THE EFFECT OF LONG TERM HOUSING ON THE HIGH RATES OF MORBIDITY AND MORTALITY IN WOMEN EXPERIENCING HOMELESSNESS

By

GIANNA MARCHE JORDAN

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A Thesis Submitted to The Honors College

In Partial Fulfillment of the Minor
With Honors in

Health and Human Values

THE UNIVERSITY OF ARIZONA

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Approved by:

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Dr. Vincent Del Casino
Department of Geography and Development

Abstract:

The issue of homelessness is an increasing problem in the United States, with the number of people experiencing homelessness increasing in the past two years. Historically, deinstitutionalization in the 1970s along with welfare reform in the 1990s had a drastic impact on the number of people experiencing homelessness. With the belief that the individual was responsible for their condition, homeless outreach focused on addressing individual behaviors such as substance abuse and mental illness as the reason a person was experiencing homelessness. This belief ignored any structural factors such as politics, the economy, gendered issues, and race as aspects that could contribute to someone experiencing homelessness. With a shift from a behavioralist view to a structuralist view, a Housing First program emerged as an alternative to the treatment first method. The Housing First Programs provide someone experiencing homelessness with housing immediately and does not require them to abstain from substances or access mental health treatment. By giving someone housing, the ability to make choices in their life, and reducing the harm they may encounter a Housing First program would reduce the high rates of morbidity and mortality in women experiencing homelessness.

Chapter I

Introduction

Framing the Issue

Homelessness is an issue that affects people of all races, ages, and genders across the United States. Unfortunately, this issue is increasing in severity as the number of people experiencing homelessness has been increasing since 2017. (U.S Department of Housing and Urban Development 2018). The increase in people experiencing homelessness is surprising

considering the rate of unemployment is at low levels, indicating that other factors beyond employment are affecting people experiencing homelessness. This thesis will examine what factors have led to the increase in people experiencing homelessness and how this increase intersects with access to health care, particular mental health care. It does so by tracing the history of homelessness practice and the relationship between those practices and the overall experience of homeless individuals in the United States.

I became interested in this topic when I began witnessing homelessness first hand during an internship at a women's shelter that had temporary housing and a walk-in shelter where women would come every morning to shower, eat, wash clothes, get new clothes, and gain access to other key resources. Throughout my time at the women's shelter, I was able to learn about the women's situations, how they became homeless, what their lives were like, and the ways they were trying to get off of the streets. I learned that there were many reasons people became homeless and that getting off of the streets is not as simple as getting a job. I became familiar with treatment-centered housing programs, where people experiencing homelessness were required to remain sober and engage in mental health treatment to gain temporary housing and then long term housing. Breaking their sobriety meant losing their housing. I felt that this method was ineffective because addiction and mental health issues are serious and not having a stable housing environment can make complying with treatment or abstaining from substances increasingly difficult. Because of this, I have grown increasingly interested in how social scientists theorize the challenges related to homelessness and the ways in which these studies have impacted policy today.

Situating Homelessness Studies

Homelessness is an area of concern across the social sciences today. While homelessness studies serves as a foundational understanding on the current policies regarding homelessness and where they originated from, a broad range of literatures will inform this analysis, including gender studies, mental health studies, and other studies relating to women experiencing homelessness. Each of these approaches offers a unique perspective on the issue because they focus on different aspects of the challenges related to homelessness. I will be using studies on homelessness throughout the past century to examine the different methodologies used to discuss homelessness, where there was a shift in methodologies, and what current methodologies dominate the discussion around homelessness in the United States. This body of literature has developed over time out of an interest to provide social scientific analyses of how we might best address homelessness from either an individual or social level.

Gender studies analyzes how gender affects or is affected by societal, governmental, and historical aspects (Shohat 2002). I will be looking at gender studies that focus on women, with regards to women and mental illness along with women and homelessness. Examining these studies will illustrate the ways in which gender can affect someone experiencing homelessness. Studies on women experiencing homelessness, for example, is, first-and-foremost, a branch of gender studies that examines what the differences are between women experiencing homelessness and men experiencing homelessness. Looking at gender studies of homelessness provides insights into how being a woman and experiencing homelessness impacts one's mental and physical health. In taking up a gender studies approach, I will be able to isolate issues that uniquely impact women experiencing homelessness. In particular, I will be able to examine how

women experiencing domestic violence, living as the head of the household, and having children contribute to their potential to be homeless and how gender politics impact their experience of homelessness.

Mental health studies focus on policies regarding mental health and their treatment, changes in perspectives on mental health, and current research and methods. Drawing on these studies, allows me to look at how mental health issues, which are prevalent among people experiencing homelessness, also impact individual experiences of homelessness. As Bailey et al. (2015: 370) argues, "Between one-fourth and one-third of homeless persons have a serious mental illness such as schizophrenia, bipolar disorder, or major depression." Mental health treatment is often a required aspect of support when people experiencing homelessness attempt to gain housing. This is particularly true when women attempt to gain long term housing, so using mental health studies to establish knowledge about current treatment options is important. Over the course of the last fifty years or so, different ideological positions related to health care rights have emerged, impacting both access to as well as philosophies undergirding mental health outreach.

Finally, there has been a shift in homelessness practice in the United States in recent years. Specifically, some states and counties have adopted a 'housing first' approach where people experiencing homelessness are given long-term housing without being required to get mental health treatment or be sober. This shift has resulted from a changes in the scholarship on homelessness as it relates to policy. In particular, scholars have taken a more structural approach to the causes of homelessness and how to address the societal factors that often contribute to a person experiencing homelessness and their inability to get off of the streets. In so doing, these

scholars have argued that individually-based behavioral change models that rely on sobriety or mental health treatment fail to understand the much larger, long-term problems that people experiencing homelessness are embedded with.

Outlining the Thesis

In this thesis, I develop a historical analysis that allows me to trace the different approaches to homelessness and the changes in those approaches over time. In this process, I examine not only how policy of and theory related to homelessness studies has changed but also how those changes may have caused increases in the number of people experiencing homelessness or preventing them from getting off the streets. In taking this historical approach, I analyze the treatment first approach that arose in the 1970s and 1980s in response to the move toward deinstitutionalization of social services and how this approach has located the cause of homelessness (and its solution) on the individual. This approach also situates the homeless themselves as uniquely responsible for ending their own homelessness. In addition, this thesis analyzes how a housing first program in the 1990s emerged as a way to help people experiencing homelessness that suffer from mental illness and how programs like this have become more widespread. Within this approach, a shift has occurred that locates responsibility for the care of the homeless not in the individual but in the need to address the larger structural and social factors that produce the environment for homelessness in the first place. After establishing what each approach consists of and how they were developed, I offer a critical analysis of the current literature to see what approaches are advocated for today in regards to women experiencing

homelessness. I will examine if and how either one of the other approach is suggested and if the two major approaches are brought together.

The remainder of this thesis is organized around the three substantive chapters. Chapter 2 examines the history of homelessness practice focusing on how the individual have become responsible for their own support over time as the result of deinstitutionalization and welfare reform and lead to the development of treatment first programs. Chapter 3 focuses on a structuralist and gendered response to homelessness where responsibility shifts from the individual to social and political structures where a housing first method can emerge. Chapter 4 analyzes the presence of behavioral or structural aspects in the current literature regarding homelessness.

Chapter II

Shifting Responsibility from Society to the Individual

This chapter examines the historical factors that have resulted in the individual being responsible for managing their own homelessness. The focus of this chapter is on how changes in federal and state policy forced people out of institutions that had historically housed them and onto the streets. It further analyzes changes in policy that meant that related services to homelessness - such as mental health services - had created further challenges in serving a growing homeless population. The chapter is organized historically, tracing the establishment of policies around deinstitutionalization in the 1960s and 1970s and into the Reagan Era in the 1980s, when a an even deeper retreat from social service support further limited efforts to support homeless people in the U.S.

The Roots of Deinstitutionalization

In the big picture, deinstitutionalization was intended to relocate patients in mental hospitals into community settings after psychotic drugs became available to treat mental illness in the 1970s (Bassuk and Gerson 1978). Patients with a mental illness would no longer need to live in a mental hospital to receive their treatment but would live in the community and access community health centers for their treatment. The process by which deinstitutionalization was carried out resulted in people who had previously lived in the hospital living on the streets because there was not adequate structures in place to accommodate them, “problems such as homelessness are not the result of deinstitutionalization per se but rather of the way deinstitutionalization has been implemented” (Lamb 2001: 84). This contributed to increases in

the number of people experiencing homelessness at the time and the large portion of people experiencing homelessness that suffer from mental illness currently.

Deinstitutionalization was initiated by President John F. Kennedy after passing the "Mental Retardation Facilities and Community Mental Health Centers Construction Act" of 1963. This act shifted the delivery of inpatient psychiatric care in long-term facilities to community centers that were assigned the ability to provide outpatient care to people with mental illnesses. The goal of deinstitutionalization was to reduce inpatient population by fifty percent in twenty years. After enactment of this legislation there was a large decrease in the number of inpatients from 559,000 in 1955 to 110,000 in 35 years (Mechanic and Rochefort 1990). By the early 2000's, the census shows that total patients in mental hospitals had decreased by 90% (Davis et al. 2012). The amount of patients that were discharged from mental hospitals far exceeded the initial goal and overwhelmed the inadequate community health centers that were supposed to serve them.

The early (and drastic) decrease in patients receiving long-term facility-based care was a result of discharges of inpatients and a decrease in admissions into mental hospitals. The pressure thus was pushed to community health centers, raising an important question along the way - could these organizations provide adequate care to the mental health patients, particularly the homeless? Although patients were being removed from hospitals, the goal was that there would be a social safety net through community centers and welfare programs so that these shift in treatment wouldn't have a large negative impact. Welfare programs like social security, disability, and food stamps would allow persons with mental illness to live in the community and care for themselves.

As a result of the massive decline in inpatient care, people living with mental illnesses became increasingly responsible for their care and well being; it was no longer the responsibility of state mental hospitals to ensure they received their medications and psychiatric care. The responsibility was shifted from an institution to the individual. Unfortunately, many communities, particularly lower-income ones, did not have the resources to support the individual, "The fact that psychoactive drugs could ameliorate disordered behavior at the individual level… and prompted more favorable attitudes towards the release of patients among the general public, state hospitals faced the problem of where to place patients newly ready for discharge. There were few facilities available for aftercare" (Gronfein 1985: 444). The social safety net of community mental health centers was not large or sophisticated enough to support the volume of patients being discharged from mental hospitals.

Furthermore, as deinstitutionalization took hold in the 1970s, the lack of federal funding placed the financial responsibility on the states. As a result, many states began to further rely on a network of private mental hospitals and Managed Behavioral Health Organizations to meet the needs of the mental health population (Davis 2012). This trend of voluntarism, where multiple entities meet the needs of the population largely bypassing government regulation, results in the formation of a shadow state. This developed into what Geiger and Wolch (1986: 351) call "a new institutional form that fulfills many of the functions of government but also makes many public policy decisions in the absence of governmental preemption." An increase in private hospitals and organizations supporting the mental health population thus emerged, while the new public policy, which became reliant on this network of private for-profit and nonprofit organizations, radically changed the landscape of care and support for persons with mental

illness. These changes were further exacerbated by the wide variation of support developed in different states.

Social Service Decline in the Reagan Era

On the heels of the rapid decline in mental health services in the 1970s, which has been traced to an increase in homelessness (Devine, Rubin, and Wright 1992), the free market policies of President Ronald Reagan put increasing pressure on state governments and federal agencies to reduce investments in public housing spaces and aid to families more generally. At the end of Reagan's first term as president, for example, the federal government had reduced the number of households receiving federal aid by over a million households (Wolch and Akita 1989). The downstream impact was a further increase in homelessness in the U.S. While Congress tried to intervene with legislation to support shelters supporting homeless people, including the Act of 1987, which was signed into law reluctantly by Reagan, the federal government under Reagan maintained a strictly austere approach to social service support. Thus, while money was provided to shelters, it did so without addressing the issues that were causing the increase in people experiencing homelessness (Mitchell 2011). The larger result of Reagan's policies was to limit the effectiveness of the social safety net for homeless people. This put further pressure on individuals to manage their own care and support.

Housing was not the only focus of disinvestment during Reagan's two terms as president. He also pushed for decreased budgets for welfare policies like Social Security, Food Stamps, Medicare, Medicaid, and unemployment insurance (O'Connor 1998). This decrease in the social safety net was based on the belief that individuals were dependent on the government when they

should be responsible for themselves. This attitude directly impacted the population of people experiencing homelessness, as the number of people experiencing homelessness grew from a reduction in social welfare and funding of low income housing. The notion that homelessness was a choice of individuals and not a structural problem further implied that an individual was experiencing homelessness as the result of their actions; they were responsible for getting off the streets.

The larger social safety net, which was in place prior to Reagan, was intended to support persons with mental illness who were no longer in mental hospitals. With inadequate resources already in place, a decrease in funding for this social safety net would increase the number of people with a mental illness who found themselves now experiencing homelessness. Even after Reagan left office, President Bush and then President Clinton did little to reinvest in the larger institutional structures of mental health care that could support those people who are less likely to manage their care individually. And, the debate continued as "the issue of where those with SMI [Serious Mental Illness] should be housed has brought attention to the rapid growth of the homeless population in the United States over the past several decades. It is estimated that 636,017 adults are homeless on any given night in the United States, with as many as 2.15 million experiencing homelessness on an annual basis; of these, 25% to 33% have an SMI" (Davis et al 2012: 262). This increase in people experiencing homelessness with a mental illness is a result of the lack of community resources available to someone with a mental illness, along with inadequate mental health treatment in homelessness outreach programs.

Welfare Reform in the 1990s

In the 1990s, welfare support was further reduced through the passing of The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which cut federal assistance to many Americans. This welfare reform aimed to reduce dependence on federal programs by encouraging the individual to be responsible for their wellbeing "emphasizes work, personal responsibility, economic self-sufficiency, and strong families" (Lichter and Jayakody 2002: pg 117). The passage of this bill further harmed an already vulnerable group, particularly low income single mothers.

For example the PRWORA ended Aid to Families with Dependent Children, a program that supported single mothers by providing them with cash so they would be able to support their families. Although the Clinton Administration supported a new structure - the Aid to Families with Dependent Children was replaced by Temporary Assistance to Needy Families (TANF) - this support structure limited the amount of time someone could receive federal aid and their lifetime limit of receiving aid. The goal of this reform was to reduce the number of people receiving federal aid by forcing them to become self sufficient. This bill, of course, relied on the assumption that the individual alone was responsible for their financial situation and the individual would be able to improve it. The legislation thus required a person receiving temporary aid to attain employment within two years, implying that persons receiving federal aid do not work and if they did they would no longer need financial assistance. With women making up ninety five percent of adults receiving welfare, single mothers were victimized by this legislation (Harris and Mullan 1996). The reduction in welfare for single mothers contributed to the increase in women experiencing homelessness in female heads of the household.

Female-headed households, especially those with young children, have long been a group that is vulnerable to homelessness. The enactment of TANF did not help this population. In fact, TANF reduced the financial aid female headed households could receive, even if they had employment. With only one person providing for a household there was a growing risk. As Merves (1992: 236) suggests:

> Budget cuts affect female-headed families so adversely because these families rely heavily on social welfare programs as a result of their low income and their family responsibilities. A recent study by the Bureau of the Census found that 70% of female-headed families receive benefits from one or more means-tested or nonmeans-tested programs.21 For example, one-third received Aid to Families with Dependent Children.

With a majority of female-headed households receiving federal assistance and one-third receiving Aid to Family with Dependent Children (AFDC), PRWORA immensely reduced the money female headed households could receive putting them at a greater risk of experiencing homelessness.

Although there are male-headed households that experience homelessness, female-headed households represent an unproportional amount of families experiencing homelessness. Only 23% percent of families are headed by females, while 70% to 90% of the families experiencing homelessness are female-headed families (U.S Census Bureau 2018). The discrepancy between the number of female-headed families nationally and the number experiencing homelessness show they are a vulnerable group.

The Rise of the Responsible Individual in Homelessness Outreach

The individual became increasingly responsible for their own care as a result of deinstitutionalization, placing the responsibility of psychiatric care and income generation, in particular, on the individual. Put more generally, welfare reform placed financial responsibility on people instead of the government. This shift in responsibility transcended into homelessness outreach, with the individual homeless person becoming increasingly responsible for managing their own care and navigating an ever-increasing and complex Shadow State of for-profit and nonprofit homelessness organizations. This can be observed in the emergence of continuum of care, or treatment first programs, as a way to address the issue of people experiencing homelessness.

This approach to homelessness outreach relies on the fact that the individual is the cause of their homelessness due to substance abuse, mental illness, and chronic unemployment. The main concept these programs focus on is a person's substance abuse or mental illness. As Dordrick (2002: 9) suggests from one study on homelessness "there was virtual unanimity among staff and residents that substance abuse was the cause of their homelessness and the key to its solution." This assumption, about the role of substance abuse in causing someone to experience homelessness, means that in order for someone to gain housing they have to abstain from using substances. A person must be receiving substance abuse treatment, not using substances, and be working towards housing readiness in order to move from temporary or transitional housing to permanent independent housing (Henwood et al. 2010). If someone who is in a treatment first program breaks their sobriety they will lose their housing and be forced to begin the cycle of going from the streets to a shelter to transitional housing and ultimately long

term housing (Gulcur, Padgett, Tsemberis 2006). If a person enters into a treatment first program they relinquish much of the control they have over their life.

A person experiencing homelessness that is living on the streets has more control and freedoms in their life, even though they are living in poor conditions. The transition from having more freedom to living in a treatment first program requires a person experiencing homelessness to give up much of their control, "clients submitted to rules requiring treatment compliance, abstinence, curfews, limited visitation, and a loss of privacy" (Miller & Flaherty 2000). Because a person is believed to have made poor choices that resulted in them experiencing homelessness, their ability to make choices is reduced.

Conclusion

Beginning with the process of deinstitutionalization, which transitioned care from large mental hospitals to the community, the individual has become increasingly responsible for them experiencing homelessness. The belief that responsibility is placed on the individual was enhanced through further policy changes by the Reagan administration which drastically reduced welfare support. These federal cuts were based on the assumption that individuals who were receiving welfare support were not employed and if they just gained employment they wouldn't need financial assistance. However, many of the recipients were employed and as a result female-headed households were negatively impacted by the significant reduction in the amount of welfare support they could receive. The individual becoming increasingly more responsible manifested itself in homelessness outreach. Because it was believed that a person was experiencing homelessness as a result of poor life choices; treatment first programs, where

individuals had little control over their life, emerged as a way to address the issue of homelessness. These programs identified substance abuse and mental health noncompliance as reasons someone was experiencing homelessness, so in order for them to gain housing a person would have to abstain from substances and receive mental health treatment. These programs failed to recognize structural factors such as lack of affordable housing, racism, criminalization of the poor, and domestic violence that could contribute to someone experiencing homelessness.

Chapter III

A Structural and Gender Response to Homelessness

This chapter examines the shift from responsibility being placed on homeless individuals to responsibility being placed on larger societal and structural factors. In a structuralist response to the behavioral approaches found in "treatment first," factors such as race, socioeconomic status, and education level are instead examined as contributing to a person experiencing homelessness. Structurally-informed programs try to account for more than an individual's responsibility. In this discussion, I focus on a gendered response, which examines issues that solely affect or are more prevalent among women such as unemployment, underemployment, and domestic violence to show how the structures of homelessness have disproportionately impacted women.

Locating Responsibility in the Social, Political, and Economic Sphere

In the shift of responsibility from the individual, larger issues such as social issues, politics, and economic conditions are acknowledged as factors that can affect someone experiencing homelessness. Social issues, such as race and socioeconomic status, for example, can make certain individuals more vulnerable to experiencing homelessness. National and local politics can lead to someone experiencing homelessness or continue to locate responsibility at the individual level. Economic conditions, such as unemployment rate, availability of low income housing, and inflation of rent are also factors that can contribute to someone experiencing homelessness. This section thus outlines each of these sets of conditions and discusses their impact on homelessness more generally.

The issue of race inequality in the United States manifests itself in people experiencing homelessness with an overrepresentation of African Americans and other minority groups. African Americans make up 13.4% of the general population in the United States but the prevalence in the homeless population is over double the general population at 34.6% (US Census 2018; HUD 2018). This inequality represents the vulnerability of African Americans to experience homelessness. As a result of structural racism, African Americans are more likely to experience reduced employment opportunities, reduced wages and residential segregation.

In the realm of the socioeconomic, a person living in poverty is more likely to experience homelessness than someone who lives above the poverty line. African Americans, in particular, are extremely vulnerable to experience homelessness because almost one third live in poverty (The State of Working America). As Parsell and Marston state (2012: 38) "homelessness is generally an experience that is symptomatic of a range of problems that occur when people are unable to afford housing and thereby excluded from the housing market." If someone is struggling financially, or spending a large portion of their income on rent, they are more susceptible to experience homelessness. Many African Americans living in poverty, live in areas that are concentrated with African Americans living in poverty. These areas have fewer employment opportunities, poor education systems, and fewer services to aid people living in poverty, these factors can prevent someone from ever leaving the impoverished neighborhood they grew up in (National Alliance to End Homelessness). Along with African Americans having high rates of poverty, housing discrimination increases their risk of experiencing homelessness.

Rental discrimination is still prevalent in today's society; although a person can't directly be refused because of the Fair Housing Act, many African Americans face subtle or indirect

forms of discrimination. When African Americans attempt to find a rental unit they often face many barriers that prevent or increase the difficulty of obtaining a place to live. For example, Lundy and Massey (2001: 466) argue that "compared with whites, African-Americans were less likely to get through and speak to a rental agent, less likely to be told of a unit's availability, more likely to pay application fees, and more likely to have credit worthiness mentioned as a potential problem in qualifying for a lease." With a shortage of affordable housing units, rental discrimination can prevent African Americans from finding a home or result in them living in inadequate environments. When someone who is African American attempts to leave an unsafe neighborhood or unfit housing they face many barriers as a result of racism as well.

The criminalization of the poor and subsequent criminalization of people experiencing homelessness is a social issue that also contributes to the issue of homelessness. The criminalization of the poor is a result of the perceived lower status people with lower socioeconomic position have in society. This can manifest in the criminal justice system, where persons of low socioeconomic status, especially those that receive welfare or other financial assistance, are treated poorly as if they have the same status as criminals (Gustafson 2009). Beyond being treated poorly, someone with less financial means doesn't have the same privileges in court that someone with more financial means has. If someone is arrested and doesn't have the money to pay for their bail, they sit and wait in jail until their case is heard. Stevenson (2018: 512), for example, argues that "the use of money bail to determine custody status suggests that pretrial detention may form a type of poverty trap, where defendants who are too poor to pay for pretrial release suffer economic consequences downstream. Such consequences include the stigma of a criminal record, the destabilization of incarceration, or the

burdens of probation compliance." A person in jail, without the ability to afford bail, is more likely to plead guilty or accept a plea deal that is unfavorable to put an end to the pretrial waiting. This issue is disproportionately experienced by people living in poverty or in the lower class, with 50 percent of defendants unable to afford a bail of $5,000 or less because typical defendants make less than $7,000 a year (Dobbie et al. 2018). The 'bail trap' effectively criminalizes the poor, with people spending more time in jail, pleading guilty to charges they may not have committed, and having their lives disrupted by having a criminal record.

A person having a criminal record drastically affects their ability to find employment, or employment with sufficient income, and housing. Someone with a criminal record is more likely to be unemployed or underemployed than someone without a criminal record (Western and Beckett 1999). With most jobs performing background checks and not willing to employ convicted criminals, the only available jobs are low-wage and low-skill. Earning a lower-income job limits the housing that someone with a criminal record could afford, but public housing for low-income residents often excludes someone with a criminal background. Although this policy was designed to protect other residents, it harms people with a criminal background who have non-violent offenses, offenses from years ago, or were innocent (Carey 2004). Exclusion from low-income housing leaves someone with a criminal record few options for affordable housing. With low availability of housing opportunities, someone with a criminal record may end up being homeless. The California Department of Corrections found that in urban cities up to half of parolees were experiencing homelessness (California Department of Corrections 1997). Experiencing homelessness contributes to a parolee making parole violations or being rearrested,

reinforcing the cycle of the criminalization of the poor (Roman and Travis 2004). Once someone has experienced homelessness they are susceptible to laws criminalizing the homeless.

In addition, the process of criminalizing the homeless begins with municipal activities to limit the visibility of people experiencing homelessness by remodeling public places. Through remodeling places like parks and sidewalks, benches are removed or made impossible or uncomfortable to sleep on, parks are changed to reduce the amount of comfortable grass to sleep on, public bathrooms and bus stops are removed from areas where there a high concentrations of individuals experiencing homelessness. These changes are typically done when an area has been renovated, or gentrified, and large numbers of people experiencing homelessness would deter people from living or visiting these areas for fears of safety and disruption (Mitchell 2011). When changing the physical landscape of an area doesn't eliminate the presence of people experiencing homelessness, local and state governments pass laws that further criminalize their activities. Increases in the population of people experiencing homelessness, especially in areas that have had dramatic increases in this population has led cities to pass laws that punish people experiencing homelessness, force them to move their encampments, take their personal property, or harass them.

A majority of these anti-homeless laws emerged in the 1980s as the population of people experiencing homelessness increased. Although these laws don't specifically target people experiencing homelessness, they target the activities that are predominantly seen in someone experiencing homelessness. Some of these laws make standing, sitting, or sleeping in public places during the day and night, begging or panhandling, and sharing food with people experiencing homelessness illegal. These laws limit what a person can do and where they can do

it if they seem to be experiencing homelessness, "homeless people— or people who appear homeless or are otherwise deemed undesirable by local authorities—can be cited and arrested under municipal laws for their presence in public" (Fisher et al. 2015: 8). Anti-homeless laws attempt to reduce the number of people experiencing homelessness in cities by making their necessary activities to survive illegal without providing additional shelter beds or mental health resources. These laws don't reduce the number of people experiencing homelessness but just increase the number of individuals going back and forth from the jails to the streets.

The economic conditions in a city, a state, or nationally can also impact the rates of people experiencing homelessness. As a result of welfare reform there is often more low income households than there are low income units. This leads to many people and families not being able to afford housing. This reduction in federal funding for low-income housing places a large financial burden on state and local governments to provide enough units in order to prevent a housing shortage (Ringheim 1993). In areas where the cost of living, specifically rent, has increased disproportionately with wages people can no longer afford where they once lived.

Another cause of the decrease in affordable or low-income housing is increasing gentrification in areas where there was more affordable housing. Gentrification is a process that occurs when developers build or remodel buildings, typically in inner city areas, creating nicer apartments and homes along with restaurants and stores to accommodate new residents with more expensive taste (Smith 1982). The flux of new residents creates a rent gap, where they pay significantly more than the current residents and eventually rent and the cost of living increases in this area to match the new environment, resulting in residents not being able to afford their home anymore (Smith 1979). One form of low-income housing is single room occupancy. "SRO

dwellings are hotel or apartment buildings where individuals can rent small dormitory-style rooms (usually under 18 m^2) on a daily, weekly or monthly basis. Bathrooms are typically shared and SRO rooms do not have in-unit kitchens or cooking facilities" (Bowen et al. 2015: 1123). Buildings that house SROs are vulnerable to gentrification, resulting in residents who have lost affordable housing and are at risk of experiencing homelessness. Along with a significant number of SROs being eliminated from cities, the resources for these residents are also eliminated as well for new developments, "Many SROs were transformed into boutique hotels, and for SRO rooms that remained, rents skyrocketed. In San Diego, for example, SRO rents increased 80% between 1980 and 1985" (Staeheli and Mitchell 2008: 54). With the destruction of affordable housing units many residents are either displaced to different areas where there are fewer resources, have to find someone to live with, or end up homeless.

The lack of affordable housing or low-income housing units is a large predictor of people experiencing homelessness. Although a behavioral approach to homelessness focuses on individual factors, such as mental illness and substance abuse as an explanation as to why someone is experiencing homelessness, scholars argue that these factors are miniscule compared to the lack of affordable housing. These individual factors would not have as much of an effect on a person experiencing homelessness if there were more low income housing units available. "Individual problems," Gillispie and Shinn (1994: 510) argue, "such as mental illness or substance abuse, contribute little to overall rates of homelessness: They have no influence on the number of low-income housing units and only a marginal impact on the numbers of low-income households." With a shortage of low-income housing units, low-income households are forced to compete for the available units, those who are unable to secure housing either end up paying

more for housing, end up staying with families or friends, or homeless (Crowley 2003). The existing lack of affordable housing is exacerbated by increases in rent prices without equal increase in wages.

Increases in rent and the cost of living have a further impact on people living in poverty, who have to pay a larger portion of their income on rent because their income is stagnant. Many people living in poverty pay more than 50% of their income on housing, a large financial expenditure on housing creates a vulnerability for a financial crisis from loss of employment, health emergency, or unexpected expense. This concept is most prevalent in California, which has 30% of the country's homeless population and the largest number of unsheltered persons (HUD 2018). The drastic increases in rent observed in California have attributed to the significant number of people experiencing homelessness. Contrary to previous beliefs that if a person has a job they won't be homeless, almost half of homeless adults in California in 2009 had a job within a month of them experiencing homelessness (Culhane 2009). This signifies that the issue of homelessness extends far beyond the responsibilities of the individual and is affected by larger economic structures.

Vulnerability, Gender, and Homelessness

Although women can experience homelessness as a result of the same reasons that men experience homelessness, there are several risk factors that are more prevalent in women experiencing homelessness. Gendered responses to homelessness aim to identify and analyze issues that solely affect or are more prevalent in women experiencing homelessness. Domestic violence is a large contributor to women experiencing homelessness because if a woman is

financially dependent on her abuser or living with them when they try to leave the abusive environment they can't afford a place to live or don't have anywhere to go (Hague and Malos 1997). While there are male single parents, women with children are more likely to experience homelessness because of their sole financial contribution and caretaking along with reduced social support. With a smaller social network to offer support, when a female-head of the household experiences financial hardships they are more likely to experience homelessness because they have fewer people they can fall back on (Johnson 1989). This makes female-headed households a much more vulnerable group to experience homelessness than male-headed households.

Both men and women can be victims of domestic violence, however 24.3% of women have experienced domestic violence in their lifetime while 13.8% of men have experienced it (Center for Disease Control and Prevention 2017). This gender discrepancy is a precursor for women being at a higher risk of suffering housing instability as a result of domestic violence (Tolman and Rosen 2001). Being a victim of domestic violence contributes to women experiencing homelessness because of lack of employment, previous negative rental history, and limited availability of housing options.

Women with jobs who are in abusive relationships suffer negative effects of their abuse at work and it may jeopardize their employment status. Female domestic violence victims miss more hours of work than women who aren't in an abusive relationship due to recovering from injuries, trying to hide evidence of abuse, or their abuser preventing them from going to work (Browne, Salomon, and Bassuk 1999). Women in abusive relationships are more at risk for losing their employment as a result of the disruptive behaviors of their abusive partner (Riger,

Ahrens, and Blickenstaff 2000). With the effects of the abuse or the abuser themselves threatening the employment or amount a female victim of domestic violence can work, they can have less financial means to support themselves if they attempt to leave their abuser.

When a female domestic violence victim attempts to find housing in order to escape the abuse, they may have difficulty finding housing due to poor rental history, lack of affordable housing, or having a criminal record. Women who are or have been in an abusive relationship often relocate in order to avoid their abuser or to move to a location their abuser does not know, to a prospective landlord frequent moves do not make an attractive renter and could be reason to deny someone (Martin and Stern 2005). As previously stated, having a criminal record excludes someone from receiving public housing or rental opportunities and some female victims of domestic violence are likely to have a criminal record. "Some domestic violence survivors may have a criminal history. This is not uncommon because of arrests that are related to the abuse or to surviving the abuse. For example, women may be forced to participate in illegal activities by their abusive partners" (Baker et al. 2010: 431). With limited opportunities to obtain housing on their own, female victims of domestic violence have fewer resources available to them when they attempt to leave an abusive situation.

Women who have left their abusive partner may find safe housing in domestic violence shelters, a place specifically designed to house and keep domestic abuse victims safe from their abusers. The availability of beds in domestic violence shelters ranges depending on the location and in a study of available shelter space in 2008, the National Network to End Domestic Violence found that over 3,000 women were not able to stay in a domestic violence shelter due to inadequate number of beds (National Network to End Domestic Violence 2008). If there are

no beds available in a domestic violence shelter a woman has the option of staying at a homeless shelter. Although staying in a homeless shelter would give someone a place to sleep, they are not all capable of handling domestic violence situations and cannot offer the same protection to victims as a domestic violence shelter can (McChessney 1995). The housing resources available to women fleeing an abusive relationship are limited, and can be completely unavailable at times, which can contribute to the further violence women experiencing homelessness suffer from.

Domestic violence against women largely contributes to the number of women who experience homelessness with domestic violence being one of the leading causes for women experiencing homelessness (Olsen and Sullivan 2016). This violence only increases, as women experiencing homelessness are the most susceptible group to face violence. Living on the streets or in and out of shelters places women experiencing homelessness at an extremely high risk of being a victim of violence, one third of women experiencing homelessness have been the victim of violence (Gelberg, Leake, and Wentzel 2001). Although women are experiencing homelessness at a higher rate than they have before, men still make up the majority of people experiencing homelessness which can make women more susceptible to experience violence living on the streets.

As a result of the increased threat of violence for women experiencing homelessness some women, specifically younger women, enter into relationships for protection. Although the intention of these relationships is to reduce the amount of violence a woman experiencing homelessness faces, many times they experience violence from their partner. However, the possible abuse they could face on the streets alone forces them to stay with their partner for some form of protection (Watson 2016). The increased risk of violence that women experiencing

homelessness encounter highlights the importance of an alternate approach to homelessness and gender studies analyzing the issue.

The Emergence of "Housing First"

The larger factors that extend beyond the individual have an effect on a person experiencing homelessness and their inability to get off the streets. An individual approach to homelessness doesn't acknowledge or factor in these forces which contributes to many individuals experiencing homelessness for long periods of time. The Housing First model emerged in New York by Pathways to Housing as a way to address the increasing issue of homelessness, specifically in people who were chronically homeless with a mental illness (Locke, Montgomery, and Pearson 2009). This approach took the responsibility off of the individual by providing long term housing without the requirement of the individual getting mental health or substance abuse treatment (Nakae, Gulcur, and Tsemberis 2004). The Housing First program relies on the assumption that housing is an human right, consumer choice, and harm reduction.

The concept that housing is a human right was not developed by the Housing First program. The United Nations defined housing as a basic human right in 1948, but programs used to address the issue of homelessness have given housing to someone after they have met certain requirements (Henwood et al. 2010). The idea that housing is a basic human right relies on the basis that housing is something that should be afforded to everyone, Housing First programs believe that without adequate housing a person can not succeed in their life.

Housing First does not place responsibility on the individual to end their period of experiencing homelessness but they do believe a person is responsible to make decisions about their life. When someone experiencing homelessness attempts to gain housing through traditional methods they are told where they can live, how long they can live there, and the rules they must follow. When someone is experiencing homelessness they have very little control over their life. "The loss of control over one's life resulting from housing instability, frequent psychiatric hospitalizations, and intermittent substance abuse treatment leaves some consumers mistrustful of the mental health system and unwilling to comply with demands set by providers" (Gulcur, Nakae, and Tsemberis 2004: 651). Housing First allows someone to choose where they want to live and what type of home they want to live in. Unlike traditional housing methods, Housing First doesn't house all residents in one building they are spread out amongst a variety of residences, "The condition of homeless hostels has been widely criticised (Rosengard 2001) and congregate settings have been recognised as bringing people into contact with others who are misusing drugs (Neale 2001)—hardly conducive to addressing addictions or coping with mental health problems" (Atherton and Nicholls 2011). This separation of residents also allows a person who has experienced homelessness to have the sense that they are more than someone who has experienced homelessness and they can be a member of a community. The opportunity to be able to make a choice about such a significant aspect of their life allows someone to be able to make future decisions regarding other aspects of their life, thus "allowing consumers to immediately live independently and to have control over where they live, with whom they live, and who enters their home; to abstain from substance or alcohol use or not; to engage in psychiatric services or not; or to otherwise comply with treatment demands, actually decreases time spent

homeless" (Greenwoood et al. 2005: 225). In traditional homeless outreach, individuals are not given the opportunity to make choices about their life because it relies on the belief that the individual made poor choices that resulted in them experiencing homelessness. The Housing First model believes that an individual having a choice in matters of their life, when they have had little control over their life, empowers them to make future positive decisions.

Housing First and the Move to "Harm Reduction"

Housing First Programs also rely on harm-reduction strategies, which originated in Amsterdam as a response to the high rates of substance abuse and prostitution in the Red Light District. Unlike traditional drug programs, harm reduction doesn't require the cessation of illegal substances or dangerous behaviors. The aim of harm reduction is to prevent or reduce negative outcomes that arise from those behaviors, "harm reduction shifts the focus away from drug use itself to the consequences or effects of addictive behavior. Such effects are evaluated primarily in terms of whether they are harmful or helpful to the drug user and to the larger society, and not on the basis of whether the behavior itself is considered morally right or wrong" (Marlatt 1996). By providing services such as clean needle exchanges, methadone clinics, and condoms to sex workers the harm reduction program reduces negative risks that are associated with drug use and sex work without punishing participants for their behaviors.

Housing First programs use this concept with regards to people experiencing homelessness. Substance abuse is high among people experiencing homelessness but Housing First does not require that members abstain from alcohol or drugs in order to receive housing or to maintain it. Substance use and abuse has many risks associated with it, but for people

experiencing homelessness these risks are increased due to the environment they live in. Injecting drugs on the streets or in unclean environments, along with prevalent sharing of needles, increases the risk that people experiencing homelessness have of developing an infection or contracting a disease (Brouqui, Foucault, and Rault 2001). By providing a safe and clean environment for someone experiencing homelessness to live in, the Housing First program reduces some of the risks associated with substance use and abuse. The scattered-site approach to housing also removes people experiencing homelessness from situations where the majority of people they are around are people experiencing homelessness that also use or abuse substances.

These aspects of Housing First contribute to the effectiveness when compared to continuum of care, or treatment first programs. When these two have been compared to each other, Housing First programs are more successful at keeping members housed, reducing substance abuse, and reducing the use of medical services, specifically emergency services. Housing First programs acknowledge the fact that there are many larger forces that can lead to someone experiencing homelessness so it is not expected for the individual to end their period of experiencing homelessness.

With a higher percentage of individuals who remained housed and less utilization of emergency medical services a Housing First program would be more effective than a treatment first program at reducing the high rates of mortality in women experiencing homelessness (Briscombe et al. 2017; Gulcur et al. 2003). Because women experiencing homelessness experience violence, especially major violence, at such high rates a Housing First program could reduce this due to the fact that individuals are housed immediately and in residences where there are very few other people experiencing homelessness. With a safe and clean place to live a

woman would be able to bathe regularly and have safer menstrual hygiene practices which would have a positive impact on their health. People experiencing homelessness often suffer from infections as a result of them being exposed to the elements constantly, if they no longer have to face the elements all the time their risk of developing these infections would decrease (Brouqui, Foucault, and Raoult 2001). Although Housing First programs do not require participants to abstain from using or abusing substances, being in a clean environment that is away from other people also using substance, which can lead to needles being shared, could reduce the risk of infections that arise as a result of drug use.

Conclusion

With the number of people experiencing homelessness increasing, scholars began to look past the individual and identified structural factors that contribute to someone experiencing homelessness. Economic conditions, such as a lack of affordable housing due to gentrification or a decrease in low-income housing units limit the places someone of a low socioeconomic status can live. In many cities a shortage of low-income housing units along with a surplus of households that need low-income housing units leaves many people with the inability to afford a place to live and can lead to them experiencing homelessness. Along with economic conditions that make it difficult for people living in poverty, the criminal justice system adversely affects poor and homeless members of the community. The cash for bail system, where someone who has been arrested has to pay money in order to get out of jail before their trial, oftentimes forces people of lower socioeconomic status to accept poor plea deals or plead guilty to charges they didn't commit because they can't afford their bail. Having a criminal record, however, excludes

someone from gaining public housing, which limits where someone can live after they are released from jail and contributes to the high number of parolees that experience homelessness. In many cities there are also laws and ordinances that target the activities of people experiencing homelessness. The purpose of these laws are to reduce the visibility of a cities homeless population by making many of the everyday activities of someone experiencing homelessness illegal. This contributes to someone entering the cycle of going from living on the streets to being in jail and back.

These structural factors can all contribute to someone experiencing homelessness but they have a profound effect on African Americans experiencing homelessness. African Americans constitute a much larger portion of the homeless population than the general population. This overrepresentation of African Americans experiencing homelessness is the result of more African Americans living in poverty, racial discrimination when they try to gain housing, and reduced employment opportunities.

Women are also vulnerable to experience homelessness if they are female-heads of the household or victims of domestic violence. Reliance on federal assistance and a reduced network of support cause female-headed households to experience homelessness at extremely high rates because when a financial or personal situation arises they don't have the same resources to address them. A woman being a victim of domestic violence is one of the largest precursors to them experiencing homelessness because in many situations they are financially dependent on their partner, have a poor financial situation because of their abuse, and have limited housing options when they attempt to leave the situation.

Analyzing how these structural factors contribute to someone experiencing homelessness has led to the emergence of Housing First. This program gives a person experiencing homelessness housing immediately without requiring them to be abstaining from substances or receiving mental health treatment. Allowing someone who is experiencing homelessness to have long-term housing from the beginning reduces many of the risks they could face living on the streets and is a more effective approach to homelessness than treatment first programs. Because of their efficacy, Housing First programs would have a positive impact on the high rates of morbidity and mortality in women experiencing homelessness.

Chapter IV

Conclusion: Where Do We Go From Here?

This chapter analyzes the shift from a behavioralist approach to a structuralist one in the literature on homelessness. It also examines the approaches that are being discussed in the current literature, if there is one approach that is more prevalent than the other or if there is a blend of both approaches. As an overall conclusion to this chapter, I also traces how these different approaches are often discussed in tandem and what this signals for the future of homelessness outreach and support, particularly as it applies to the complexity of homelessness amongst women.

What Does Each Approach Offer?

I begin this section with a comparison of the two major approaches to addressing the challenges of homelessness - behavioralism and structuralism. While the behavioral approach focuses on the individual, the structural approach seeks to locate both the cause and response to homelessness at the scale of society. Within the context of this comparison, the behavioral approach tends to align its practices with efforts to manage individual mental health, housing support, substance abuse, and domestic violence support in different places, while the structural approach identifies race, socioeconomic condition, politics, and gender as factors that can contribute to someone experiencing homelessness and aims to reduce their effects Each approach reflects the core philosophies and ideologies outlined throughout this thesis. It is clear that the behavioral approach centered in the individual focuses on the notion that each person should be

self-sufficient, while the structural approach clearly focuses on the role that state organizations and agencies should play. These differences are reflected in Table 4.1 below.

Table 4.1: Differences Between the Approaches

	Behavioral	Structural
Responsibility for Support	Individual	Society
Treatment First	X	
Housing First		X
Domestic Violence	Tied to the Self/Partner Relationship	Tied to the Larger Problem of Structural Violence (Tolman and Rosen 2001)
Substance Abuse	A choice of the individual that must be stopped before they receive housing (Dordrick 2002).	Something that can be influenced by an individual's environment or life experiences. (Atherton and Nicholls 2011)
Mental Health Treatment	Required for the individual to have housing (Miller and Flaherty 2000).	Something an individual has to choose. (Gulcur, Nakae, and Tsemberis 2004; Greenwoood et al. 2005).
Inability to Afford Housing	A result of the individual not being self-sufficient (Lichter and Jayakody 2002; O'Connor 1998).	A result of the lack of affordable housing (Gillispie and Shinn 1994; Crowley 2003; Culhane 2009)
Access to Housing	Something that is earned through self-advocacy (Henwood et al. 2010).	Something that is a right and is part of one's citizenship. (Locke, Montgomery, and Pearson 2009).

As you can see in the chart, the behavioralist approach to homelessness arises from the notion that an individual is at fault for them experiencing homelessness and should therefore be responsible for ending their period of homelessness. The belief that agency is an explanation for someone experiencing homelessness has evolved from the idea in the mid 1960's that someone experiencing homelessness was a drunk and completely responsible for their situation to the idea that someone is experiencing homelessness due to addiction or mental illness and only needs some support to end their period of homelessness. Historically, people who experienced homelessness were believed to be homeless because they had poor personality traits and made bad decisions. The societal image of a homeless person fit a very specific mold. "The stereotypes and images of deviants, dossers, alcoholics, vagrants and tramps, prevalent until the 1960s, have often been associated with people deemed to be homeless for these reasons" (Neale 1997: 49). Because it was believed this type of person was experiencing homelessness because of their poor decisions, homelessness outreach relied on the individual making changes in their lives. Literature on the issue did not identify housing as a cause for people experiencing homelessness but focused on the actions of the individual that could be altered.

This conceptual idea of who experienced homelessness was altered during the period of deinstitutionalization. Although someone having a mental illness wasn't their choice or fault it was believed that they could be productive members of society if they followed their treatment, so if they didn't follow this and experienced homelessness as a result then it would be their fault. People with a mental illness could use new psychoactive drugs and take care of themselves with the assistance of community mental health clinics. The literature began to reflect a behavioralist approach where the responsibility of having a mental illness was shifted from large state

hospitals to individuals and the community, with the belief that individuals with a mental illness would be able to control their health. However, as the process of deinstitutionalization progressed and more and more individuals were discharged from mental hospitals and ended up experiencing homelessness, scholars realized there was a lack of community resources to handle this population and placing the responsibility on the individual was not effective. Alternative methods to address the issues of homelessness and mental health treatment were explored as a direct result of the inadequacy of the current programs.

With the issue of homelessness persisting, and even increasing, with homelessness outreach programs that placed responsibility on the individual scholars began to examine structural factors that could lead to homelessness. The main concept that came from this was the understanding that without sufficient low-income housing units the issue of homelessness would remain. Although this was the most prevalent and obvious structural analysis on the issue of homelessness there were many others that originated from different fields. Feminist, or women's studies, analyzed how welfare policy changes, homelessness outreach programs targeted for men, and domestic violence all contributed to the increases in women experiencing homelessness. The racial inequality in the people who experience homelessness, with African Americans overrepresented in homeless populations when compared to the general population, illustrated how racism and discriminatory practices made minority groups vulnerable to experience homelessness. Analyzing these structural forces led the literature, and subsequently homelessness outreach programs, to shift from placing the responsibility on the individual to more responsibility on structures.

Although there was a shift in the literature the responsibility on the individual wasn't abandoned, with some scholars believing there should be more responsibility on the individual or that a person experiences homelessness as a result of individual and structural factors. Currently there is some disagreement in the literature with some scholars taking a structuralist approach and others taking a structure-agency approach. The scholars who take a structure-agency approach acknowledge the structural factors that can lead to a person experiencing homelessness but argue that certain individual choices can contribute to that. There is some debate over which approach is more suitable however they both acknowledge that structural forces affect a person experiencing homelessness.

Discussion

This thesis has discussed the evolution of homelessness outreach from responsibility being placed on the individual to responsibility being placed on larger structural factors in order to analyze how a long term housing approach would affect the high rates of morbidity and mortality in women experiencing homelessness. Homelessness outreach that places responsibility on the individual requires participants to abstain from substances and receive mental health treatment in order to gain housing because it is believe those personal issues are the cause of them experiencing homelessness. However, these treatment first programs are often ineffective at reducing a person's substance use or mental health compliance because they fail to recognize and reduce the effects of outside forces. A housing first approach acknowledges some of the outside forces that can lead to a woman experiencing homelessness or prevent them from ending their period of experiencing homelessness. Being a victim of domestic violence, being a

female head of a household, or being under or unemployed contribute to women experiencing homelessness which greatly increases their risk of being victims of violence, developing infections, and contracting diseases which all contribute to the high rates of morbidity and mortality in women who are experiencing homelessness. A housing first approach that would remove them from this situation immediately and allow them to have stable long term housing with access to supportive services such as addiction and mental health treatment, offers a more effective way of ending a woman's period of experiencing homelessness. This would reduce the risks associated with experiencing homelessness and in turn have a positive impact on the rates of morbidity and mortality.

The implementation of housing first programs has primarily occurred in the past one to two decades. As a result of this the majority of studies analyzing housing first programs focus on its efficacy and cost effectiveness when compared to treatment first programs. Although these studies have shown they keep people experiencing homelessness housed longer and there is a reduction in health care costs they don't analyze what the overall impact on the health or rates of morbidity and mortality in women experiencing homelessness (Larimer 2009; Kushel et al 2009) In the future, research on homelessness outreach will move from establishing housing first programs as a viable option to address the issue of homelessness to studying how this approach affects people experiencing homelessness in the long-run. Many of these studies follow participants over the course of a year to a couple of years, but a longitudinal study over a longer course of time would give more detailed results into how being housed in long term person addresses the high rates of morbidity and mortality in people experiencing homelessness.

Many of these studies focus on people experiencing homelessness but there needs to be more research focusing on housing first programs and women specifically (Briscombe, Cefalu, and Hunter 2017). Because women experiencing homelessness face risks and challenges that are different than men experiencing homelessness, studies addressing the impact a housing first program has on women experiencing homelessness would more accurately account for these differences. Although a housing first program recognizes that structural factors can contribute to someone experiencing homelessness, they have little impact on altering these factors. There needs to be research on more holistic homelessness outreach programs that not only provide immediate long term housing but also increase the number of low-income housing units, shelters and resources for domestic violence survivors, support systems for female headed households, and policies to reduce discriminatory rental practices. Addressing these issues would not only aim to prevent the number of people that end up experiencing homelessness but would also ease the difficulty someone experiencing homelessness face when they attempt to end their cycle of homelessness. Research on the impact of policy changes at the municipal and state level to address the structural forces that affect someone experiencing homelessness would highlight ways in which the amount of people that experience homelessness could be reduced in a proactive manner.

Overall Conclusion

This thesis used past and current literature to complete a historical analysis on policies and events that led to the increase in people experiencing homelessness, homelessness outreach programs that focused on altering the individual, and homelessness outreach that gave the

individual control over their life. Although there is plenty of literature on these topics, only relying on literature could limit the information I had access too. Performing a study, working with other scholars or researchers, and doing field work could all add more details and expertise to this thesis. These different views could expand the scope of this study and reduce some of the limitations that I may have experienced solely relying on the literature that was available to me. I also primarily used literature regarding homelessness outreach in the United States however, there is a body of literature regarding implementation of programs similar to the housing first program in other country which could add to the information I found. I aimed to only include literature that dealt with the issue of homelessness in the United States because there are factors and situations that are unique to people experiencing homelessness in the United States that wouldn't apply to people in other countries.

Although this thesis doesn't include data or results from a primary study, it does compile literature relating to homelessness over the past several decades and analyzes the current state of homelessness outreach. The use of literature from different time periods and fields of study has allowed me to formulate a thesis that attempts to encompass a broad view of how social scientists and policy makers think about people experiencing homelessness that includes policies and events that affect this issue. A document of this type can be used to provide someone considering doing research on this topic with a substantial amount of background information.

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