the data, thus making it challenging to generalize across studies and come to a solid conclusion on the causes and solutions to the homeless problem plaguing the United States (see Table 2). In an extensive literature review, Dennis, Levine, and Osher (1991) assert that psychiatric disabilities, especially those that inhibit a person from functioning in society (i.e. working, maintaining relationships, etc.) can precede and expedite homelessness. In fact, homelessness is a health risk for someone who is mentally ill (Dennis et al., 1991). Additionally because practitioners find



it fundamentally challenging to treat the homeless population, a homeless status can make getting help even harder, perpetuating the vicious cycle.

To assess the link between mental health and homelessness, Dennis et al. (1991) examine literature that uses self-report measures of treatment history and current symptomatology, clinical data from records, and diagnostic and clinical exams to determine mental health status. Although self-report is often used, it is unreliable especially because symptom scales are designed to detect distress, which is very common amongst the homeless (Dennis et al., 1991). As a result, mental illness might be perceived to be more prevalent than it actually is due to stress caused by unstable living conditions rather than a DSM diagnosed mental illness. Additionally treatment history does not reflect current mental health status and functionality, while diagnostics and exams are more accurate, but expensive and time consuming. In the literature reviewed by Dennis et al. (1991), approximately 47% of the literature used shelter studies, 30% limited their data to homeless health care seekers, 22% relied on self-reports, and less than 1% used a combination of self-reports and physical examinations. As a result, much of the current literature should be scrutinized because of the limited scope of the populations sampled and the lack of reliability and accuracy in self-report methodologies. However, in their literature review, Dennis et al. (1991) found that on average consistently one-third of the single adult homeless population has a severe and persistent mental health disorder. To conclude, Dennis et al. (1991) assert that various factors impact homelessness, including a fluctuating economy, a lack of affordable housing, little to no mental health institutions, and deficits in community care for the most vulnerable of our population (see Table 2).

Because little research has been done regarding the quality of life of homeless and vulnerably housed individuals (HVH) and stress has been shown to influence mental illness diagnoses, Gadermann, Hubley, Russell, & Palepu (2013) examined the subjective quality of life of the abovementioned individuals by using multiple scales and self-report measures, including the QoLHHI MDT Scale for Health. Gadermann et al. (2013) found that physical and mental health conditions are endemic amongst homeless and vulnerably housed individuals compared to the general population. As a result, Gadermann et al. (2013) assert that the QoLHHI MDT Scale for Health is the most accurate tool for assessing the concerns, values, and goals of this population. This scale also enables

researchers to understand the context of the homeless populations concerns and to determine which recommendations are relevant.

To better understand populations living in duress, Flèche and Layard (2017) use the Behavioral Risk Factor Surveillance System (BRFSS) and the Panel Study of Income Dynamics (PSID) to examine people classified in the bottom 10% for life-satisfaction (people in “misery”). The surveys provide data on income, employment, family status, education, and mental and physical health allowing the authors to determine the significance of mental and physical health on misery (mental anguish) holding all other factors constant.

For the United States, using the PSID, the authors focus specifically on the bottom 6% who are labeled as living in misery. Of those living in misery, 27% are living in poverty, 13% are unemployed, 14% report physical health problems, while 61% have been diagnosed with a depression or anxiety disorder, and 40% are currently receiving treatment for a mental health condition (Flèche & Layard, 2017). Although, the above-mentioned statistics are solely descriptive, it is apparent that the substantial prevalence of mental illness is a far greater contributor to misery than poverty, unemployment, and physical health problems. To determine the explanatory power of income, physical health and mental health, using a linear multivariable regression, the authors found that mental and physical health impact misery significantly more than either income or unemployment (Flèche & Layard, 2017). Additionally, mental illness is a strong predictor, compared to income and unemployment, of the fluctuation in misery over the course of someone’s lifetime. Consequently, housing and health policymakers should incorporate these findings and direct greater attention to mental health since it is strongly correlated with many factors that impact homelessness, including poverty, employment status, and health state.

### Housing

In line with Dennis et al. (1991), Newman and Goldman (2009) assert that the greatest flaws and shortcomings in U.S. public policy have produced the homelessness crisis amongst those who are severely and persistently mentally ill (SPMI). By reviewing assisted housing programs and comparing them with the needs and preferences of people

with severe mental illness, the authors highlight the gaps in government-assisted housing programs and in research that seek to develop ideas for effective policies and future research. Although there are mainstream programs for low-income housing and affordable housing programs designed for people with “special needs,” including mental illness, there is still 30% of the homeless population who are mentally ill who are living on the streets (Dennis et al., 1991; Newman & Goldman, 2009). Because of decreased functionality, the mentally ill, impoverished, and/or homeless population is at a high risk for an exacerbation of their clinical symptoms.

Until the 1960s these high-risk individuals resided in institutions, but since then policy has emphasized community care, though because of a deficit in infrastructure, this has resulted in a lack of adequate care (Newman & Goldman, 2009). To provide safe and affordable housing, the government has various options, including many mainstream housing assistance programs and some special needs programs. The mainstream housing programs are largely administered by the Department of Housing and Urban Development (HUD). HUD provides three types of housing assistance; the first and most typical being housing units owned and operated by local public housing authorities (PHA's), the second consisting of privately owned developments adhering to Fair Market Rent (FMR) rules in return for construction and rehabilitation financing, and the third dispensing housing vouchers that cover the difference between 30% of the household's income and FMR (Newman & Goldman, 2009). As a result, the government has various tools to decrease homelessness, through for example, the housing choice voucher program and perhaps, community outreach that includes education initiatives aimed at attempting to decrease the stigma against people who are mentally ill. However, with the fierce competition, the mentally ill are often disadvantaged due to their difficulty in navigating bureaucratic mazes to secure subsidized housing. Additionally, because housing assistance is a lottery-based program, many households (more than three times) who qualify for assistance do not receive it (Newman & Goldman, 2009). The extreme competition for vouchers puts the mentally ill at a further disadvantage for receiving the help that they need. While there are inadequate sources of government support for the homeless, people who are mentally ill are at an even greater disadvantage—perhaps

because of the stigma against those with mental illness and because of the increased difficulty many of these people have navigating the system.

As a result, there are other programs specifically designed for people who are severely and persistently mentally ill. Before the McKinney Act of 1987, housing for the mentally ill was the responsibility of states and communities, resulting in unequal opportunities and benefits around the country. Unfortunately, the McKinney Act has had little impact on the asymmetrical affordable housing landscape. Now known as the McKinney-Vento Homeless Assistance Act, the goal of the policy is to allow local communities to make housing program decisions similar to the 1987 version. Local jurisdictions fight for McKinney-Vento housing funds allocated for Transitional Housing (24-month time limit), Permanent Housing, Shelter plus Care (S+C), and the moderate rehabilitation of single room occupancy (“SRO Mod Rehab”) housing (Newman & Goldman, 2009). Although only Permanent Housing and S+C are exclusively for the homeless with disabilities, all programs offer a different range of useful services for the homeless. Regrettably, while approximately 46,000 homeless persons with mental illness utilized the myriad of housing accommodations in 2005, Newman and Goldman (2009) estimate that that statistic represents a measly 5% of the annual total of homeless people living with mental illness. As a result, the authors recommend that affordable housing needs to be at the center of policy research, debate, and reform (Newman & Goldman, 2009).

### Psychological Theory

It is common knowledge that people categorize and generalize in their everyday lives. The cognitive ability to quickly generate categories and make generalizations and inferences in the moment allows for fast decision-making, quick actions and reactions, and the ability to build upon a vast knowledge network. All of these abilities are essential for survival and success in the real world. Although categorization and generalization facilitate these quick and efficient cognitive processes, they also enable the debilitating and problematic assumptions and perceptions that have been made about specific groups of people and individuals throughout history and in the present. This includes both the homeless and mentally ill populations. As a result, it is imperative that the effects of these

generalizations be understood in order to prevent harmful generalizations and biases both in research and legislation. Moreover, with these biases in mind, policy should be assistive rather than punitive.

To describe how some categories of people are generalized, also known as psychological essentialism, Prentice and Miller (2007) conducted an extensive literature review. Prentice and Miller (2007) define psychological essentialism as the belief that a category has an essence about it that defines specific properties of the group and is defined by membership that is “involuntary and immutable.” The most commonly essentialized categories include gender, ethnicity, race, and physical disabilities (Prentice & Miller, 2007). Although psychological essentialism occurs at different rates across disparate groups of people, it affects people's perceptions of others, leading to bias, conflict, and generalizations that can be harmful to the generalizer and the generalized. Prentice and Miller (2007) point out that the most essentialized categories can be attributed to biological determination. Because there is a common belief that biology and DNA affect the way people look, the belief that the people in the essentialized category have commonalities in a lot of their observable features begins to explain why people stereotype and are biased against the poor, homeless, mentally ill, and others.

To demonstrate the way that essentialization can be harmful, Williams and Eberhardt (2008) illustrated that participants who increasingly considered race to be a biological construct were more okay with current racial disparities, thinking that they were unproblematic and pedestrian. The authors explain that they hypothesized that someone who believes that race is a social construct would react negatively to a news article describing racial disparities and be more critical of it compared to someone who asserts that race is biologically determined (Williams & Eberhardt, 2008). Because “biology” is perceived as more egalitarian, if someone believes in biological determination they are more likely to accept current disparities and are more easily able to exonerate themselves from any responsibility or blame for their opinions and actions. For example, some people believe that black men are inherently more violent than others, justifying police shootings, higher incarcerations rates, etc. As a result, essentialism begins to clarify how people easily explain away homelessness and mental illness by

chalking the homeless populations circumstances up to flaw in character, a conscious decision, and/or biological determination.

However, although essentialism can lead to incorrect categorization, stereotyping, and bias, it is much more complex and can have some positive effects. Prentice and Miller (2007) describe a study that found that some aspects of essentialism were associated with less prejudice towards gay men and lesbian women. The authors explain that the decrease in prejudice was a result of the reduction of responsibility attributed to the individual for belonging to the category rather than an understanding and acceptance of gay men and lesbian women's sexuality (Prentice & Miller, 2007). Although a reduction in prejudice is positive, and this strategy could possibly be used in absolving the homeless and mentally ill populations from any blame, I question the lasting effects of essentialism's effect on prejudice and if it is truly something positive that will carry over into how people think and act. As a result, when increasing awareness and educating policy makers and the general public about homelessness and mental illness, rather than focusing on exonerating the homeless and mentally ill populations from blame through a biological argument, empathy, compassion, and systemic policy changes should be the goal.

### Housing Theory

In the 1980s homelessness began to rise in the United States, Canada, and some parts of Europe (O'Flaherty, 1993). Because high rent has a significant and positive relationship with homelessness, the housing market appears to be related to homelessness. However, the connection between housing and homelessness remains controversial (O'Flaherty, 1993). As a result, O'Flaherty (1993) sought to develop a theory of the housing market that included homelessness using the Sweeney model. The primary components of the model included the assumptions that: a) the rent function is determined by market clearing given that consumers are distributed by income and housing is distributed according to quality and, b) high income consumers consume high quality housing, while the homeless population has low or no income. Costs and quality of housing are also shaped by how housing is maintained and its present net rent value. Additional assumptions of the model suppose that a housing unit is abandoned when its

net rent falls to zero and that construction happens when the value of the housing equals the cost of construction. Furthermore, because O’Flaherty (1993) also incorporates uncertainty into his model, he found that because housing owners are left the option to hold on to low value housing and not rebuild in times of economic hardship, the number of low quality housing options increases for a short period of time until “prosperity” returns, increasing rebuilding and decreasing the availability of low quality (meaning low income) housing on the market. This in turn, increases homelessness. Additionally, O’Flaherty (1993) claims that shelters decrease the number of homeless people living on the street, but also allow for those who would not otherwise be homeless to live in shelters. This superficially increases the homeless rate. However, just because a portion of people living in shelters would not be homeless if shelters did not exist, this is not to say that they would not be living in poverty and/or low quality housing. As a result, O’Flaherty (1993) recommends using past homelessness to assess current and predict future homelessness. Furthermore, O’Flaherty (1993) asserts that there are different costs associated with entering and leaving homelessness. Moreover, the costs of leaving homelessness are often greater. Although costs associated with entering homelessness include a loss of possessions, an investment in learning how the homeless community functions, and risks to one’s mental and physical health, the costs to exiting homelessness are often much more difficult to surpass and include costs for searching for employment and housing and often require a housing deposit.

### Costs and Savings

Although it has been demonstrated that a lack of housing is an important contributor to the homeless epidemic in the United States (Dennis et al., 1991; Newman & Goldman, 2009), the cost savings benefits have yet to be explored in depth. As a result, to study the severely mentally ill homeless population and the benefits of housing, Larimer (2009) used a quasi-experimental design that compared housed participants with those on a waitlist for housing. When housing is not predicated on participants being “substance free,” this is known as a “Housing First” policy. A total of 95 participants were offered housing, while 39 participants on the waitlist served as the control group. Throughout the study, housing and service costs averaged around \$1120 per month per

resident. Using data from Medicaid, local jails, hospitals, shelters, detoxification centers, and social services, in combination with self-reports, Larimer (2009) found that compared to the control group, participants housed had \$3,569 *less* cost per month during the first six months that they were housed. Additionally, housed participants demonstrated a decrease in the number of alcoholic drinks they had per day the longer they were housed. Although participants were not randomly assigned to a condition, resulting in the quasi-experimental design of the study, Larimer's (2009) research demonstrates the importance of housing in not only reducing the number of homeless people on the streets and aiding in curbing addictive and self-medication behavior, but also in reducing the unnecessary and inefficient costs associated with homelessness.

Comparably, in a randomized controlled trial using inpatients from a public and private hospital, Basu, Kee, Buchanan, and Sadowski (2012) used a Housing First Model to assess the impact of housing and case management on homelessness. The model included three components consisting of short-term housing (respite care) after hospital discharge, stable housing after recovery from hospitalization, and case management that took place in the hospital, respite, and housing sites. Participants were randomly assigned to an intervention or usual care group. When they were ready for discharge, the intervention group (n = 201) received on-site intervention from a social worker at the hospital. They received additional case management throughout their housing transitions. The usual care group (n = 206) received the usual care provided by a hospital social worker. Basu et al., (2012) found that the intervention group averaged a *savings* of \$6,307 per person annually. In addition, subgroups comprised of those classified as chronically homeless and those diagnosed with HIV had an annual *cost savings* of \$9,809 and \$6,622. Subsequently, Basu et al., (2012) demonstrate the positive effect that not only housing, but also case management can have on the homeless population and on cost savings.



## ***Section 2***

### **San Francisco**

#### Introduction

Up until this point, I have reviewed the past literature examining how to define homelessness, the problems of stereotyping, the relationship between homelessness and mental illness, and to some degree, substance abuse. Overall, the literature has concluded that around 30% of the homeless population is mentally ill (Dennis et al., 1991; Larimer, 2009; Newman & Goldman, 2009; Sinaiko & McGuire, 2006) and that homelessness is a problem that is as complex and multidimensional a problem as mental health alone is. Additionally, the limited research has indicated that our current national policy inadequately addresses the homeless epidemic which is related to the lack of affordable housing, housing programs that lack on-site services, and complicated bureaucratic barriers that prevent access to help (Dennis et al., 1991; Newman & Goldman, 2009; Meschede, 2011). Furthermore, psychological essentialism, a lack of empathy, continuity of care, and case management, contribute to the homeless epidemic (Basu et al., 2012; Prentice & Miller, 2007; Williams & Eberhardt, 2008). As a result, because San Francisco is a large city within the United States, and has a large population of people living on the streets, I will examine San Francisco's homeless population as a case study in order to determine if the city as a whole fits within the trends explained across the literature reviewed above. First, I will summarize the city's background, overall demographics, and spending statistics. Then I will conduct my analysis, perform a robustness check, and finally make policy recommendations that could improve living conditions within the city. Finally, I will conclude by making general policy recommendations for all of the United States, comment on general trends and limitations of my examinations, and make my final remarks.

#### Background

In 1999, The Coalition on Homelessness interviewed 282 homeless men and women in San Francisco in order to understand the mental health system from the perspective of the mentally ill homeless population. Spanglet, Martin, Connor, Kahan, &

Friedenbach (1999) found that of the mentally ill homeless population, 92% were willing to enter a program if it met their individual needs. However, of the 63% of people who tried to access services, 31% never received the help they needed and asked for. Additionally, 51% reported having a negative experience or interaction when attempting to access services. Nonetheless, the mentally ill homeless population communicated that their top needs consisted of housing, counseling, and medication. Spanglet et al., 1999 recommend that a community based mental healthcare system, tailored to meet the needs of the individual will not only be more successful at ensuring a long-time recovery, but also reduce San Francisco's high costs (see the statistics and spending section) associated with the untreated mentally ill homeless population. However, due to rising housing costs in San Francisco and the inadequacies of the minimum wage (Jungle, 2018), homelessness in the city is increasing (Connery, 2017).

### Statistics and Spending

The 2017 San Francisco Homeless Point-In-Time Count and Survey revealed that the homeless population in the city totals 7,449 people with 4,353 of that homeless population classified as unsheltered (Connery, 2017). However, it is important to note that the definition of homelessness for the survey was very strict, not including people who were staying with family or friends, in jails, hospitals, rehabilitation facilities, or families living in Single Room Occupancy (SRO) units (Connery, 2017). As a result, the number of actual homeless in San Francisco is much higher. Nonetheless, using the 2017 San Francisco Homeless Point-In-Time Count and Survey, Connery (2017) asserts that 61% are male and identify as White (35%), Black (34%), Multi-racial (22%), or Hispanic/Latino (22%). Additionally, 75% of the homeless population indicated that they had previously experienced homelessness and 59% had been homeless for more than a year. Furthermore, it is important to note that Hahn, Kushel, Bangsberg, Riley, and Moss (2006) determined that San Francisco's homeless population is aging and their use of emergency services, hospital admissions, and chronic illnesses are increasing.

Although the city has spent 275 million dollars on supportive housing this fiscal year, homelessness in San Francisco is as bad as ever with chronic homelessness increasing from 1,574 people in 2015 to 2,138 in 2017 (Connery, 2017). Strikingly, 41%

reported using drugs and alcohol, 39% said they had experienced psychiatric and emotional problems, 31% reported a chronic health condition, and 29% indicated they suffered from Post Traumatic Stress Disorder (Connery, 2017). These self-reports align with previous literature that cites mental illness, addiction, and complicated policies that are too confusing to navigate as the main reasons for why homelessness is increasing (Dennis et al., 1991; Larimer, 2009; Newman & Goldman, 2009; Sinaiko & McGuire, 2006; Table 2). Additionally, homeless youth reported their top five responses for why they are homeless: emotional abuse, financial issues, conflict at home, mental health issues, and physical abuse (Connery, 2017; Table 4). Various studies have found that substance abuse, conflicted relationships, and mental illness contribute to homelessness indicating that homelessness is often not an isolated problem, but one correlated with many other personal, environmental, physical, mental, and health related factors (Newman & Goldman, 2009; Piat et al., 2015).

The waiting list for nighttime beds in San Francisco has risen to 1,100 people and Public Works has picked up more than 679 tons of trash from homeless encampments, including more than 100,000 used syringes (311 San Francisco, 2018). Most recently, 1,123 people were on the 90-day emergency shelter list and around 500 people were on the waitlist for methadone and substance abuse residential treatment (HSA, 2018; Coalition on Homelessness, 2016). Although the city has devoted a large portion of its spending on homelessness, improved service systems are needed. In fact, it is estimated that the city has spent \$20.7 million dollars *criminalizing* homelessness, without solving the problem (Coalition on Homelessness, 2016). For example, the San Francisco Police Department notes that in 2015, their officers cited homeless people 11,000 times for lying, sleeping, or resting on the street (San Francisco Open Data, 2015). With each fine totaling at least \$76 and doubling over time if not paid, resulting in an arrest warrant being issued, and later affecting that person's ability to obtain credit and even affordable housing, a vicious cycle is enacted, preventing the homeless from resting and denying them access to housing and future possibilities.

Furthermore, in San Francisco, the homeless population indicated that the main reasons they became homeless were due to losing a job, substance abuse, and/or eviction (Connery, 2017; Table 4). Because the average rent in San Francisco is a staggering

\$3,907, well exceeding the monthly earning of someone working a minimum wage job (\$2,240/month), the loss of housing is unfortunately a very realistic scenario for many in such an expensive city (Jungle, 2018). Once homeless, people experience a variety of barriers to exiting homelessness including an inability to afford rent, obtain a job, and a lack of available housing (Connery, 2017). As a result, San Francisco illustrates much of what the literature above revealed: homelessness results from a lack of accessible and affordable housing, a lack of housing assistance, a low minimum wage, and an overall failure of policy (Braiterman et al., 2017; Dennis et al., 1991; Larimer, 2009; Newman & Goldman, 2009; Meschede, 2011; Routhier, 2011; Table 2). Additionally, while 35% of the homeless population is receiving government aid through food stamps, 54% reported not wanting government assistance. However, the homeless population reported accessing services provided by the city such as free meals (52%), emergency shelters (39%), and health services (25%) because many (33%) are living on \$99 dollars or less a month.

### Analysis

Using data from the Department of Housing and Urban Development (HUD), I compiled total year round beds available in the United States for the homeless population. Total year round beds are defined as the beds available to the homeless population in emergency shelters, temporary housing, and safe haven housing across the United States. As seen in Figure 1, total year round beds available to the homeless population are decreasing. Additionally, while total year round beds in California have remained constant, San Francisco experienced a sudden decrease right before the Great Recession (Figure 2, Figure 3). As mentioned above, the 2017 San Francisco Homeless Point-In-Time Count and Survey revealed that the homeless population in the city totals 7,449 people with 4,353 of that homeless population classified as unsheltered (Connery, 2017). Because San Francisco had only 2,759 beds available in 2017, it makes sense that 4,353 of San Francisco's homeless population are unsheltered because those beds simply do not exist (Figure 3).

In line with previous literature, the lack of appropriate housing appears to be a large contributor to the homelessness epidemic in San Francisco (Braiterman et al., 2017;

Dennis et al., 1991, Larimer, 2009; Newman & Goldman, 2009; Meschede, 2011; Routhier, 2011; Table 2; Table 4). Additionally, as illustrated in the literature review above, because high rent has a significant and positive relationship with homelessness, it can be argued that San Francisco's expensive housing market is related to the city's significant homelessness problem (O'Flaherty, 1993). With an opposing view to the pervasiveness of homelessness, while O'Flaherty (1993) argues that shelters decrease the number of homeless people living on the street, he also asserts that shelters allow for those who would not otherwise be homeless if shelters did not exist, to live in shelters, superficially increasing the homeless rate reported. However, just because a portion of people living in shelters would not be *technically* homeless if shelters did not exist, this is not to say that they would not be living in poverty and low-income housing. Moreover, because there are not enough shelter beds in San Francisco or enough affordable housing units, those living in poverty do end up homeless instead of in low income housing (Coalition on Homelessness, 2016). With housing costs increasing and with the minimum wage's inability to match the cost of living in the city, few people can realistically afford to live in San Francisco (Connery, 2017; Jungle, 2018). As a result, San Francisco is as an example for why increasing the number of available shelter beds might be beneficial.

### Robustness Check

To verify that the trends seen in San Francisco are not isolated I conducted a robustness check by compiling the data for total year round beds in various cities around the country. The cities chosen were Omaha, Nebraska, Tucson, Arizona, and New York City in New York. I chose these cities because they are located in various geographic regions around the United States and therefore possibly have different characteristics such as housing markets, homeless populations, mental health facilities, and social norms. This is important, because I wanted to verify that what is happening in San Francisco is not an isolated trend. As a result, I would like to be able to generalize my findings to the country as a whole. While, Omaha, Nebraska demonstrated similar trends compared to San Francisco, California (a decrease in available beds during the Great Recession, subsequent increases in beds, and then a recent decrease in total year round beds available), Tucson, Arizona experienced an increase in available beds during the

Great Recession followed by a similar overall decrease in the most recent years (Figure 4, Figure 5). While the trends seen during the Great Recession varied across San Francisco, Omaha, and Tucson, they all demonstrated consistent declines in available beds in the most recent years. However, most surprisingly, New York City did not follow any of the same trends of the other cities (Figure 6). Instead of demonstrating a decline during the Great Recession and in recent years, New York City has experienced a consistent increase in total year round beds available from 2007 to 2017 (Figure 6). Possibly this could be because currently the housing market in New York is not as prosperous as it seems. Because housing owners are left the option to hold on to low value housing and not rebuild, the number of low quality housing options increases for a short period of time until “prosperity” returns, increasing rebuilding and decreasing the availability of low quality (meaning low income) housing on the market (O’Flaherty, 1993). However, this is surprising because the median sales price for housing in New York City has continued to increase over the past five years (Trulia, 2017). Nevertheless, the number of sales and median rent has decreased in recent years, possibly indicating that New York City’s housing market is not as prosperous as it appears to be, explaining why shelters and the beds they provide have not declined (O’Flaherty, 1993; Trulia, 2017). On the other hand, the median rent, median sales price, and number of housing sales in San Francisco has continued to increase, indicating prosperity in the area and incentivizing owners to renovate and increase their housing pricing (Trulia, 2017). As a result, using New York City as an example, examining the city’s housing market, shelter system, and funding allocation could be beneficial in determining how other cities around the country, including San Francisco can increase the number of shelter beds available to the homeless population.

### Policy and Recommendations

In 2003 and 2007 when Gavin Newsom was re-elected as San Francisco’s Mayor, he ran on a platform of ending homelessness (Albertson, Anarchy, Brahinsky, Freidenbach, Kennedy, Hootman, . . . Sipes, 2007). However, under Newsom’s leadership, the shelters in San Francisco deteriorated. In a survey of 215 San Franciscan shelter users living in city-funded shelters troubling statistics were revealed. The survey

found that 55% of shelter users reported some form of abuse including, physical violence, sexual abuse, verbal abuse, and harassment. Additionally, 32% of shelter users reported that they did not feel safe in the shelters due to rude and neglectful staff, physical violence, overcrowding, and stolen property. Furthermore 56% of the survey takers indicated that the shelter staff did not respond to their comments, concerns, and suggestions, further perpetuating feelings of helplessness and contributing to the unsafe environment. Many also indicated that their basic hygiene and supply needs were not met, solidifying the fact that only one third of the city's shelters met basic hygiene requirements (Albertson et al., 2007). Furthermore 50% of residents indicated that they suffered from a physical or mental illness and 59% asserted that the shelters were not meeting their needs. Because everyone has a right to a certain "standard of living" under article 25 of the Universal Declaration of Human Rights, it is important that shelters begin to be better funded in order to be able to provide basic resources and supplies, such as but not limited to, food, clothing, housing, medical and social services, and a safe environment. Moreover, shelter residents hope to see improvements in how the staff treats them, better facilities, fair enforcement of the rules, and access to services including healthcare and mental health services (Table 5). Because the number of homeless people in San Francisco and many other cities including Omaha and Tucson exceeds the number of beds available, the priority should be increasing the number of shelters and beds available. In addition, once the number of beds available increases, with additional changes in safety and cleanliness, a larger percentage of the homeless population would use shelters and develop positive relationships with the staff, increasing shelter and program retention rates and the homeless populations chances for finding more permanent housing, reducing emergency service costs for the government.

A couple of years later in 2009, the Coalition on Homelessness sought to review the shelter reservation system in San Francisco in order to be able to offer recommendations on ways to improve the flawed system. While, in San Francisco the number of homeless people exceeds the number of available beds, the homeless population is repeatedly turned away from vacant beds every night after waiting for hours because the emergency reservation system is systematically dropping reservations and breaking down (Howey, Freidenbach, Mohre, Do, Westort, Buchbinder, & Parkinsen,

2009). As a result, Howey, Freidenbach, Mohre, Do, Westort, Buchbinder, and Parkinsen (2009) attempt to give a voice to the people the reservation system affects. Although the researchers only surveyed 215 people out of the entire San Franciscan homeless population, 45% of participants revealed having had a negative experience accessing a shelter. Of the negative experiences, 29% of people indicated that the negative experience was because no bed was available. Additionally, 29% of people indicated that they had a negative interaction with the shelter staff, 19% experienced long waits, and 7% reserved a bed, only to find that the bed was not available upon arrival to the shelter. On average, shelter seekers were turned away three times in one year from a shelter in San Francisco. Moreover, it took the homeless around 182.5 hours (seven days) to obtain a bed in a shelter after having made initial contact. Furthermore, even after securing a bed in a shelter, one third of the homeless population reported only having access to a bed for one night, while 34% indicated having a 7 night shelter stay, versus 22% of participants who had a six month stay, and 12% who had a 3 month reservation in a shelter. As a result, even if a homeless person manages to obtain a shelter bed, that person will have to wait for that bed for an extensive amount of time, and then experience negative interactions while staying in the shelter. Furthermore the majority of the time, shelter seekers only have access to shelter beds for a short period of time, which in turn does not provide them with an opportunity to seek help, employment, or procure another safe place to sleep for the future.

Precisely because the homeless population had firsthand experience dealing with the unreliable shelter reservation system along with the frustrating experiences at shelters, the participants had recommendations for improvements (Table 5). Overall respondents indicated a desire for a mix of equal access and special need prioritization. Additionally, 21% of participants responded by saying that staff training could be improved, and 19% indicated a desire for an increase in beds. As a result, the Coalition on Homelessness recommends that accessibility to both the reservation system and the shelter be improved by increasing the total number of beds available, simplifying the reservation system, increasing the length of stays, and making bed availabilities visible on the system.

Because of the faulty reservation system and lack of availability in San Francisco's shelters, many are forced to rest and sleep on the streets. As a result, the



homeless population is subject to harassment by local community members and police for living on the streets (*Harassment and Displacement in the Mission: Community Experiences Survey*, 2014). To document the harassment faced by the homeless population, the Coalition on Homelessness surveyed 117 people living in the Mission District. The majority identified as Latino, African American, and White. Additionally, their sample consisted of 59% of participants identifying as men, 21% identifying as women, and 11% asserting that they were transgender female. Moreover, 56% indicated they were disabled. While previous literature has not found outcome differences between age, sex, disability, etc., in the homeless population, federal housing programs do ask that participants report these demographics including if they or a household member has a disability (Meschede, 2011; Rosenheck et al., 2001; Sinaiko & McGuire, 2006). However, because personal identity and the intersection between race, gender, etc. can impact social interactions through generalization producing psychological essentialism, it is important to report these demographics (Blair et al., 2013; Fiske, 2002; Prentice & Miller, 2007). Furthermore, 55% of the participants indicated that their housing situation was unstable, resulting in 29% seeking shelter, 23% living on the street, 11% camping in parks, 20% living in SROs, and the remainder couch surfing or renting their own apartments. Moreover, 66% of the survey-takers indicated that their current income did not meet their needs for food, housing, and medical care. Most strikingly, 30% of participants stated that they were cited for quality of life offenses in the Mission including resting in public, carrying an open container, and smoking. Forty-one percent of participants indicated that they had experienced physical violence by many individuals. Police, neighborhood residents, and commuters were the top harassers. Problematically, people of color seem to be targeted disproportionately in a neighborhood that is continually becoming more gentrified (*Harassment and Displacement in the Mission: Community Experiences Survey*, 2014). Although the study focuses around the heart of the Mission District (at 16th and Mission), which is only a small part of San Francisco, and uses a limited sample size, the diversity of the survey takers allows for generalization. In order to better be able to protect and help the residents of the Mission, the residents themselves recommend that more housing, access to public restrooms, and

the availability of food would make the Mission a safer place to reside, making San Francisco a better city.

### ***Section 3***

#### **General Policy Implications**

Because homelessness, especially chronic homelessness associated with the most vulnerable subgroups (including the mentally ill) is a result of a failure of U.S. public policy (Dennis et al., 1991; Newman & Goldman, 2009) and a decrease in homelessness has been demonstrated to reduce the economic costs associated with homelessness (Kee et al., 2012; Larimer, 2009), it is important to examine the different factors that contribute to homelessness. Flèche and Layard (2017) examined the effect of mental illness on misery compared to significantly more studied aspects of life such as poverty, unemployment, and physical health. Because the average mental health expenditure of wealthy countries only accounts for 5% of the total health expenditure budget and there is little focus on mental health in current research, it is not surprisingly that mental health and homelessness are not at the forefront of research. As a result, homelessness and mental health are not a priority in current policy debates.

Furthermore, the researchers hypothesized that part of the reason that mental anguish is more challenging to overcome is due to its invasion of a person's mental capacity to think (Flèche & Layard, 2017). As a result, people's ability to adapt to changing circumstances becomes more difficult and less likely. Consequently, more accessibility to cognitive behavioral therapy, especially for those diagnosed with depression and anxiety disorders is recommended. Additionally, Rosenheck (2001) found that housing affordability and social capital service system integration resulted in a greater probability of being able to access assistance and exit from homelessness within twelve months. Furthermore, Newman and Goldman (2009) suggest that housing subsidies, landlord prejudice against renting to mentally ill populations, and housing and service ratios should be further studied to examine what would make for effective policy. Moreover, although Braiterman et al., 2017 examined various variables such as—average temperature, unemployment rate, urban percentage of population, and number of households receiving rental assistance—that could possibly contribute to homelessness, the researchers found that minimum wage and housing assistance significantly impacted the homeless rate. Therefore, policy makers should focus on providing access to mental healthcare, increasing the minimum wage, reducing bias, augmenting the availability of

affordable housing, and implementing education campaigns to reduce the stigma and negative perceptions of the mentally ill homeless population (Table 3).

Due to the comorbidity of homelessness and mental illness, it is important to treat mental illness and homelessness together. Therefore, Dennis et al. (1991) recommend that in the short-term, organizations that can develop trust, a rapport, and create acceptance in the community are necessary. Additionally drop-in centers that provide essentials including mental and physical health care are imperative. In the long-term, comprehensive systems of care that include intensive treatment, outreach, engagement, and case management will be important in helping people recover and stay recovered. Finally, in addition to health and social services, a range of affordable housing options and community-based residential care could possibly eliminate homelessness amongst the most vulnerable subgroups in the homeless population (Dennis et al., 1991).

### **Trends and Limitations**

It is difficult to determine the causality between homelessness and mental illness. Sometimes mental illness and poverty lead to homelessness and other times the daily stress, trauma, and inhumane living conditions characteristic of extreme poverty and homelessness lead to depression and other mental illnesses (Palmer, 2016). Although the unemployment rate (4.1%) has evened out since the Great Recession, according to the U.S Bureau of Statistics and the U.S Bureau of Census, the number of people living in poverty (48,208,387 people) and the poverty universe of all ages in the United States has increased and even surpassed the levels documented during the Great Recession (Figure 7, Figure 8). Because my analysis indicated that housing and an inability to afford the cost of living in cities plays an important role in homelessness, understanding poverty in the United States is important in getting an accurate picture of why homelessness has been increasing and estimating the number of people at risk for homelessness. However, because the poverty universe measure does not include “noninstitutionalized group quarters,” meaning college dormitories, military housing, etc., or children under the age of 15 who are not related to the reference person in the household through birth, marriage, or adoption (i.e. foster children), the latest estimate of 310,899,910 people living in poverty in the United States is an extremely conservative number (Figure 8).

Additionally, leaving out college students and foster children excludes groups who are at a high risk for mental illness; the fact that these individuals could be living in poverty is extremely problematic because they are more likely to end up homeless (Kessler, Amminger, Aguilar-Gaxiola, Alonso, Lee, & Ustun, 2007). By simply measuring poverty with a definition that excludes groups at a high risk for mental illness, we cannot create policy to help people and prevent them from becoming homeless.

Although there is a mental health and homelessness crisis in the United States, medical service expenditures per capita have steadily increased according to the U.S. Bureau of Economic Analysis (Figure 9). However, the data is a combination of the Medical Expenditure Panel Survey (MEPS) and data from multiple sources, including large claims databases that cover millions of enrollees and billions of claims (Figure 9). As a result, the spending reported might not actually represent the level of mental health care people are receiving and might be inflated due to charges associated with simply visiting the doctor and not actually receiving treatment, let alone quality and/or efficient treatment. Additionally, mental illness and homelessness are not highly searched terms on Google in the United States, California, or San Francisco especially compared to poverty, crime, and unemployment; thus, begging the question, what really matters to us and how does this affect policy and the lives of the people who are often in need of help but overlooked? (Figure 10, Figure 11, Figure 12, Figure 13, Figure 14).

Additionally, while the goal of this paper has been to compile previous research on homelessness and mental illness in San Francisco and at the national level in an extensive literature review, I have only managed to make a small dent in all of the existing literature. While empirical work conducted in San Francisco is hard to come by, the literature that does exist is informative, but unfortunately all survey based. As a result, because of demand statistics, the incentive to possibly misrepresent one's current or past health and homeless status, paired with the overall unreliability of surveys, this data should be scrutinized and supplemented with further research. Additionally all analysis conducted were trends based instead of regressions based. As a result, all conclusions are simple observations of the eye instead of statistically significant results that can be interpreted at a much higher and more generalizable level.

### **Concluding Remarks**

Because U.S. programs for the reduction of homelessness insufficiently provide a comprehensive system of care, it is important to understand the functioning of and needs for improvement of current homeless services. While the principal modus operandi, the continuum-of-care (CoC) model of homeless services theoretically is a comprehensive system of care intended to tackle various aspects of homelessness such as outreach, assessment, housing and other services, it has not succeeded in housing the chronically homeless which includes the severely mentally ill (Meschede, 2011). As a result, through a qualitative study assessing the achievements and failures of homeless services, Meschede (2011) asserts that there is a discontinuity between what providers and consumers perceive as important factors in reducing the number of homeless people on the streets (Table 6). Because much of the CoC model relies on receiving service first (such as detox treatment) before housing needs are met, many individuals who are not able to follow the programs rules and restrictions and are concerned with overcrowding and personal safety in shelters, end up living on the street for long periods of time. As a result, a Housing First policy might be the solution (Basu et al., 2012; Larimer, 2009).

However, outreach and the development of trust could possibly be the keys to reaching the part of the homeless population that is more severely impaired by medical and mental health issues including substance abuse problems. In fact, a previous study found that consumers will access services immediately before and after being housed compared to a group that was not housed (Pollio, Spitznagel, North, Thompson, Foster, 2000). Furthermore, consumers will use drop-in and counseling services following the same model, possibly due to the fact that the services are rooted in forming relationships rather than providing a material good. As a result, housing the homeless might be one way of getting them into services and getting them into services might also help house them. Hence, we need a policy that attends to each and provides access to a comprehensive system of care.

In fact, a study comparing shelter usage in Denmark and the United States found that because the United States has a less developed welfare system, minimal affordable housing, and a larger extent of poverty, the U.S. has a larger homeless population (Benjaminsen & Andrade, 2015). However, Benjaminsen and Andrade (2015) also found

that both countries have episodically and chronically homeless populations who often have substance abuse and mental health issues. This is important for two reasons. The first is that we could greatly decrease a large portion of our homeless population, the transitionally homeless, if we modeled our welfare system off of the Scandinavian model, which includes income equality, large-scale public housing, and a vast social support system. Second, while there may be additional challenges to successfully housing the episodically and chronically homeless population, Benjaminsen and Andrade (2015) discuss the potential of housing first programs and how they have been demonstrated to be effective in both Denmark and the United States (Basu et al., 2012; Benjaminsen, 2016; Larimer, 2009).

Importantly, even crucially, providing services that consumers wish to consume could aid in increasing retention rates and decreasing homelessness. Because there is a discrepancy in what service providers and the general homeless population view as important, it is instrumental to provide both what providers and researchers deem necessary, and what consumers desire. In Meschede's (2011) survey, although consumers stated they needed more access to affordable housing and dental and medical services, providers focused more on substance abuse and psychiatric disability services (Table 6). Moreover, service providers theorized that mental health, substance abuse, and medical issues were the main causes of homelessness. However, consumers emphasized more structural and institutional causes for their homelessness such as high rent and unemployment. Although providers tended to focus on overall mental health more, they did recognize the lack of community care in society today and attributed loss of relationships and estrangement from loved ones and systems of care to the homeless problem. In fact, respite care providers acknowledge that most of the time, members of the successfully housed homeless population have often had exceptions made for them that enable them to form trusting relationships and to then get moved into an ideal living unit (Meschede, 2011). As a result, it is possible that a more flexible and comprehensive system that focuses more on personalized care would be beneficial for the homeless population.

To conclude, in an attempt to end homelessness especially for the mentally ill, we should focus on developing affordable housing, providing skills training, and increasing

accessibility to services for the homeless population (Gordon, 2017). As demonstrated in the housing section, there are various tools that the government can use to increase affordable housing (Newman & Goldman, 2009). However, we should also focus on outreach, forming relationships and trust with the homeless community, and providing access to healthcare (Meschede, 2011; Pollio et al., 2000; Table 3). Finally, a policy that emphasizes the importance of permanent housing while also expecting providers to be well versed in a variety of sectors including health, substance abuse problems, and housing options would allow for a more integrated system of care to be implemented (Meschede, 2011). As a result, future research should aim to examine affordable housing options that meet the needs and preferences of the mentally ill in order to facilitate better access, increase retention rates, and facilitate improved long-term outcomes.

Additionally, because New York City's total number of year round beds has been constantly increasing, the city's housing policies, shelter system, homeless population, and mental health services should be examined and possibly used as a model for other cities around the United States. However, this is not to say that New York City struggles less with homelessness or has better systems of care, but simply that how they have managed to increase shelter beds should be recognized and understood. Moreover, public policy experts, economists, and mental health providers should team up and collaborate to create new policies that enable governments to serve their communities and the poor and homeless to accept the help they need and gain access to the additional services they desire (Table 6). Along with mental illness, poverty, and homelessness comes isolation from the people one loves and access to the systematic care one needs (Table 1). A policy that could take both the psychological and physical aspects of the homelessness crisis into account would better serve the poor, homeless, mentally ill populations, and indeed, all of us.



### List of Graphs and Tables



Figure 1. Total year round beds in the United States.

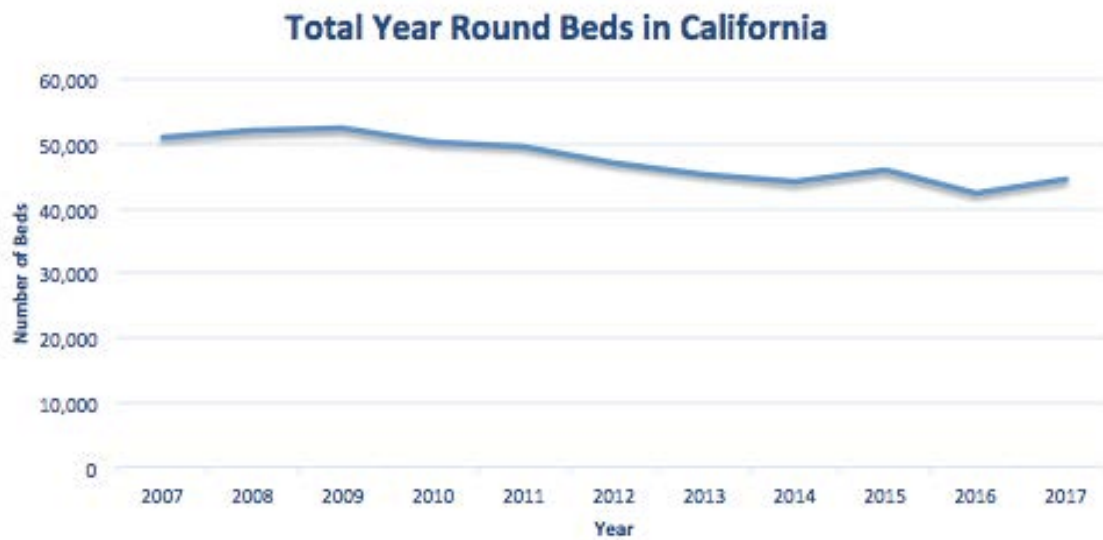


Figure 2. Total year round beds in California.



Figure 3. Total year round beds in San Francisco.

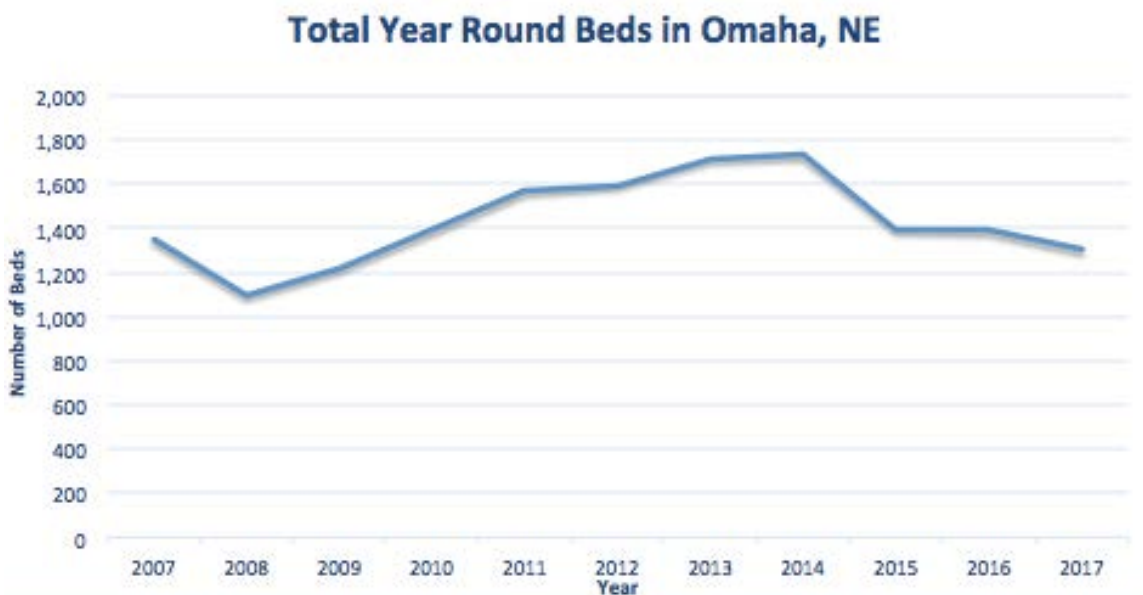


Figure 4. Total year round beds in Omaha, Nebraska.

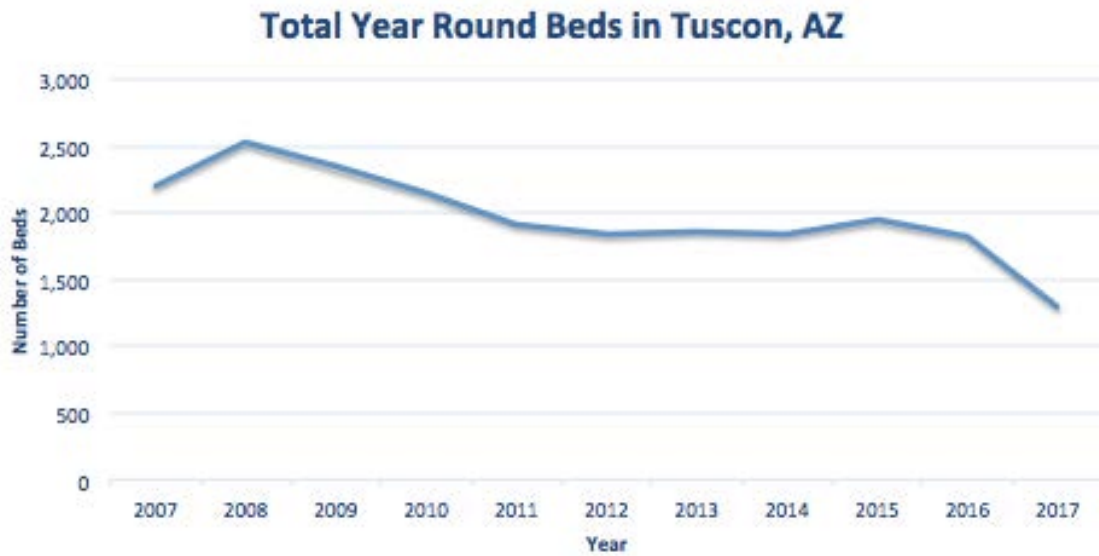


Figure 5. Total year round beds in Tucson, Arizona.

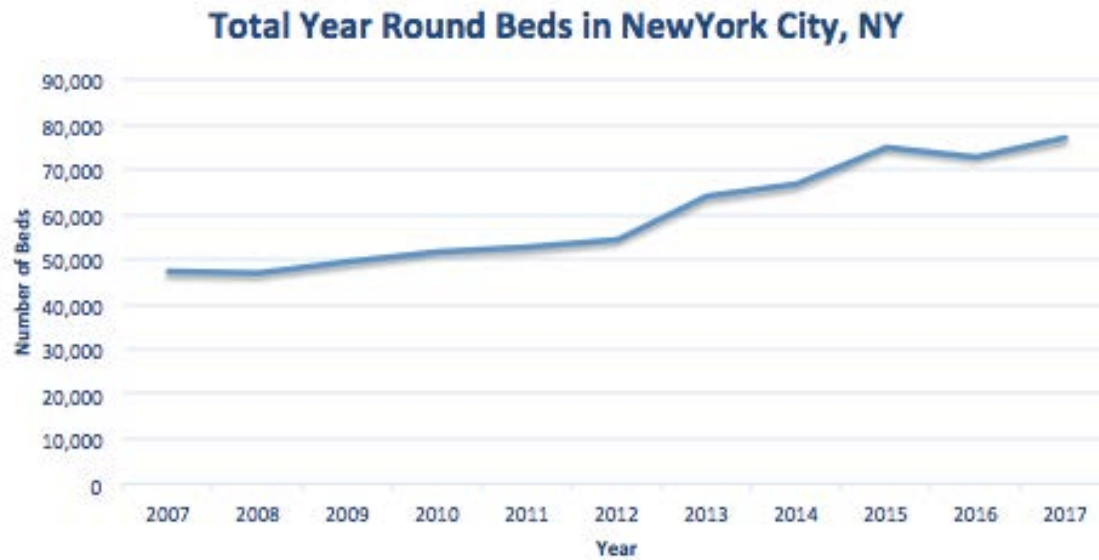


Figure 6. Total year round beds in New York City, New York.

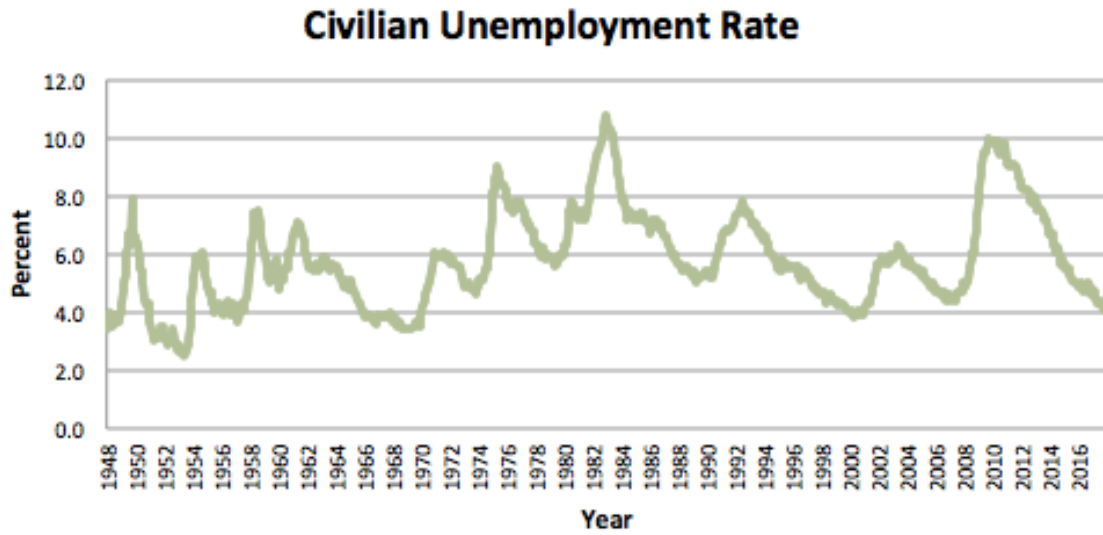


Figure 7. Civilian unemployment rate.

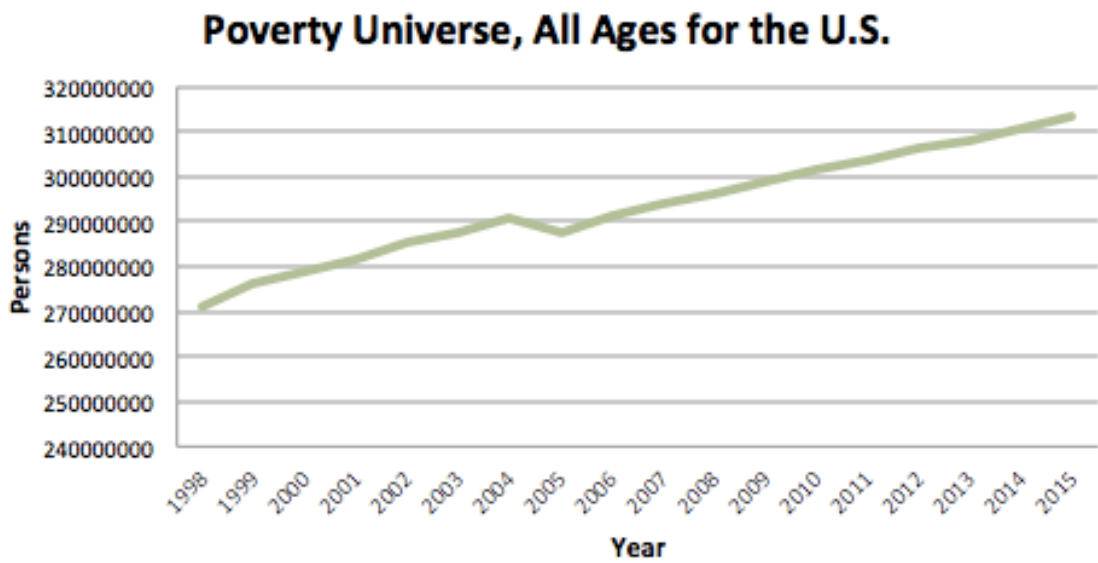


Figure 8. Poverty universe, all ages for the United States.

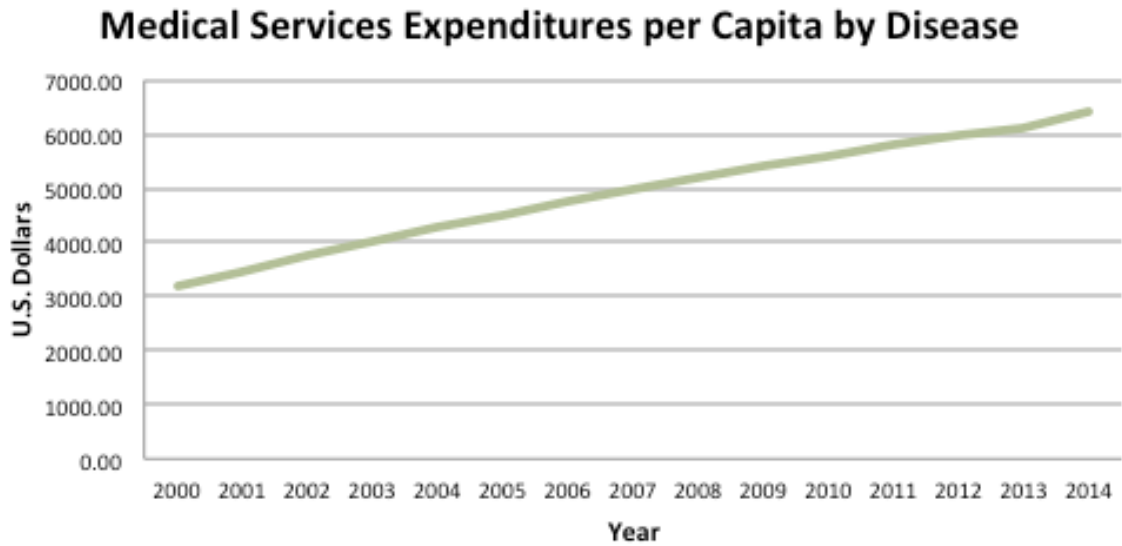


Figure 9. Medical services expenditures per capita by disease.

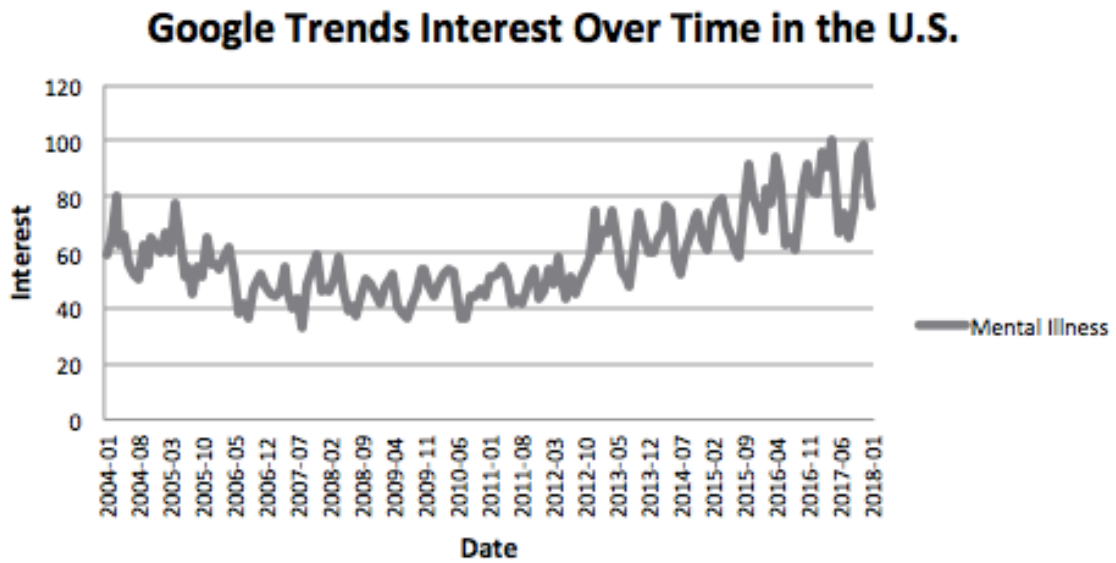


Figure 10. Google trends interest over time in the United States. Keyword: mental illness.

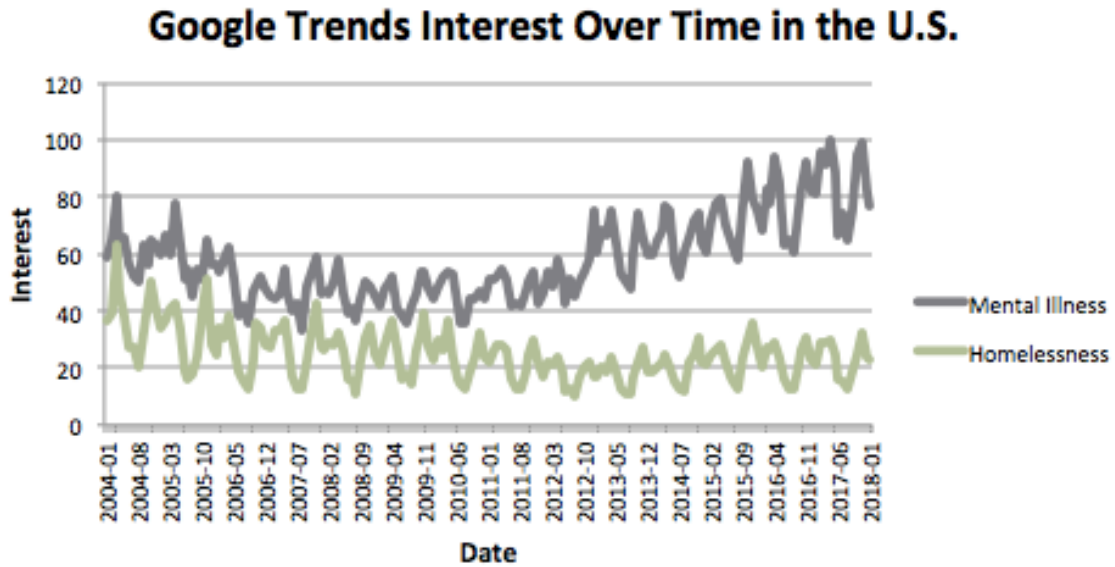


Figure 11. Google trends interest over time in the United States. Keywords: mental illness and homelessness.

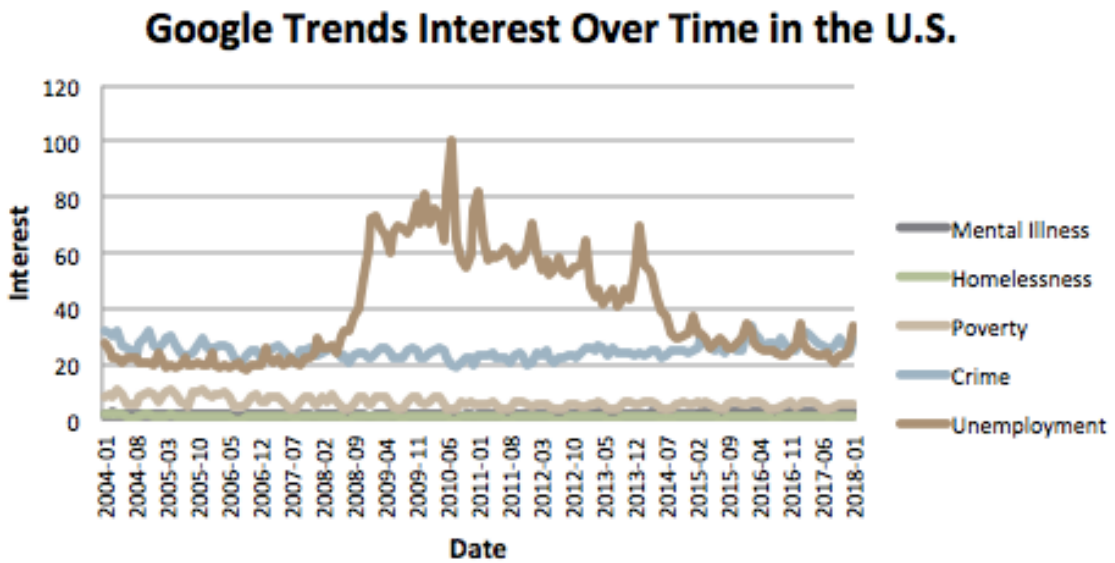


Figure 12. Google trends interest over time in the United States. Keywords: mental illness, homelessness, poverty, crime, and unemployment.

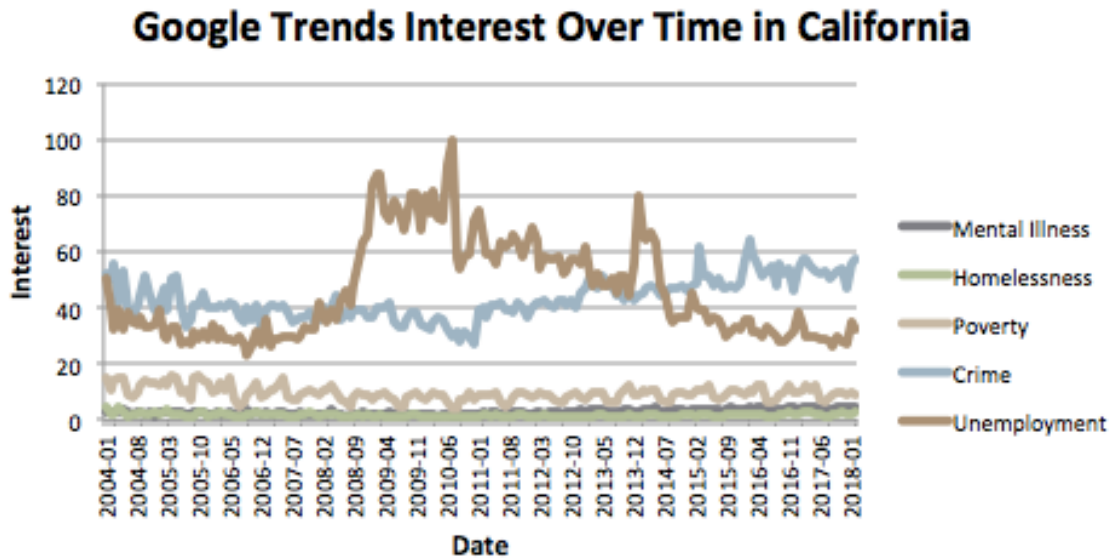


Figure 13. Google trends interest over time in California. Keywords: mental illness, homelessness, poverty, crime, and unemployment.

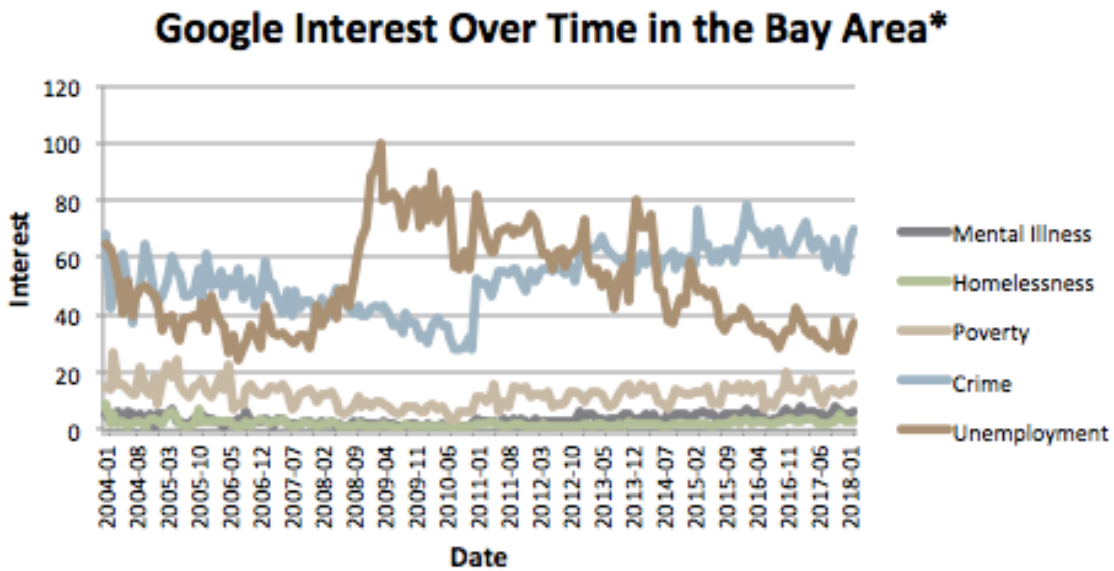


Figure 14. Google trends interest over time in the Bay Area. Keywords: mental illness, homelessness, poverty, crime, and unemployment.

\*San Francisco, Oakland, and San Jose

Definitions of Homelessness	Author	Year
Loss of a dwelling unit from a natural disaster, an accident, or a combination of economic hardship, political and legal circumstances, and personal behavior	Crane & Warnes	2000
Not having a home, having little access to social support, and having few social connections	Johnstone, Parsell, Jetten, Dingle, & Walter	2016
Loss of complete autonomy, the lack of support from friends and family, and a sense of endurance while struggling to survive within an ecological system	Teo & Chiu	2016

Table 1. Definitions of homelessness.

Causes of Homelessness	Author	Year
Psychiatric hospital patients released post 1975 and severe and persistent mental health disorders	Dennis, Levine, & Osher	1991
Prosperity, shelters overestimate homeless rate, and greater barrier to exit out of homelessness	O'Flaherty	1993
Poverty	Kessler, Amminger, Aguilar-Gaxiola, Alonso, Lee, & Ustun	2007
Mental illness and addiction	Dennis, Levine, & Osher; Sinaiko & McGuire; Larimer, Newman and Goldman	1991, 2006, 2009, 2009
Lack of adequate care and subsidies, difficulty in navigating bureaucratic mazes to secure subsidized housing, lottery based housing programs do not meet housing demands, and competition for vouchers further puts the mentally ill at a disadvantage for receiving the help that they need	Newman & Goldman	2009
Lack of accessible housing	Larimer	2009
Failure of policy	Dennis et al., Newman & Goldman, Meschede	1991, 2009, 2011
Lack of affordable housing and a failure of government	Downs	2011
Increasing unemployment rates and decreasing real incomes for the lowest earners	Routhier	2011
Failure of CoC model	Meschede	2011
Lack of appropriate housing and case management	Basu, Kee, Buchanan, and Sadowski	2012
Low minimum wage and a lack of housing assistance	Braiterman, Jacobs, & Murray	2017

Table 2. Causes of homelessness.

Policy Recommendations	Author	Year
Develop trust and a rapport, drop-in centers that provide essentials including mental and physical health care, a comprehensive system of care that includes intensive treatment, outreach, engagement, and case management, and a range of affordable housing options and community-based residential care	Dennis, Levine, & Osher	1991
Housing First policy	Pollio, Spitznagel, North, Thompson, Foster	2000
Affordable housing and social capital service system integration	Rosenheck	2001
Housing First policy	Larimer	2009
Affordable housing and education to decrease prejudice	Newman & Goldman	2009
Housing First policy	Larimer	2009
Outreach and development of trust	Meschede	2011
Housing First model and a comprehensive system of case management	Basu, Kee, Buchanan, and Sadowski	2012
Increase the minimum wage and augment the availability of affordable housing	Braiterman, Jacobs, & Murray	2017
Develop affordable housing, provide skills training, and increase accessibility to services	Gordon	2017

Table 3. General policy recommendations to reduce homelessness.



Causes of Homelessness in San Francisco	Author	Year
Consumers do not receive the help that they need and have negative experiences with providers	Spanglet, Martin, Connor, Kahan, & Friedenbach	1999
Homeless population is aging, hence more illness	Hahn, Kushel, Bangsberg, Riley, and Moss	2006
Abuse in shelters leads to more people on the streets and shelters are not funded adequately	Albertson, Anarchy, Brahinsky, Freidenbach, Kennedy, Hootman, . . . Sipes.	2007
Essentialism of the homeless	Prentice and Miller	2007
Biological determination beliefs	Prentice & Miller; Williams & Eberhardt	2007, 2008
Lack of shelter bed availability, long waits, short stays, and negative experiences in shelters leads to more people on the streets	Howey, Freidenbach, Mohre, Do, Westort, Buchbinder, and Parkinsen	2009
Housing costs increasing, low minimum wage, emotional abuse, financial issues, conflict at home, mental health issues, physical abuse, losing a job, substance abuse, inability to afford rent, and a lack of available housing	Connery	2017

Table 4. Causes of homelessness in San Francisco.

Policy Recommendations for Homelessness in San Francisco	Author	Year
Programs that meets individual needs, counseling, and access to medication	Spanglet, Martin, Connor, Kahan, & Friedenbach	1999
Improvements in the staff behavior, better facilities, fair enforcement of the rules, and inceased access to services in shelters	Albertson, Anarchy, Brahinsky, Freidenbach, Kennedy, Hootman, . . . Sipes.	2007
Focus on education and the development of empathy and compassion	Prentice & Miller	2007
Mix of equal access and special needs prioritization shelters, increased beds in shelters, better staff, increase the length of stays, and simplify and improve the shelter reservation system	Howey, Freidenbach, Mohre, Do, Westort, Buchbinder, and Parkinsen	2009
More housing, access to public restrooms, increases in food availability, decrease the criminalization of substance abuse disorders and homelessness, and stop police harassment of the homeless	The Coalition on Homelessness	2014
Stop ciminalizing homelessness	Connery	2017

Table 5. Policy recommendations to decrease homelessness in San Francisco.

Consumer Theorized Causes	Provider Theorized Causes	Consumer Solutions	Provider Solutions
High rent	Poor mental health	Increased access to affordable housing	Increased substance abuse clinics
Unemployment	Substance abuse issues	Increased access to dental services	Increased psychiatirc services
Substance abuse	Medical problems	Increased access to medical services	Increased access to medical services

Table 6. Consumer and provider opinions.

## References

- 311 San Francisco. (2018). Retrieved from <https://sf311.org>
- Albertson, J., Anarchy, D., Brahinsky, R., Freidenbach, J., Kennedy, C., Hootman, J., . . . Sipes, B. (2007). *Shelter Shock: Abuse, Cruelty, and Neglect in San Francisco's Shelter System* (Rep.). San Francisco, CA: The Coalition on Homelessness.
- Basu, A., Kee, R., Buchanan, D., & Sadowski, L. S. (2012). Comparative Cost Analysis of Housing and Case Management Program for Chronically Ill Homeless Adults Compared to Usual Care. *SSRN Electronic Journal*.
- Benjaminsen, L. (2016). Housing first: Ending homelessness, transforming systems, and changing lives. *Housing Studies*, 32(1), 115-116.
- Benjaminsen, L., & Andrade, S. B. (2015). Testing a Typology of Homelessness Across Welfare Regimes: Shelter Use in Denmark and the USA. *Housing Studies*, 30(6), 858-876.
- Blair, I. V., Havranek, E. P., Price, D. W., Hanratty, R., Fairclough, D. L., Farley, T., . . . Steiner, J. F. (2013). Assessment of biases against Latinos and African Americans among primary care providers and community members. *American Journal of Public Health*, 103(1), 92-98.
- Braiterman, S., Jacobs, R., & Murray, S. (2017). Economic Factors Affecting Homelessness in Abstract the United States.
- Coalition on Homelessness. (2009). Employment and Homelessness. Retrieved from <http://nationalhomeless.org/factsheets/employment.html>
- Coalition on Homelessness. (2016). San Francisco Fact Sheet on Homelessness . Retrieved from <http://www.cohsf.org/wp-content/uploads/2014/08/general-factsheet2016.pdf>
- Connery, P. (2017, June 21). San Francisco Homeless Point in Time Count Reports. Retrieved February 9, 2018.
- Crane, M., & Warnes, A. M. (2000). Evictions and Prolonged Homelessness. *Housing Studies*, 15(5), 757-773.
- Dennis, D. L., Levine, I. S., & Osher, F. C. (1991). The physical and mental health status of homeless adults. *Housing Policy Debate*, 2(3), 815-835.
- Downs, A. (2011). What's Wrong with American Housing? *The Brookings Institution*.
- Estimate of People of All Ages in Poverty for United States. (2016, January 05). Retrieved November 14, 2017.

- Fiske, S. T. (2002). What we know now about bias and intergroup conflict, the problem of the century. *Current Directions in Psychological Science*, *11*(4), 123–128.
- Flèche, S., and Layard, R. (2017) Do More of Those in Misery Suffer from Poverty, Unemployment?. *Kyklos*, *70*: 27–41.
- Hahn, J. A., Kushel, M. B., Bangsberg, D. R., Riley, E., & Moss, A. R. (2006). Brief report: The aging of the homeless population: Fourteen-year trends in San Francisco. *Journal of General Internal Medicine*, *21*(7), 775-778.
- Harassment and Displacement in the Mission: Community Experiences Survey* (Rep.). (2014). San Francisco, CA: The Coalition on Homelessness.
- Howey, N., Freidenbach, J., Mohre, G., Do, J., Westort, B., Buchbinder, A., & Parkinsen, L. (2009). *The Runaround: An Examination of San Francisco's Byzantine Shelter Reservation System* (Rep.). San Francisco: The Coalition on Homelessness.
- HSA 90 day emergency shelter waitlist | DataSF | City and County of San Francisco. (2018). Retrieved February 12, 2018.
- Johnstone, M., Parsell, C., Jetten, J., Dingle, G., & Walter, Z. (2016). Breaking the Cycle of Homelessness: Housing Stability and Social Support as Predictors of Long Term Well-Being. *Housing Studies*, *31*(4), 410-426.
- Jungle, R. (2018, January). Rent trend data in San Francisco, California. Retrieved February 16, 2018, from <https://www.rentjungle.com/average-rent-in-san-francisco-rent-trends>
- Kessler, R. C., Amminger, G. P., Aguilar-Gaxiola, S., Alonso, J., Lee, S., & Ustun, T. B. (2007). Age of onset of mental disorders: A review of recent literature. *Current Opinion in Psychiatry*, *20*(4), 359–364.
- Laird, Gordon. *We, The Resource. The Price of a Bargain: The Quest for Cheap and the Death of Globalization*. Toronto: Emblem Editions, 2010. 243-44.
- Larimer, M. E. (2009). Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons With Severe Alcohol Problems. *Jama*, *301*(13), 1349.
- Meschede, T. (2011). From Street Life to Housing: Consumer and Provider Perspectives on Service Delivery and Access to Housing. *Cityscape*, *13*(1), 71-93.
- Newman, S., & Goldman, H. (2009). Housing Policy for Persons with Severe Illness. *Policy Studies Journal*, *37*(2), 299-324.

- O'Flaherty, B. (1993). An economic Theory of Homelessness and Housing. *The Journal of Housing Economics*, 4, 13-49.
- Piat, M., Polvere, L., Kirst, M., Voronka, J., Zabkiewicz, D., & Plante, M. (2015). Pathways into Homelessness: Understanding How Both Individual and Structural Factors Contribute to and Sustain Homelessness in Canada. *Urban Studies*, 52(13), 2366-2382.
- Pollio, D. E., Spitznagel, E. L., North, C. S., Thompson, S., & Foster, D. A. (2000). Service Use Over Time and Achievement of Stable Housing in a Mentally Ill Homeless Population. *Psychiatric Services*, 51(12), 1536-1543.
- Prentice, D. A., & Miller, D. T. (2007). Psychological essentialism of human categories. *Current Directions in Psychological Science* *Directions in Psychological Science*, 16(4), 202–206.
- Quigley, J. M. (1996). The Homeless. *Journal Of Economic Literature*, 34(4), 1935-1941.
- Quigley, J. M., & Raphael, S. (2001). The Economics Of Homelessness: The Evidence From North America. *International Journal of Housing Policy*, 1(3), 323-336.
- Rosenheck, R. (2001). Service Delivery and Community: Social Capital, Service Systems Integration, and Outcomes among Homeless Persons with Severe Mental Illness. *Health Services Research*, 36(4), 691-710.
- Routhier, G. (2011). The Economics of Homelessness. Retrieved February 16, 2018, from <http://www.coalitionforthehomeless.org/the-economics-of-homelessness/>
- The Runaround: An Examination of San Francisco's Byzantine Shelter Reservation System* (Rep.). (2009). San Francisco, CA: The Coalition on Homelessness.
- San Francisco Open Data. (2015). Retrieved February 16, 2018, from <https://data.sfgov.org/>
- Sinaiko, A. D., & McGuire, T. G. (2006). Patient Inducement, Provider Priorities, Resource Allocation in Public Mental Health Systems. Resource Allocation in Public Mental Health Systems. *Journal Of Health Politics, Policy And Law*, 31(6), 1075-1106.
- Spanglet, L., A., Martin, C., Connor, M., Kahan, J., & Friedenbach, J. (n.d.). *The of Homeless People with Mental Illness Homeless People with Mental Illness* (Rep.). San Francisco: The Coalition on Homelessness.
- Teo, P. L., & Chiu, M. Y. (2016). An Ecological Study of Families in Transitional Housing--'Housed but Not Homed'. *Housing Studies*, 31(5), 560-577.

Trulia. (2017, August). Real Estate Data for San Francisco. Retrieved April 16, 2018, from [https://www.trulia.com/real\\_estate/San\\_Francisco-California/market-trends/](https://www.trulia.com/real_estate/San_Francisco-California/market-trends/)

Trulia. (2017, March). Real Estate Data for New York. Retrieved April 16, 2018, from [https://www.trulia.com/real\\_estate/New\\_York-New\\_York/market-trends/](https://www.trulia.com/real_estate/New_York-New_York/market-trends/)

U.S. Bureau of the Census. (n.d.). Retrieved February 26, 2018.

U.S. Bureau of Economic Analysis, (n.d.). Retrieved February 26, 2018.

U.S. Bureau of Labor Statistics. (n.d.). Retrieved February 26, 2018.

Williams, M. J., & Eberhardt, J. L. (2008). Biological conceptions of race and motivation to cross racial boundaries. *Journal of Personality and Social Psychology*, *94*(6), 1033–47.