A Comparative Study between Mental Health of Homeless Populations in the United States and Spain

By
Talia Helman

A THESIS

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Honors Baccalaureate of Science in Microbiology
(Honors Scholar)

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Talia Helman for the degree of Honors Baccalaureate of Science in Microbiology and Honors Baccalaureate of Arts in International Studies presented on June 8, 2017. Title: A Comparative Study between Mental Health of Homeless Populations in the United States and Spain.

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Dr. Ray Tricker

Many people around the world suffer from a mental illness, and too few receive the help they need. Mental illness is especially prevalent among the homeless. Homelessness is represented in all ages, ethnicities, and genders, and is especially represented among first world countries such as the United States and Spain. These two countries provide a unique opportunity to assess how the United States and Spain address mental illness and homelessness based upon the differences in the social structures of both countries. Homelessness affects those that are living without a home, however, it is a public health and social issue as well. It is also important to analyze this problem to help those that are suffering, and to evaluate the extent to which the United States' and Spain's national policies are addressing mental health and homelessness economically, socially, and humanely.

Key Words: homeless, mental illness, stigma, incarceration, national policy

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I understand that my project will become part of the permanent collection of Oregon State University, Honors College. My signature below authorizes release of my project to any reader upon request.

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Talia Helman, Author

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1. Introduction

It is beneficial to study and understand the United States' and Spain's policies towards mental illness in homeless populations, especially with common issues in society such as treatment for the mentally ill and stigma associated with mental illness. The United States and Spain have significant differences with regards to culture, politics, and attitudes towards health care systems. There is much to be learned from each, with regards to the number of homeless and mentally ill, how they are treated, their national policies regarding mental illness and homelessness, and incarceration rates and criminalization of the mentally ill and homeless. Knowledge obtained from a comparison of these two countries will yield insight into the strengths and weaknesses of programs in the United States and Spain.

In the United States, with a total population of 318 million individuals, one percent, 2-3 million individuals, experience a night of homelessness annually (22). Of these, 10% are chronically homeless, which is defined as being continuously homeless for a year or at least four episodes of homelessness within the past 3 years (22). Many individuals who suffer from a mental illness are homeless. Approximately 43.8 million Americans suffer with mental illness each year, nearly 13% of the total population. According to the National Alliance on Mental Illness (2015), 30% - 40% of people who are homeless in the United States suffer from a severe mental illness or substance abuse disorder as well. Often times, mental illness is not treated with the same concern as many other illnesses.

Out of the total 47.2 million people living in Spain, 40,000 are homeless, approximately 0.09% of the population (23). In Spain, 9.2% of the population is suffering from mental illness (14). Many people in Spain receive more treatment

however, due to the increased access to health care as a result of their socialized healthcare system. The homeless and mentally ill in Spain and the policies derived to treat this population provide a unique perspective when compared to the United States.

The United States is an interesting country in which to study the topic of mental illness in homeless populations due to its large overall population, the amount of those suffering with mental illness, it's private healthcare policies and other national social policies relating to the homeless. Spain is situated close to many other poverty-stricken nations, has a high unemployment rate, and has national socialized health care policies. A comparison of the two countries and how they each attempt to meet the needs of its population has potential to provide relevant information about mental health and homelessness in the United States and Spain.

2. Significance of Study

There are approximately half a million homeless people on any single given night in the United States (4). Homelessness is an incredibly complicated topic as it has multiple root causes. The causes for homelessness in the United States are similar to many other countries around the world, and valuable information can be obtained by understanding different approaches to deal with the problem. This is why learning more about how other countries handle homeless populations is critical. This study is significant as it analyses both the United States and Spain.

By gaining a better understanding the current climate of mental illness in homeless populations and how the United States compares to a country with socialized health care and radically different policies regarding the treatment of mentally ill, it will be more apparent as to what the United States might change. This study is of value because current practices in the United States not serving the needs of the homeless adequately and the burden of homelessness is also felt economically due to the cost of homelessness on the American public. According to a study done by the University of Texas in 2010, homelessness costs over 15,000 dollars per homeless person per year due to costs of jail time, hospitalizations, emergency shelters, and other resources in the United States (24). With current practices, the cost to the public is immense and the burden on the justice system due to crime and incarceration of the homeless is staggering, with thousands of arrests each year in the United States for crimes such as loitering or panhandling (23). This comparison will give insight as to what programs, resources, and facilities are most needed in the United States as well as a better understanding on how to

serve the mentally ill and homeless and reduce economic burdens and unnecessary incarcerations.

Homelessness is a crucial national issue in the United States and Spain. Many current policies are providing temporary solutions for many greater systemic issues. One of these underlying issues is mental illness. Mental illness in homeless populations is a rampant problem that continues to increase with the decline of facilities available. Homeless populations who also suffer with mental illness are especially at risk for victimization, limited housing options, and are often incarcerated for incidences that should be handled by mental health professionals.

Mental illness affects many people in the United States and Spain. Many times this population does not receive the adequate treatment needed and is often stigmatized to the extent that their disease exacerbates. Often, people with mental illnesses do not receive adequate treatment and are faced with marginalization and social stigma, which act to exacerbate the symptoms of their disease. The stigma surrounding mental illness often emerges as a result of widespread misinformation and lack of knowledge about mental health.

3. Limitations of Study

There is a wealth of knowledge on this topic, thus obtaining all information possible is incredibly difficult. Also, much of the data for how many homeless live in each country can be very skewed. The information can be different based on time of year, surveying methods, location, and willingness of the participant. Thus some of the data is inaccurate. It is also very difficult to obtain the most recent data, as the numbers are always changing. This study was also limited by the inability to interview a director for a homeless organization in Spain.

4. Review of Literature

The following literature review provides a framework for analysis and comparison of mental health and homelessness in the United States and Spain.

4.1 The United States of America

Mental Health of the Homeless in the United States

In 2015, the United States housing and Urban development survey based on a one-night count of people sleeping on the streets, estimated that 564,708 people in the United States were homeless. Of these, 104,083 (24%) were identified as severely mentally ill (4). This number could be significantly underestimated as it is very difficult to obtain mass sums of data for such a varying population. Experts report the continued assumption that 30% of the homeless [population] have a serious mental illness (4). Data in regards to mental illness in homeless populations is often difficult to obtain due to the always fluctuating population. Analysis of known data about mental illness in homeless populations will be done with the understanding that although the numbers and statistics are incomplete, the underlying prevalence of mental illness is unchanging.

Risk of the Mentally Ill Becoming Homeless

In the United States, people with untreated serious mental illness comprise an estimated one-third of the total homeless population (4). These individuals make up a very large percentage of the homeless, and are the most vulnerable and at risk. People with serious mental illness are reported to be 10-20 times more likely than the general population to become homeless (4). The mentally ill are at an extremely high risk for ending up on the streets, which can further increase their disease. Mental illness comes

in many forms and is represented in varying degrees on the streets. Most represented among the homeless are illnesses such as schizophrenia, bipolar disorder, major depressive disorders, and PTSD (especially from those who have served in the military). Many of these individuals have had trauma or other abuse in their lives. A large percentage of homeless mentally ill had difficult upbringings and have frequently experienced direct forms of abuse, which has been defined as verbal, emotional, physical, and sexual, which later continue to be problematic once they are on the streets (10). Abuse such as the kind many of these people experience while they are younger can negatively affect psychosocial and behavioral outcomes in adulthood, and thus typically leads to homelessness or uncontrolled mental illness (10). It is imperative to understand the degree and type of trauma experienced in order to provide adequate assessment and treatment of youth who have been victimized and now are suffering with a mental illness because of it (10). The addition of a lack of a home to these emotional issues causes mental illness to further increase.

Victimization

Being homeless puts stress on already stressful mental diseases, and leaves individuals susceptible to victimization. Victimization can include theft, physical and sexual assault, emotional abuse, and murder. Individuals with serious mental illness are especially vulnerable to being victimized, which further demoralizes individuals and leaves them feeling isolated from society and distrustful of others (6). A national crime victimization survey in 2005 interviewed 936 patients with chronic and severe mental illness, among them more than one quarter had been victims of a violent crime in the past year, a rate more than 11 times higher than the general population (6). With many mental

illnesses, such as schizophrenia, it is difficult to know who to trust due to the disorder inhibiting many social cues and perceptions. Victimization is said to be especially associated with social isolation related to disorders such as schizophrenia (6). People with mental illness are vulnerable, and may lack the capability to know whom to trust. People with mental illness are more likely to be victims of robbery, assault or rape (6). Women were found to be victimized at a higher rate than men. The risk of victimization has been found to decrease with an increase duration of outpatient commitment (6). The positive outcomes of treatment have been correlated to reduced risk of victimization which leads to better overall health for the individual. Outpatient commitment reduces criminal victimization through improving treatment adherence, decreasing substance abuse, and diminishing violent incidents, thus the importance of individuals receiving adequate treatment is not only imperative to their mental health, but also for their general overall safety (6). Victimization causes increased stress upon a homeless person, especially those suffering with mental illness.

Deinstitutionalization

In the United States, the rates of the mentally ill on the streets have continued to rise since the deinstitutionalization of psychiatric facilities in the 1950s. Homelessness has emerged from the closing of state mental hospital without providing replacement housing and treatments for people with serious mental illness. Without resources it is very difficult for people with serious mental illness to live independently thus many take the streets and are left with untreated mental illness. In 2006, Markowitz published data on 81 United States' cities analyzing the correlation between decreasing availability of psychiatric hospital beds and increase in crime, arrest rates and homelessness. He found

that as state hospital bed capacity decreased the number of mentally ill homeless individuals increased along with crime and arrests associated with homelessness. In a study done in New York, it was found that within six months, 27%-38% of patients discharged from state mental hospitals were homeless or had 'no address' (4). This data emphasizes the lack of treatment facilities and housing options available for those suffering from different mental illnesses after they are discharged from hospitals. Individuals are not receiving the treatment they need or in some cases are not receiving treatment at all, for the past 20 years, 40% to 50% of all individuals with schizophrenia or bipolar disorder are receiving no treatment for their mental illness at any given time (3). In 2015, 3.85 million people with the most severe psychiatric diseases were untreated (3). These numbers could be for many reasons, including: lack of facilities available, inability to get access, and the mental illness itself. Many homeless do not have access to adequate mental health care programs with a remarkable negative influence on their clinical and cognitive outcomes (7). There is an urgent need to adequately house and treat these individuals.

Anosognosia

The current solution for housing the mentally ill in homeless shelters is not adequate as many homeless shelters do not have the resources needed to treat the mentally ill (1). Many of these individuals not only suffer from a mental illness, but they also have anosognosia; a complete or partial lack of awareness of different neurological and/or cognitive dysfunction (8). The addition of anosognosia causes increasing problems in terms of providing individuals with proper care as most times the individual does not realize they have a problem and thus do not seek help. This aspect also makes it

more difficult for individuals to adhere to treatment programs, take appropriate medication, and maintain trust, therefore, is imperative that these individuals receive treatment from mental health professionals. Often many homeless shelters and other facilities in the United States are not equipped to handle many of these difficult cases.

Homeless Shelters Housing the Mentally Ill

Currently many homeless shelters around the United States are so over populated by mentally ill wanderers they take on the appearance of hospital psychiatric wards (4). With current shelters being over crowded, understaffed, and lacking the resources needed to help many of these individuals, many researchers are looking for alternative solutions. Many studies have shown that the best way to address this issue is through supportive housing and treatment programs. Supportive housing has shown a reduction of rates of homelessness, hospitalizations, psychopathology, and substance abuse, with an improvement of financial stability and quality of life (7). It is important that these facilities have the adequate resources and training to help individuals with mental illness, clinicians have argued that mental health needs are best met with the context of meeting basic survival needs – food, clothing, shelter, housing, employment, and entitlements (11).

Stigma Toward Mental Illness and Homelessness in the United States

According to Webster's Dictionary, the definition of stigma is a mark of disgrace associated with a particular circumstance, quality, or person. In the United States, stigma is heavily associated with mental illness and with the homeless. Stigma affects the mentally ill in many ways; it portrays the mentally ill poorly, inhibits their opportunities to receive help, and hinders their ability to adapt in mainstream society. In 1999, the Secretary of Health and Human services stated; fear and stigma persist, resulting in lost opportunities for individuals to seek treatment and improve or recover (1). The homeless also experience quite a bit of stigma as society perceives them as failures, lazy, or unstable. Stigma towards the mentally ill and homeless in the United States affects the quality of life of those suffering from either or both life circumstances.

Stigma Increasing

The 1999 Surgeon General reported that stigma towards mental illness has intensified over the past 40 years, even though understanding of mental health has improved (1). Much of the stigma associated with mental illness is due to the negative connotations accompanying mental illness throughout history. In history, the mentally ill have often been correlated with violence, violent behavior by individuals with untreated severe mental illness is the main cause of stigma, which affects all mentally ill regardless if they are violent or not (1).

Stigma continues to remain a challenge in today's society as many mental illnesses are not fully understood. According to The Treatment Advocacy Center, stigma against people with mental illness has increased over the past half century, and continues to increase (1). Like many other illnesses, there is still much to know about mental

illness. With the recent prevalence of mass shootings, the stigma associated with mental illness has remained. A study was preformed after the Newtown massacre which was committed by a mentally ill man. The study reported that after the incident 46% of the respondents believed people with serious mental illness are, by far, more dangerous than the general population (1). As long as violence is associated with the mentally ill, stigma will remain despite scientific and medical research efforts.

Media Portrayal of the Mentally Ill

Despite the United States' progression in knowledge about the mentally ill and the biological reasons for these illness stigma has progressed, much of this has been intensified by the media. Stigma is exacerbated in many ways; a large outlet is through the media. The media often negatively portrays the mentally ill with stories of violence, destruction, and the adverse implications of homelessness. There have been many studies tracking the increase of stigma towards the mentally ill in the United States. One study tracked stigma and discrimination towards the mentally ill in the media and found that between 2005 and 2014 there was a 28% increase (1). Media outlets have the ability to sway the public, especially in relation to mental health. In 2012, a survey tracked people's impression of shootings in the United States that were associated with mentally ill persons. The survey and news story showed a significant increase of negative attitudes to and stigma against mentally ill persons, this study showed the influential role the media holds. The media has been central in increasing stigma towards mental illness, even with the increase of understanding towards biological causes of mental illness.

Stigmatization of the Homeless

The homeless population in the United States is often stigmatized as well, often paralleling with their mental health problems. The mentally disabled homeless are commonly characterized by the society as disheveled and dirty; wearing clothes inappropriate to the season' pushing their possessions in a shopping cart; urinating and defecating in public; shouting and gesturing animatedly to trees, store windows, or passersby; or remaining mute and withdrawn when approached (11). Although these could all be definite true descriptions of behaviors, these behaviors are often there as a result of untreated mental illness. Many mentally ill homeless are attempting to maintain their self-identity and preserve their humanity while balancing their mental illness. Many homeless are stigmatized as being outcasts of society, while they are straining to live in a world with mental health problems. Living on the streets in the United States is taboo, often difficult for people to understand, thus creating stigma towards the homeless.

Summary

Stigma and labeling can be detrimental for the mentally ill and homeless. Stigma stereotypes and dehumanizes these populations which can inhibit their ability to obtain a job, acquire a loan for a house, maintain relationships, or adjust to societal conceptions. Public figures and mental health professionals have found that stigma consistently hinders the mentally ill's ability to live as well as inhibits the homeless from obtaining a more stable life. Stigma intensifies many of the issues that the mentally ill and the homeless are faced with.

Homelessness and Housing in the United States

The United States has one of the highest rates of homelessness among developed nations, estimated to be 6.2% in 2011, approximately 20 million people (2). Homelessness is an equal opportunity condition, like mental illness, this can happen to anyone, even in a developed country like the United States. According to Charles Walker, in the Journal of Nursing, "homelessness is more than having no address or phone number; it's a disengagement from main-stream society—from friends, family, neighborhood, community. Homelessness means being disconnected from the social support systems that usually provide help in time of crisis; it means being without structure, being utterly alone" (11). Many major prominent cities such as Los Angeles, Seattle, San Francisco, New Orleans, and even the state of Hawaii have declared homeless emergencies. Some cities stated that the number of homeless people is the city's worst problem. Homelessness is a large part of United States' society, the homeless can be seen every day, in almost every city.

Factors Contributing to Homelessness

In the United States, there are many factors contributing to homelessness, including: a lack of affordable housing, income discrepancies between the poor and the rich and unemployment, substance abuse, past emotional or physical trauma, post-traumatic stress, and the mental health deinstitutionalization movement (2). Homelessness is often more prominent in large cities as there are larger disparities between low and high incomes. Often times, housing costs in large cities make living impossible. In 2015, The Housing and Urban Development Office of Policy Development and Research released that "7.72 million renter households whose incomes

were below 50 percent of the area's median income were paying more than half their income for housing costs (18). The people living in these situations are the most likely to become homeless due to the high cost of housing. These houses have severe rent burdens and their tenants are at high risk of being evicted due to inability to pay rent, which can lead to homelessness (18). High cost of housing is not the only risk factor for homelessness, many homeless have experienced adverse childhood experiences such as abuse, household dysfunction, and neglect which have been shown to predict negative outcomes in adulthood, including increased risk for homelessness, mental illness, addiction, and chronic disease (13). Adverse adult experiences such as war can adversely affect people as well, which is apparent among veterans, who represent approximately 13% of adults experiencing homelessness (13). Many of these populations experienced increased homelessness after the deinstitutionalization of mental hospitals. Deinstitutionalization started in the 1950s as a call for civil rights reform for psychiatric patients. Society wanted a reform that called for greater individual autonomy and community efforts to help the mentally ill. The mentally ill that didn't have the financial or familial resources were forced to take the streets following the deinstitutionalization process. Many of the patients discharged did not have these resources and ended up becoming homeless (7). Community mental health centers were promised as an alternative to state hospitals, however after deinstitutionalization, more people were let out of state mental hospitals, but a fraction of the community care networks were actually built afterwards. Thus, today the United States witnesses the results of this process by the amount of mentally ill that remain in homeless populations.

Harmful Living Conditions

Being homeless can cause detrimental outcomes in one's life that can often be so severe that that being homeless can be fatal. Some homeless live in severely dangerous and unhealthy living conditions, are forced to forage for food and shelter, and do not receive adequate medical care. The mortality rate of the homeless is 4-9 times higher than the general population (7). This is mostly the result of infectious diseases and traumatic injuries as well as high rates of untreated hypertension and diabetes, which are manageable diseases that can be treated by today's medicine, but without access to medicine and treatment these diseases can be fatal (7). The mortality rate is not only the result of disease, but of the dangerous situations one might encounter on the streets. While living on the streets many people experience disproportionately high amounts of trauma, abuse, violence, and neglect daily (5). The accumulation of all these risk factors leads to an incredibly high mortality rate of the homeless.

Homelessness and Mental Illness

Homeless persons with co-occurring serious mental illness are among the most vulnerable and hardest-to-reach populations (20). In the United States, 20% to 25% of the homeless population suffers from some form of severe mental illness. In comparison, only 6% of Americans are severely mentally ill (15). Individually, people with severe mental illness, such as schizophrenia, tend to have a profound lack of trust, fear of closeness, and the desire for autonomy, which can lead to a disconnect from society and often causes many homeless people to avoid social institutions (11). Diseases such as schizophrenia also make it extremely difficult to live daily life, apply for benefits or maintain a job without adequate treatment. Soon, some people with major mental illness become attached to homelessness as a way of life, one that demands minimal social

expectations and few interpersonal contacts (11). This is emphasized in the lack of admissions into professional centers; people with serious chronic mental illness constitute less than one-fourth of all admissions to community mental health centers (11). This could be due to this inherent lack of trust, stigma towards mental health, or inability to obtain access (11). Many people with mental illness instead frequent city shelters, these shelters have now substituted as an alternative to state mental hospitals (11). Mental health issues are significant reasons for people becoming homeless, but homelessness, especially at an early age, can in turn exacerbate the mental illness. Being precariously housed in places not fit for human habitation can severely affect someone, especially when that person is already suffering from a mental illness. As the number of young to middle-aged adults at risk for chronic mental illness as risen, there has been appreciable increase in the absolute number of homeless people living with mental illness (11). The number of homeless people suffering from mental illness is significant in the United States.

Housing First Versus Treatment First

In the United States, half of the mentally ill homeless population also suffers from substance abuse and dependence (15). For those who are suffering from a mental illness as well as a substance abuse illness it can be even more challenging to find an adequate solution for the homeless. Substance abuse not only increases the risk for homelessness, but substance abuse is a key obstacle to mental health recovering, putting consumers at greater risk of health problems, victimization, and incarceration (20). Two general schools of thought have been proposed to help the homeless who are also suffering from a substance abuse as well: Housing First and Treatment First. The Housing First

approach focuses on establishing basic needs of individuals before trying to treat the addiction. The Treatment First approach aims to address the addiction before other needs, such as housing and employment. Treating an individual suffering from substance abuse and/or mental illness who is also homeless is extremely challenging and each approach has its advantages and weaknesses.

Housing First

The Housing First approach to addressing substance abuse in homeless populations is rooted in Abraham Maslow's hierarchy of needs, one of the most cited theories of human behavior (14). According to Maslow, one's basic needs of shelter, food/water, safety, and friendship must be met before one is able to reach self-actualization. Maslow defines self-actualization as "becoming everything that one is capable of becoming" (14). Those that promote Housing First often describe the model as oriented towards recovery. In keeping with Maslow's hierarchy of needs, the model is based on the assumption that until an individual has a home, and unless their basic safety and security needs are met, she or he will not have an adequate platform for which to successfully address other challenges, such as psychiatric symptoms, addiction, or employment (14). Housing first offers stable housing without requiring treatment adherence or sobriety, thus practicing harm reduction policies regarding substance use and consumer choice (20). In a study of 83 persons living in New York in 2010 needing a housing first or treatment first program, the housing first clients were significantly less likely to use or abuse substances when compared to the treatment first clients (20). The members in this study utilizing Housing First treatments were also less likely to use substance abuse treatment services and drop out of the program entirely. Although many

Housing First treatment programs have been successful, those enrolled in the programs tend to have problems pursuing potential next steps such as higher education or increased social relationships (14). The Housing First approach aims to use the method of harm reduction to help reduce substance abuse amongst homeless populations.

Treatment First

The Treatment First approach is shaped by the belief that there is a greater need to address psychiatric symptoms, addictions, and socialization skills before allowing access to permanent housing. The Treatment First program has been in practice longer than the Housing First program and been previously thought of as the norm for substance abuse treatment programs. In the Treatment First approach it is required to have more life skills and achieve healthier habits before one can receive a house (14). The Treatment First approach has been described as primarily shaped by the belief that consumers should 'earn' housing by demonstrating moral worthiness and sobriety, this approach can be seen in many other social welfare policies in the United States (14). Once one achieves sobriety the Treatment First program finds housing for that individual, normally this consist of a group housing situation. Before an individual is able to get clean the Treatment First program tends to have a lack of affordability, which results in ongoing housing insecurity and ultimately could lead to relapse (14).

Comorbidity of Homelessness and Mental Illness

Creating policies and finding solutions for the homeless epidemic in the United States is not easy, particularly due to the large number of people who are homeless. It is especially difficult due to the co-occurring dilemma mental illness and homelessness. Many believe that homelessness exacerbates the mental illness and by giving them

several good nights of sleep, an adequate diet, and warm social contact, some of mental illness symptoms might subside (11). Current services for the homeless often fail due to their lack of continued care. It is unlikely for many homeless to achieve residential stability and remain off the streets unless they have access to continued treatment and services (15). There are currently 20 million people in the United States that are homeless most of whom require social services and some sort of treatment.

Incarceration and Criminalization of the Mentally Ill and Homeless in the United States

A 2014 survey by the United State Adult State and Federal Prison Inmates (ASFPI), examined the relationship between being homeless with serious mental illness and risk of arrest. The survey found that mentally ill homeless individuals had a lifetime risk for arrest ranging between 63% and 90% (4). A recent random survey of homelessness in all jails in the United States found that 15.3% of inmates had experienced homelessness at some point in the year prior to incarceration (31). Among the United State ASFPI, 9% of inmates reported an episode of homelessness in the year prior to arrest (31). This rate is 4-6 times the estimated rate in the general United States' adult population after allowing for age, race/ethnicity, and gender (31). Lower Rates among ASFPI compared to inmates in all United States' jails is correlated to the crimes committed by homeless individuals are often less serious crimes and are the result of 'survival behavior', such as loitering, panhandling, and petty theft (31). Homeless inmates were more likely to be currently incarcerated for a property crime, but also to have had previous criminal justice system involvement for both property and violent crimes, to suffer from mental health and/or substance abuse problems, and to be more likely to have been unemployed and/or living with a low-income (31). Considerable attention has been given to the high levels of criminal justice system involvement of homeless individuals, as arrests of the homeless is far more common than the general population (31).

Legality of Homelessness

Over the past 25 years a trend has increased to turn to the criminal justice system to respond to people living in public spaces. (23). Measures and laws include targeting homeless persons by making it illegal to perform life sustaining activities in public. These activities include sleeping/camping, eating, sitting, and begging in public spaces. In many cities, performing these activities usually results in criminal penalties for violation (23). Making life sustaining activities illegal directly affects homeless persons and contributes to the large percentage of inmates who have experienced homelessness. The offense among homeless individuals in prison was more likely to be a property crime (31). However, petty crimes and laws that specifically target the homeless are not the only factors contributing to the incarceration of the homeless, many other factors are involved.

Factors of Incarceration

A study investigating the rates and correlation of homelessness among United States Adult State and Federal Prison Inmates found four types of explanatory factors for the high rate of homeless and criminal justice system involvement (31). The first factor correlates with the fact that homelessness itself may be crimogenic, reflecting the efforts of homeless individuals to survive on limited resources and thus the need to panhandle or be involved with low level crimes (31). Another contributing factor is the poor health status most homeless have. Substance abuse and/or mental illness among homeless individuals increases their risk of criminal justice involvement (31). The third explanatory factor is varied socio-demographic characteristics such as being male, single, young, poor, of a minority ethnicity or being poorly educated. These varied socio-demographic characteristics have been found to be associated with both homelessness

and risk of criminal justice involvement (31). The final factor is that incarceration increases risk of homelessness, thus is a bi-directional factor which then could potentially lead to increasing risk for incarceration. Incarceration reduces community and family ties as well as limits opportunities for employment and public housing. The study investigating the rates of homeless individuals among United States Adult State and Federal Prison Inmates found a sizable proportion of homeless inmates became homeless as a result of prior incarceration (31). These factors among others contribute significantly for the high proportion of inmates who have experienced homelessness in their lifetimes.

Cost of Incarceration

The incarceration of the mentally ill and homeless has huge costs on the people suffering from the illness or from homelessness and on society. Homelessness and incarceration are co-influential. High rates of homelessness and evidence of poor health status, such as mental illness, as well as disadvantaged socio-economic characteristics were major contributors to incarceration (31). Lack of understanding of mental illness and lack of mental health treatment facilities have contributed greatly to current practices of incarcerating the homeless. A study analyzing the relationship between homelessness and incarceration rates found recent homelessness to be 8 to 11 times more common in jail inmates; the increased risk was attributed in part to mental illness (4). The incarceration of the mentally ill has negative implication on those suffering from mental health issues. It is estimated that 20% of inmates are mentally ill, and that suicide is the leading cause of death in jails (9). By incarcerating individuals instead of providing treatment programs the underlying issues are going unresolved. Criminalization measures are also not cost efficient. A study conducted by a supportive housing initiative

found that jail costs were on average two to three times the cost of supportive housing (23). Additionally, according to a study investigating the rates of homelessness among United States Adult State and Federal Prison Inmates found that homeless inmates are subject to much longer average incarceration (31). The study also found that when the homeless develop a criminal record it is harder for them to find employment in the future, thus further relying on tax dollars due to inability to become a successful job holding member of society. It has also been found that the development of a criminal record can lead to additional incarcerations, which are costly (31). By providing supportive housing to those individuals suffering from homelessness and/or mental illness not only treats individuals for primary issues, but saves society money.

Local government Responses

Cities around the United States are responding harshly to many homeless, especially those living on the streets. A survey done by the National Coalition for the Homeless the National Law Center on Homelessness and Poverty in 2006 studied 224 cities around the United States to survey how these cities treated their homeless. Of these cities, 28% prohibited camping in particular public places in the city and 16% had a complete city wide prohibition on camping (23). Many homeless rely on camping to have a place to sleep at night, by making camping against the law many homeless are left without shelter. Within these cities, 27% prohibit sitting/lying in certain public places, 39% prohibit loitering in particular public places in the cities, and 16% prohibit loitering city wide (23). According to Kari W. of Corvallis Community Outreach, many cities across the United States are not equipped with day time services for the chronically homeless, and thus many homeless do not have anywhere to spend their days. Thus anti-

loitering laws can severely diminish where the homeless are able to spend their time. Even more cities have imposed stricter restrictions, 43% prohibit begging in particular places and 21% have city wide prohibitions on begging (23). From 2002 to 2006 there has been a 12% increase in laws prohibiting begging in certain public places across the United States (23). Not only are these laws increasing, but the needs of the homeless are not being met. A survey done by the United States conference of Mayors reported that 71% of the 24 cities surveyed reported a 6% increase in requests for emergency shelters. Although many cities have shown an increase in laws pertaining to the homeless, such as begging and loitering, many do not have the resources to prevent the homeless from doing these things, thus many homeless are left with no choice but to sleep on the streets or loiter.

The survey done by the National Coalition for the Homeless the National Law Center on Homelessness and Poverty in 2006 studied 224 cities around the United States, of these a few specific cities' laws were highlighted. These laws range from a ban on panhandling to imposing curfews. In Atlanta, Georgia, a comprehensive ban on panhandling in tourist areas and anywhere in the city after sunset was passed. A violator can be fined up to $1,000 dollars or imprisoned for up to 30 days (23). These bans not only put stress on the homeless by limiting their earnings, but also require them to pay a fine which many homeless cannot pay. Other cities such as Dayton, Ohio allow panhandling but require a license and prohibits persons from panhandling without a "registration" issued by the Chief of Police (23). Other laws punish those that are trying to help the homeless. Some cities, such as Dallas, Texas and Miami, Florida have passed laws prohibiting groups from feeding homeless persons in cities, parks, or in designated

areas of the city (23). Laws such as these inhibit humanitarian efforts and further impose the stigma against homeless people by associating these people with criminal activity. Even more cities have imposed curfews on the youth, an old fashion notion that continues in today's society. These restrictions pose a huge threat for youth experiencing homeless with no place to go but the streets (23). Courts have overturned some of these laws for violating minors' right to free expression, right to freely move, and equal protection rights (23). Locally, Corvallis, Oregon has an illegal camping ordinance, even though many of its homeless residence camp on the outskirts of town or sleep on park benches (23). Although these cities vary geographically, economically, and socially, many of them similarly have restrictive laws that unfairly target the homeless.

The Rights of the Homeless

Criminalization measures violate human rights of homeless persons. When cities place restrictive laws that focus almost exclusively on homeless populations, it can have devastating effects on the rights of the homeless. If a city places a restriction on begging, then freedom of speech concerns are raised and many courts have found begging to be protected under the first amendment (23). Many cities impose sweeps of homeless camps which result in the destruction of homeless persons' property and homes. When a city destroys homeless persons' belongings or conducts unreasonable searches of homeless persons, it violates the fourth amendment: the right to be free from unreasonable search and seizure (23). Laws that ban camping from certain parts of the city or limit loitering in parts of the city make it difficult for homeless persons to stay in downtown areas which force the homeless to stay away from crucial services and outreach. In 1996 the United States participated in the Second United Nations Conference on Human Settlements,

there the United States created the Human Rights Committee (23). The Human Rights Committee oversees the international covenant on civil and political rights. This international covenant states that the right to movement and the freedom to choose your own residence are important rights that should only be breached by the last intrusive means necessary to keep public order (23). Forcing people to live in certain areas or forcing them to move to other spaces involuntarily breaches their right to the freedom of movement. Many of these human rights breeches have been ruled illegal and have been overturned by the courts, however, many cities are slow to change their laws.

Legal Trials

Many national court trials have responded to the various laws imposed by cities around the United States. Trials have ruled that often laws placed by cities have a direct negative effect on the homeless and unfairly focus on homeless populations. Courts have found that when a law is applied to criminally punish a homeless person for necessary life activities in public, like sleeping, the law violates a person's eighth amendment - the right to be free from cruel and unusual punishment, especially when a person has nowhere else to preform that activity (23). Portland, Oregon's municipal court ruled in State v. Wicks that enforcement of Portland's camping ordinance violated basic constitutional rights and unfairly punished a person for fulfilling basic activities such as sleeping (23). Camping is now legal in Portland. Other court trails have ruled that laws placed which prevent begging or panhandling profoundly limit a person's first amendment – the right to free speech (23). The seizure of property violates the fourth amendment when a governmental action unreasonably interferes with a person or his/her property (23). When police conduct sweeps and destroy belongings of the homeless, they

severely compromises the fourth amendment. Courts have found that such actions violate the fourth amendment - the right to be free from unreasonable searches and seizures (23). The United States' court system has used many of these cases to help limit inhumane and unconstitutional laws directed at the homeless.

The United States is not only accountable for national laws, but it is bound by international human rights agreements as well. The United States has signed The International Human Rights Agreement and the Habitat Agenda with the United Nations. In 1996, the United States participated in the Second United Nations Conference on Human Settlements and signed the Habitat Agenda which states that no one should be penalized for their status, which specifically focused on those living in homelessness and poverty (23). The Habitat agenda explicitly prohibits punishment of homeless persons based on their status. Although the Habitat Agenda is non-binding the United States publicly committed to stand behind its principles by signing the agreement in front of the United Nations (23). Many cities that conduct 'sweeps' to remove people and their positions from outdoor encampments without notice or unannounced relocations of persons to other housing violates this clause (23). The United States also signed the International Human Rights Agreement, which prohibits actions that target homeless people living in public spaces (23). This agreement is an international covenant for civil and political rights of people, which also emphasizes "equal protection of the law" and prohibits discrimination based on a variety of statuses such as poverty, homelessness, and disability (23). The United States is not only bound locally to uphold the rights of the homeless, but also is held accountable by international courts.

Healthful Responses by Local Governments

Many cities across the United States are taking initiative to implement more humane laws or advocacy programs for the homeless. The survey done by the National Coalition for the Homeless the National Law Center on Homelessness and Poverty in 2006 found many examples of cities contributing positively. In Pasadena, California, the Police Department and the Department of Health have formed a Homeless Outreach Psychiatric Evaluation Team. This program has created three teams of mental health and law enforcement officials to provide compassionate assistance to persons in need of mental health assessment and many other services (23). This outreach by the Police and Mental Health Departments of Pasadena demonstrates law enforcements and health officials' ability to work together to promote the welfare of the homeless. Another initiative taken in Ohio was the partnership of its three largest cities: Columbus, Cleveland, and Cincinnati to fund teams of trained workers to go out to those on the streets. These teams visit people under bridges and in encampments to assist those outside the service system. They offer services at non-traditional hours, when others services are closed to provide a vital link between mainstream amenities and populations that are outside the reach of most social services (23). Other cities such as Washington D.C. have used the power of their small businesses to help the homeless. In D.C., business owners fund a day center during the hours other shelters are closed. These day centers have indoor seating, laundry, showers, and a morning meal that serves on average 260 people per day (23). Many cities' businesses complain about the homeless loitering near their businesses and deterring costumers, this solution provides the homeless with a place to be and food to eat during the day while not infringing on their rights. San Diego is another city that has put many efforts into helping the homeless, especially with legal

troubles. Many of those living on the streets have had some sort of altercation with the law whether it for charges such as loitering or panhandling in public, drug related charges, other potential charges. Often times these charges have fees attached to them, or inhibits a person's ability to obtain a job in the future. Thus to help the homeless handle their legal charges San Diego has developed a homeless court program. The program is a monthly court held at homeless shelters for homeless defendants to resolve outstanding misdemeanor criminal cases. This expands access to the judicial system and assists homeless defendants by addressing outstanding warrants and criminal offenses to remove barriers to benefits such as treatment, housing and employment (23).

Summary

Due to reduction in bed availability and the increasing stringency of standards for involuntary mental hospitalization, psychiatric hospital care has become far less available, perhaps increasing the risk of incarceration among homeless people, especially with serious mental illness (31). In the 2008 study of Adult State and Federal Prison inmates, it was found that those that were homeless within the year prior to arrest was 7.5%, of these, 89% had a substance abuse or mental health disorder, and 64% had symptoms of mental health disorder which included mania, depression, or other psychoses indicative of a mental illness (31). Incarcerating individuals with mental illness does not provide treatment and leads to increased homelessness by limiting individual's opportunities (31).

National Policy in the United States

There are a variety of government funded programs for the homeless and mentally ill available in the United States of America. These programs are vital to the function of society as approximately 2-3 million individuals in the United States experience a night of homeless annually, and approximately 10 percent have been identified as chronically homeless due to the duration of their homelessness history (22). As well as over 25% of Americans suffer from a diagnosable mental disorder every year (22). It is critical that the United States implements national policies to help take care of and treat these populations. Homelessness is risky, dangerous, and does normally not provide adequate living situations for people. Many homeless also suffer from mental illness, these persons concomitantly suffering from both need even more resources. These populations are in need of a variety of resources, especially those provided by the United States' government.

Main Programs in the United States

There are many national, state, and local programs available for the homeless and mentally ill. Of these, there are a significant few that provide most of the resources available for these populations. The United States Department of Housing and Urban Development (HUD), is a major player in creating national policies in the United States that advocate for the homeless. HUD's mission is to create strong, sustainable, inclusive communities and quality affordable homes for all. HUD strives to meet the need for quality affordable homes, and to utilize the platform of housing to improve quality of life for those in the United States (36). HUD serves over 1 million people through emergency, transitional, and permanent housing each year (36). HUD's Office of Special

Needs Assistance Programs supports the nationwide commitment to ending homelessness by providing funding opportunities to quickly rehouse homeless individuals and their families. HUD advocates self-sufficiency and promotes the effective utilization of national resources to help those suffering from homelessness (36). A program run under HUD that promotes welfare for the homeless is the Projects for Assistance in Transition from Homelessness (PATH) (15). PATH is a national grant to the States, and provides assistance to those, especially with mental illness, trying to find stable housing (34). PATH works hand in hand with other homeless service providers in every state to make sure people with severe mental illness are identified and getting services they need (34). PATH helps communities implement housing first approach. Housing first approaches have been shown to be a more effective way in helping the homeless, specifically those with substance abuse illnesses (14). PATH also influences communities to be more involved with their mentally ill, poor, and homeless by using assertive community treatment (ACT). These ACT teams are established using PATH dollars. ACT teams are evidence based outreach models and are often used to connect chronically homeless individuals to housing and intensive services (33). This model brings trained individuals to go out into the community and reach people that truly need the help, these individuals can include homeless individuals and the mentally ill. Another national policy provided by the United States to help the mentally ill is the Substance Abuse and Mental Health Services Administration (SAMHSA) (37). SAMHSA is an agency within the United States Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities (37). SAMHSA helps

provide treatment and services for people with mental and substance abuse disorders, helps to support the families of those suffering, and build stronger communities (37). These national initiatives help prevent costly behavioral health problems and promote better health for all Americans. Another program is the National Alliance to End Homelessness (NAED), this is a nationwide federation of public, private, and non-profit organizations devoted to end homelessness. NAED's goals for the homeless in 2016 is to provide 2.480 billion dollars for the homeless in assistance programs within HUD, promote awareness of homelessness and mental illness, and provide more support within subsidized housing (37). Although these are just a few national programs available to the homeless and mentally ill and do not begin to encompass the large state and local efforts, they are pivotal to describing national policy to support the homeless.

Economic Cost of Homelessness

National policy in relation to homelessness and mental illness is critical in order to treat individuals as well as keep many unnecessary costs down. There are many areas throughout the United States that lack adequate outpatient services as well as mental health treatment services for the homeless. Lacking these facilities and national policies that promote these facilities can cost the government and its citizens. A study in New York compared length of stay in hospitals with the homeless versus with persons of low income. Among admissions for homeless patients, 51% were treated for psychiatric illness or substance abuse, compared to 22.8% of the low income group, this demonstrates that funds are not adequately being distributed to appropriate centers, such as psychiatric centers and are instead being put on emergency resources such as the hospitals (11). Using the hospital in this way is not only a misuse of emergency

resources, but is not an appropriate use of money. The study also found that lengths of stay for the homeless patients averaged 4.1 days longer than those of the other patients, even after adjusting for severity of illness, coexisting illnesses, infection with HIV and demographic characteristics, which means thousands of dollars more in hospital visits (11). Many of these patients would not have been admitted into the hospital if they had a place to live or receive care such as an out-patient treatment facility. Many hospitals, as well, are required to place homeless patients in housing upon discharge, that means, if shelters and discharge places are full they must remain in the hospital (11). In 2015, New York city reduced hospitalization for psychiatric issues. This reduction resulted in an annual saving of 18,688 dollars per person (32). Due to the lack of psychiatric facilities, homeless shelters, and low income housing for the homeless many cities face these additional expenses. Although there are many national policies to support the homeless and mentally ill, these issues are still very prevalent especially among larger cities. In 2008, a survey by the United States Conference of Mayors reported that 20% of cities listed better coordination with mental health service providers as one of the top three items needed to combat homelessness (15). These programs are cost saving and provide more beneficial outreach for those in need, especially with skilled program workers. Many programs have shown that mental health services with trained outreach workers can establish a trusting relationship through continued contact with the people they are trying to help, versus the care they would receive at a hospital which is more focused on immediate issues (15).

Providing better national policy to implement more housing and mental health facilities not only reduces expenses in the hospital, but also reduces jail time expenses.

In 2015, New York city also saved from reductions in jail and prison times for patients who were in need of psychiatric care versus jail time. Savings from this reduction were around 1,298 per person annually (32). Spending money provided by national policies would provide more benefit to the people and be more cost effective if spent on facilities other than jails or hospitals. Cost of renewing and expanding investments for permanent supportive housing is a proven, cost-efficient solution to chronic homelessness and mental illness. Both of these populations are in need of more resources especially directed towards the facilities most needed such as adequate housing (6). Those living in poverty and whom are homeless currently have poor resources available to them, and often live in inadequate housing (6). Supportive housing saves communities thousands in annual costs in reduced jail time, emergency room visits, and police and ambulance calls (34).

Programs for the Homeless

The United States provides programs for the homeless from national to local levels. Most national programs allocate resources based on the categorization of homelessness. Homeless populations are categorized by the following: chronically homeless, members of families, single individuals, persons with AIDS/HIV related illness, persons with mental illnesses, persons with substance abuse problems, veterans, survivors of domestic violence and unaccompanied youth (2). The definition of homeless family according to HUD is one or two adults accompanied by at least one minor child who are either not housed or who have had recent periods during which they lacked housing (22). Homeless youth are defined as persons between the ages 16-24 who do not have familial support and are unaccompanied-living in shelters or on the street" (22).

Adolescents ages 12-17 are the single age group most at risk for experiencing homelessness (22). National policies also use definitions of homelessness as well as definitions of housing to make programs more viable for the persons they serve. Two definitions of housing that are often used are rapid re-housing and permanent supportive housing. The definition of rapid re-housing is a short term rental assistance, landlord mediation and other housing search services, connections to employment for homeless families and individuals (35). While the definition of permanent supportive housing is a long term housing and supportive services targeted to people with disabilities who experience chronic homelessness (35). These categories make funding and national policies more efficient to address the overarching problem of homelessness.

In 2009, The United States passed the American Recovery and Reinvestment Act which included $1.5 billion for homelessness prevention and rehousing (15). These government funded programs must conduct national survey analysis to conduct homeless counts every two years in order to receive federal dollars (2). Nationally, funding for supportive housing programs is available from various programs run by the United States Department of Housing and Urban Development (HUD), within HUD are the United States Department of Veteran Affairs and the United States Interagency Counsel on Homelessness. National funding also supports the Projects for Assistance in Transition from Homelessness (PATH) (15). There are non-profit, private organizations as well, such as the National Coalition for the Homeless.

One of the original assistance programs for the homeless was the HUD McKinney-Vento homeless assistance grants program passed in 1987, which funds local, regional and state homeless assistance programs (35). This program has been the primary

source of funding for programs serving people experiencing homelessness, this program's funding is currently up for debate by congress (35). These homeless assistance grants include continuum of care program whose funds provide interventions like cost effective permanent supportive housing for chronically homeless and the emergency solutions grant which funds emergency shelters and adds new focus on interventions of homelessness prevention and rapid re-housing (35). HUD defines chronically homeless individuals as an unaccompanied individual with a disabling condition who has either been continuously homeless for a year or has had at least four episodes of homelessness in the past three years (22). Within HUD is the Health and Human Services Department (HHS) which is the principal agency for protecting the health of all Americans and supporting the delivery of essential human services, especially for those who are least able to help themselves (22).

The United States provides support for the homeless through the Projects for Assistance in Transition from Homelessness (PATH) (15). PATH reaches over 185,524 people in the fiscal year of 2014. Of these, 28% were unsheltered at the time of engagement, 64% received mental heal services and 52% had co-occurring substance abuse disorders (33). PATH funding has helped communities implement the housing first approach. Assertive community treatment (ACT) teams are established using PATH dollars. ACT teams are evidence based outreach models and are often used to connect chronically homeless individuals to housing and intensive services (33).

Founded in 1984, the National Coalition for the Homeless is a private, non-profit, national advocacy organization that exists to educate all levels of society in order to identify and put to an end the social and economic causes of homelessness. It is the

mission of the National Coalition for the Homeless to create the systemic and attitudinal changes necessary to prevent and end homelessness, while concurrently working to increase the capacity of local supportive housing and service providers to better meet the urgent needs of those families and individuals now homeless in their communities (23). The National Coalition focuses on four policy areas: civil rights of those who are without homes, housing that is affordable to those with the lowest incomes, accessible/comprehensive health care and other needed support services, and livable incomes that make it possible to afford the basic necessities of life (23).

Many of these programs are threatened to be cut. With deep cuts to many housing and safety net programs and the returning threat of sequestration these programs are at risk. Without the help from congress there is a high risk that homelessness will increase (35).

Programs for the Mentally Ill

The United States also provides many support programs to the mentally ill. One of the main national programs is the Substance Abuse and Mental Health Services Act (SAMHSA). SAMHSA focuses on high risk groups such as individuals with disabilities, immigrants, persons leaving institutions (incarceration, inpatient care for psychiatric or chronic medical conditions), youth aging out of foster care, frail elderly, persons experiencing abuse, and disaster victims (22). Current fiscal year 2015 funding for SAMHSA is 74 million, which is divided into three accounts. These accounts include two within the Center for Mental Health Services (CMHS) totally 33 million and one within the Center for Substance Abuse Treatment (CSAT) totally 41 million (32). SAMHSA homeless programs fill a gap created by HUD to fund housing rental

assistance. Many of the programs funded by HUD are extremely useful in getting people affordable housing, but there also needs to be funding to make those programs effective, which is the job of SAMHSA (32). SAMHSA helps many homeless people receive benefits that they qualify for. Many homeless are eligible for Supplemental Security Income and Social Security Disability Income but face multiple obstacles to actually receiving these benefits. Getting these benefits can allow homeless people to help pay their rent and help receive rental assistance resources (33). In 2015, the United States' Senate proposed a $25 million dollar cut (38% of the program) to SAMHSA, while house proposed a $10 million (15% of program) cut (34). These appropriations are needed and cutting them could cause devastating results for people suffering from homelessness and mental illness. Many of these funds include support for mental health and substance use treatment services for homeless populations (32).

Shortcomings of National Policy

Although the United States is doing a lot to try to combat homelessness and mentally ill, there are still many initiatives that need work and many other programs that need to be implemented. Of these are the current United States economic state, which favors the rich, lack of societal aid to those suffering, and deinstitutionalization and lack of psychiatric beds (2). The structural failings in the United States often result in many mentally ill and poverty stricken individuals becoming homeless. These failings are often viewed as personal failings and thus insure negative stereotypes about the homeless when the true cause of their misfortune is due to the failings of United States' societal failings. These failings include and are not limited to high cost of housing, generational poverty, lack of care for the mentally ill.

There is a large shortage of psychiatric beds in the United State (2). The shortage is so significant that people can for up to a month (21). The pressure for existing beds is so intense currently that patients are discharged prematurely and often have to be readmitted or end up homeless or incarcerated (21). Psychiatric units in general hospitals or private psychiatric hospitals admit individuals who have the most severe forms of mental illness, but most are not staffed to do so (21). State psychiatric hospitals are the ultimate safety net for people with mental illness because they usually do not have health insurance so they are less desirable by private psych hospitals (21). Currently there is no accepted standard regarding how many psychiatric beds are needed in the United States (21). In 1955, there were 558,239 state and county psychiatric beds available, or about 340 beds per 100,000 population, now 2016, there are about 11 beds per 100,000 population (21). Studies have been done to determine if this is an adequate amount of beds for current populations. A study done in North Carolina with a population of 3.4 million wanted to analyze how many psychiatric hospital beds were needed. From 2010 to 2012 the average emergency room preadmission wait time was 3.3 days. The authors used a computer simulation program to model different scenarios. With the goal of achieving an admission time less than 1 day they found that they needed about 39 adult psychiatric beds per 100,000 population. This population was only adult patients and assumed a median stay of 20 days not including long term extended periods (21). In a study done by the Treatment Advocacy Center in 2008 estimated the minimum number of public beds necessary for adequate psychiatric services including children and long term extended patients estimated that 50 beds per 100,000 population were needed (21). Given this data it is reasonable to establish a range of 40-60 psychiatric beds per 100,000

population as a minimum standard currently needed for reasonable psychiatric care in the United States in light of the realities of the present funding system (21). This number could vary depending on the state, advocacy programs for this population, and public funding. Mental health hospitals and psychiatric facilities are not the only answer, studies have found that approximately 75% of persons with schizophrenia could be successfully treated at home rather than the hospital with daily visits by public health nurses and guaranteed medication compliance (21).

In 2005, 71 percent of the 24 cities surveyed by the United States Conference of Mayors reported a 6 percent increase in requests for emergency shelter. Of these cities, an average of 32 percent of shelter requests by the homeless went unmet (23). Measures can be taken to reduce the amount of need for emergency shelters and psychiatric beds these include community treatment and use of assisted outpatient treatment to assure medication adherence (21). As many state hospitals beds are used only for brief hospitalizations there is little alternative for patients who need longer periods for stabilization and many emergency shelters do not have the services or funding (21). Data has shown that for families and individuals with complex needs, the most successful intervention for ending and preventing homelessness is linking housing to appropriate support services. There is a need for more affordable housing and funding the supportive services (32).

Prevention of Homelessness

The United States is a vast and powerful country and the solution to end homelessness will not come with one plan or one department. Ending homelessness and especially taking care of those suffering from mental illness while homeless takes a lot of

funding, joint effort by local, state, and national governments, the reduction of societal stigma, amongst other solutions. Homelessness is an issue that cuts across various agencies in the federal government. Service resources focus on moving chronically homeless individuals from the streets and emergency shelters into stable housing, however, this goal takes fluid joint efforts from many departments in the United States government and with the United States' national policies.

The United States Department of Health and Human Services created the Strategic Action Plan on Homelessness in 2007 (22). This service and its Strategic Action Plan was one of the first plans outlined to help end homelessness in the United States. Since then the United States has adapted the plan, but maintained its mantra: to improve access to treatments and services, improve coordination across these services, identify strategies to prevent additional episodes of chronic homelessness and itemize accountability and evaluation processes (22). The Strategic Action Plan to end homelessness serves to continue to honor its goals. Although strategies to implement these goals change with need and increased information about current homeless populations, the mission remains the same. The first goal is to prevent episodes of homelessness, the Strategic Action Plan aims to identify risks and protective factors to prevent episodes of homelessness for at-risk populations and to prevent chronic homelessness among persons who are already homeless. The plan promotes use of evidence based homelessness prevention and early intervention programs and strategies (32). Another goal of the Strategic Action Plan is to help eligible homeless individuals and families receive health and social services. The Strategic Action Plan aims to strengthen outreach and engagement activities, improve the eligibility review process,

examine mainstream programs that serve the homeless in order to improve the services to persons experiencing homelessness (32). A third goal of the Strategic Action Plan is to empower our state and community partners to improve their response to individuals and families experiencing homelessness. The plan hopes to implement homeless policy academy action plans, examine options to expand flexibility in paying for services that respond to the needs of persons with multiple problems, encourage states and local governments to coordinate services and housing, providing training and technical assistance on homelessness to mainstream service providers at a state and community levels (32). A fourth goal of the Strategic Action Plan is to develop an approach to track departmental progress in preventing, reducing, and ending homelessness for HHS clientele (32). The Strategic Action Plan hopes to do this by analyzing inventory data relevant to homelessness currently collected in HHS targeted and mainstream programs, including housing status, establish baseline data on the number of homeless individuals and families served in HHS programs, track improved access to HHS mainstream and targeted programs for persons experiencing homelessness including individuals experiencing chronic homelessness, and coordinate HHS data activities with other federal data activities related to homelessness (32).

The Strategic Action Plan on Homelessness supports programs to support those with mental illness, such as PATH and SAMHSA. The Projects for Assistance in Transition from Homelessness (PATH) 2016 fiscal year appropriations was $75 million dollars, in 2015 the program had 65 million (33). The PATH program allocates funds by formula to states to serve homeless people with serious mental illness these services include outreach, screening and diagnosis, habilitation and rehabilitation, community

mental health services, substance abuse treatment, case management, residential supervision, and housing (33). SAMHSA also coordinates homeless programs for essential mental health and substance use treatment services (33). The 2016 appropriations for SAMHSA is $100 million dollars. This funding will go to help chronically homeless families and individuals acquire and maintain permanent supportive housing (32). Funding to SAMHSA ultimately saves tax payer dollars. Supportive housing ends the cycle of frequently and inappropriately use of expensive social supports and institutional care that people with complex needs cannot break while homeless (32).

Possible Improvements

Although national policies in the United States are constantly being reformed, there is still much to do in order to serve and care for the homeless. The United States needs to increase the availability of services linked to housing for people experiencing homelessness. The United States can do this by protecting funding for programs such as the PATH program and SAMHSA. These programs the reach of the national government to those that need help, these program's funding were up for cuts last year. The United States' policies should also work to extend funding to community health centers and health centers for the homeless, protect reforms such as including the expansion of Medicaid, expand legal help to those living in homelessness, create stronger focus on connecting survivors of domestic violence with permanent housing resources, and many other programs (35). The United States can do this by continuing to fund and support programs that reach the homeless and mentally ill.

The United States is able to do this by continuing to support cost efficient interventions of homeless prevention and rapid rehousing (emergency solutions grant).

The United States focuses on key groups of at risk individuals. This can be done by increasing HUD's ability to serve and stably house low income individuals and others at risk. This year HUD's funding was increased and as a result it was able to provide over 67,000 new vouchers to house the most vulnerable people in the United States including people experiencing homelessness, domestic violence survivors, and family unification programs. Increasing funding to HUD increases access to permanent affordable housing for extremely low income individuals by modernizing the mortgage interest deduction. HUD hopes to create 25,500 more new units of permanent supportive housing. HUD funding also goes towards the Department of Veteran Affairs Homeless Assistance Programs to end veteran homelessness as well as provide supportive services for veteran families (35). HUD's goals also include increasing the capacity of the Runaway and Homeless Youth Act by improving crisis response and early intervention approaches, expanding the reach and availability of transitional living programs and providing more youth with a stable housing (35). Currently the top policy priorities for United States administration is to reauthorize HUD's homeless assistance grant programs, improve knowledge about youth homelessness and its solution, administer federal health care provisions to aggressively support programs for low income at risk population, expand the Veteran Affair's work at local level to end homelessness among veterans, and improve ability of the child welfare system to prevent homelessness (35).

The United States funds and supports many incredible national policies and programs to serve the homeless and mentally ill. Many of these programs are at risk of having funding cut and it is imperative that their work continues in order to help these at risk individuals.

4.2 Spain

Mental Health of the Homeless in Spain

As in many other countries, including the United States, mental illness is a significant problem in Spain. Spain's government, health professionals and society share a great concern for the mental health of its homeless residents. The estimate of the European Study of Epidemiology of Mental Disorders is that 19.4% of the general population in Spain suffered with mental illness over their lifetime. In the homeless population in Spain, the incidence of mental illness is high.

Mental Illness Overview

Mental illness has become an increasingly prominent focus for the Spanish government and Spanish health professionals. In recent years, more information is being sought about those experiencing mental illness. In addition, research has been undertaken to gain better understanding of the overall mental health of Spain's inhabitants. Recent studies have found that severe mental disorders are highly prevalent in Spanish society, ranging from 2-7% of the population, which is less than the approximate 13% mentally ill in the United states (25). Of these, approximately 1% of the general population are schizophrenic, 2% are bipolar, 5-7% have addictive disorders, and 4-6% have a severe depressive disorder (25). These disorders are considered severe because they are characterized by substantial declines in cognition, mood, perception, behavior, and judgement of the individual (25). The Spanish government is becoming increasingly more interested and involved in understanding the mental health of its inhabitants, the interest sparked by the increasing number of persons suffering from a

mental illness and the importance of understanding mental illnesses in general. Severe mental disorders and addictive disorders are mental health issues that have important implications both for the people suffering from them as well as for their family networks surrounding them (25). Familial networks in Spain are central to social life, and thus it is imperative that mental illness in Spain be understood in this context. Though research and studies in the realm of mental illness are more difficult to obtain because of past lack of interest in the subject, there are of late more and more relevant studies being done in Spain.

In 2012, a study was done in Murcia Spain, one of the areas hit hardest by the economic crisis of 2007 (49). Murcia was analyzed using a cross-sectional survey using a representative sample of the adult and non-institutionalized general population. A highly structured and detailed interview designed by the World Health Organization (WHO) was used. This interview process included information about mental illness, severity of the disorders, symptoms, disability, quality of life, use of services, medication use, and several risk factors of mental illness. From this survey, researchers found that major depression, alcohol abuse with or without dependence, and specific phobias were the three most common psychiatric disorders (49). Researchers also found interesting data regarding other mental health disorders. In the study, it was found that 15% of people had a lifetime history of anxiety disorders, 2.4% of people had a lifetime history of impulse disorders, and 8% had a lifetime history of substance abuse disorders. Within the period of 12 months prior to the interview, 9.7% of people met the criteria for anxiety disorders, 6.6% for mood disorders, 0.3% impulse disorders, and 1% substance abuse disorders (49). The study also determined that younger people in Spain had a higher risk

for any disorder than older people (49). This is often attributed to the marked stress that young people face during University and life directly afterwards. Overall, the study found that mental disorders are extremely common in the general population. In this population, approximately one in three respondents reported a lifetime history of any mental disorder according to DSM-IV. The types of mental disorders and their severity varied, however, anxiety disorders were found to be more prevalent than mood disorders, which are more prevalent than substance disorders (49).

Many researchers in Spain are working to understand the dynamic of major mental illnesses, in the hope of reducing the stigma of mental illness by offering factual information. They also hope that their work will lead to the better care to those whose mental illness has reduced the quality of their lives. In 2012, a study of 63 individuals with a diagnosis of schizophrenia or schizoaffective disorder were assessed for violent behavior during brief hospitalizations throughout Spain. The study found that the strongest predictors of violent behavior were the patients' lack of insight into symptoms, being sicker due to untreated mental illness, and their past history (12). A common stigma towards those with mental illness is that these persons are inherently violent. For this reason, studies looking specifically at violent episodes are extremely useful in gaining insight into why some persons with mental illness are violent and others not.

Dual diagnosis

There is a high prevalence of the comorbid presence of two pathologies: mental illness and substance abuse. The most prevalent disorders of mental illness in Spain are psychotic disorders, depressive disorders, and anxiety (28). Often times those with a mental illness also have another malady, which most times is a substance abuse disorder.

The comorbid presence of two pathologies causes a worse personal outcome for those affected. Researchers use Cloninger's Model, a systematic method for clinical description and classification of personality variants, to detect personality disorders and addictive behaviors separately, and the effects of the disorders combined (28). Using this model, researchers are able to analyze the outcomes of having two disorders. Research has found that persons with both a substance abuse disorder and mental illness disorder have less autonomy and have more invalidating circumstances than only a substance use disorder (28). The comorbidity prevalence of substance abuse and mental disease is between 55% and 85% in Spain; the co-occurrence of these two disorders is known as Dual Diagnosis (28), which is more common in men. These men usually suffer from psychotic disorders and bipolar disorders. Dual Diagnosis patients are typically younger and live with their parents. In Spain, most patients are single, have finished their primary studies but have a worse work history, with difficulty often times with keeping employment. Many suffering from a Dual Diagnosis have a higher number of suicidal attempts than those who only have a severe mental illness and no substance abuse (28). Those with a Dual Diagnosis have a more difficult time of completing treatment successfully, which is mostly due to having more relapses than those suffering just from a substance use disorder (28). Often, those with a Dual Diagnosis use health services more frequently, have more serious disorders, and more functional disability when compared to those with only a single disorder. Also those with a Dual Diagnosis have more cognitive, psychological, physical, and social impairment compared with those with only one disorder (28). Overall, those with co-occurring substance abuse disorders and mental illness have greater difficulty maintaining their health and functioning in society.

Dual diagnosis patients have a tendency for behavioral inhibition and anticipated future problems where pessimism and fear of uncertainty are predominant. Those suffering from a mental illness as well as a substance abuse disorder often have no overcoming desires, a lack of perseverance in behavior, and a lower frustration tolerance. Many of these attributes are crucial in the recovering and treatment of drug abuse. Those suffering from a Dual Diagnosis also have a tendency to be more independent, little to no sensitivity to social stimuli, and have more difficulty establishing social relationships (28). Many treatment theories for drug abuse in Spain rely heavily on the social aspect of recovery. A fear and uncertainty of the future inhibits hope, many treatments rely as well on the hope and perseverance of the individual in order to manage their disease. Thus having a mental illness is correlated with a higher risk of substance abuse, and the worse the severity of substance abuse, the more likely is mental illness for persons in Spain (28).

Women with Mental Illness

Although it is more common for men in Spain to suffer from a Dual Diagnosis, women in Spain have their own incredibly complex set of problems with regard to mental illness. Traditionally, Spanish familial dynamics are very defined and include certain societal expectations, especially for women. The woman's role in Spanish society is as the caretaker of the household; for those with mental illness, the stress of not fulfilling this role can be devastating. In the past, many women with mental illness suffered in silence, and were negatively stigmatized for having such a condition. The stigma stemmed in part from a profound lack of knowledge about mental illness. In addition, because of women's role as the caretaker, putting one's own mental health concerns in

front of the family's needs was generally not accepted. Spanish families also tended to keep the information about mental health problems extremely private. This situation obtained until 1985, when Spain deinstitutionalized its psychiatric patients, giving rise to a new social group in the general population, and especially in the homeless population (44). Deinstitutionalized mentally ill women were now being outwardly noticed in public life, when previously this population was unseen by society. After the deinstitutionalization, many women with mental health concerns were forced to take the streets, where they became a painfully visible presence, especially in larger cities (44). This transition was a new phenomenon for Spanish society and proved to be the first of many to unveil mental illness amongst women in Spain.

As divorce rates rise, women's role in society is changing, but the implications of the past expectations s remain. Presently, middle-aged divorced women often display worse psychological states than other groups due to the traditional role of women in Spain. These women have been expelled from a protective social and cultural environment where they functioned as the center of the household (44). The drastic change in their role with divorce has critical implications for their mental health. Women who find themselves homeless in Spain have a more difficult time coping with this circumstance than their male counterparts, for the home is a symbol of a fulfilling life for many women (44). Many homeless men feel that the insecurity of homelessness lies in their lack of a job or inability to obtain a job, and thus the solution to their hardships lies in gaining access to the labor market (44). For women, the familiarity of being the central role in the family and the sense of purpose and of security within a household is crucial to their wellbeing. Thus when living in homelessness, these factors cause the

most pain and hardship and thus most women's solution to the mental toll that homelessness causes requires them to find a house, where they can live on their own. Often times, the male centered environment of Spain leads to other negative circumstances, such as domestic violence, which further worsens or can initiate mental disorders.

Women with mental illness are more likely to suffer from domestic violence, and women's risk of mood and anxiety disorders increase in relation to a history of domestic violence. Many women in Spain with mental illness have been victims, or are currently victims of intimate partner violence (27). A study done in 2014, analyzing mental illness in women and domestic violence found that the most frequent forms of abuse against women with mental illness are psychological, which is 66.9% likely over a women's lifetime, physical which is 48.6% likely over a women's lifetime, and sexual which is 33.1% likely over a women's lifetime. This study found that 18% of women with mental illness suffered all three types of abuse, which is two times higher than general population of women in Spain (27). The same study discovered that 30.3% of women with mental illness suffered or had recently suffered abuse from their partner or ex-partner which is 3 x higher than the general population. The study also found that 79.6% of them had intimate partner violence toward them over the lifespan of the relationship (27). This study, done in 2014, analyzing the correlation between women with mental illness and intimate domestic violence was the first of its kind in Spain (27). This demonstrates how new this topic is amongst researchers of mental illness and how much there is still to learn with regards women with mental illness.

Women in Spain endure a paralyzing circle of mental illness and intimate partner violence. Women with mental illness are more to have a have a significantly higher risk of any mood or any anxiety disorder than men (49). Lower levels of social support for women in Spain are associated with higher rates of intimate partner violence (27). Lower levels of social support lead to more women not talking about their abusive relationship which leads to increased mental health deterioration. The study done in 2014 which analyzed mental illness in women and domestic violence found that 48.5% of battered women do not talk about their abusive situation with anyone or come to any resource or service (27). Many women with mental illness, especially in Spain, rely on their domestic partner for support. Often times, the domestic partner is the only care resource that a woman with severe mental illness has, therefore she faces very complicated circumstance - to cope with the abusive situation or to remove the sense of familial stability. Women in Spain, especially, suffer from this decision, as the familial dynamic relies on the male to be the central breadwinner for the family and the women to exist as the caretaker of the family. Domestic violence does not only pointedly affect those with anxiety or other mood disorders, but also those women who have severe psychiatric disorders. There are significantly more cases of lifelong partner violence for women with higher psychiatric hospital admissions during their lifetime (27). Intimate partner abuse is not the only type of abuse that affects the mental health of women in Spain. The male is the central familial figure; thus fathers play a critical role in the mental health of a women as well. Women who have suffered physical abuse by their father in their childhood are at a 2.22 times higher risk of suffering from a mental illness in the future.

Women in Spain suffering from mental illness are disposed to a higher risk of domestic violence, which further emphasizes their mental illness.

Concurrent Medical Problems of Persons with Mental Illness

When someone is suffering from a mental illness, often times this is the most critical focus, however, many people suffering from mental illness have other maladies. As mentioned above, persons with mental illness may suffer from substance abuse and other emotional disorders. Physically, those suffering with mental illness have a more difficult time maintaining their health. A study done analyzing the dental health of institutionalized psychiatric patients and non-psychiatric patients found that those with psychiatric disorders had significantly more dental problems. Institutionalized psychiatric patients have significantly worse dental status and more dental treatment needs than non-psychiatric patients. Institutionalized patients had an average of 3.4 teeth needing treatment and services compared to the non-psychiatric patients that needed an average of 1.9 teeth needing treatment and services (26). Among dentate patients, it was found that cognitive impairment is associated with a reduced number of teeth and an increased need for dental treatment (26). In institutionalized psychiatric patients, the carious disease process appeared to progress over time and symptomatic teeth were extracted rather than restored. This is likely because of the lack of personnel available in these hospitals and limited resources to provide preventive and restorative care to those individuals (26). Untreated dental maladies can have severe implications for the health of individuals, such as bacterial infection and reduced quality of life. Thus it is imperative to maintain close watch on other maladies that those with mental illness are more prone to suffer from, such as dental care.

Comparison of Spain to Other Countries

In 2007, the World Health Organization (WHO) designed and carried out the World Mental Health Survey Initiative to survey mental disorders in a number of countries from all over the world. Studies designed to analyze mental illness based on DSM_IV disorders look at two measurements specifically, a 12-month prevalence, which is having the illness or episodes of the illness within the last 12-months of the study or a lifetime prevalence, which is having the illness or episodes of the illness at any time in one's life. The data suggests a wide variation in the 12-month prevalence of DSM_IV disorders. The highest percentage of 12-month prevalence of a mental health disorder was in the United States at 26.4% (49). The lowest percentage of 12-month prevalence of a mental health disorder was in Shanghai at 9.8% (49). The lifetime prevalence of having at least one mental disorder also varied from a high of 47.4% in the United States to a low of 12.0% in Nigeria. (49). Other countries studied in this initiative, including Spain, were staggered somewhere in between.

Other studies such as the study done by WHO have been carried out, including one done specifically targeting European countries. In 2007 the European Study of the Epidemiology of Mental Disorders project was designed to collect data from representative samples of the adult population in 6 European countries: Belgium, France, Germany, Italy, The Netherlands, and Spain. Overall, averaging all of the European countries studied, a 12-month prevalence of any mental illness disorder was 10%, in Spain the prevalence was 9.2% (49). In Europe, a lifetime prevalence of any disorder was 25% and the prevalence in Spain was 19.4% (49). In both measurements, the prevalence of mental disorders in Spain were lower than the average of all European

countries studied. It is also important to note, that the 19.4% prevalence in Spain is lower than the approximate 25% or higher prevalence in the United States. Worldwide and European studies are crucial in understanding the prevalence of mental illness globally and within the countries surrounding Spain.

Most of the countries of Europe experienced one of their longest economic crises in 2007. Spain was one of the most seriously affected nations. The Spanish unemployment rate rose dramatically from an annual average of 8% in 2007 to 24.5% in 2014 (49). This significant increase in unemployment not only affected the economic stability of the nation, but also has had major consequences for the mental health of the inhabitants of Spain. Evidence suggests that this crisis has led to a substantial increase in the prevalence of psychological disorders, especially among men. Suicidal behavior has also increased between these years, which is significantly correlated to the economic decline. There has also been a substantial increase in the frequency of treatment of mental disorders among primary care attendees in Spain, which is significant in determining if the economic crisis has led to an increase in persons seeking treatment for mental illness disorders (49).

Economic Crisis and Mental Illness

As a consequence of the economic crisis of 2007, there were effects in terms of prevalence and severity of mental disorders in the general population of Spain. Prevalence was strongly associated with exposure to stressors related to the economic crisis. The economic crisis affected people from all population subgroups, regardless of social standing and occupational status (49). Those exposed to multiple and recent economic stressors had the highest risk of anxiety disorder. Murcia, Spain was one of the

places that was hardest hit by the economic crisis (49). It has been found that mental disorder increase amongst economic crisis can be correlated to several social characteristics. One such outcome is an increased prevalence of poor mental health services among men, who, in Spanish society, are the primary familial head of house. There has also been a correlation with increased frequency of mental disorders seen in visits to primary care physician's offices (49). Increased financial stress, with poorer health services among men in Spanish society have had detrimental effects on the overall mental health of Spanish society. With economic crisis, there is also an increased risk of suicidal behavior. There is a parallel relationship seen between stressful life events and mental disorders, specifically to depression and anxiety disorders (49).

A study done in Murcia, Spain, one of the areas in Spain hardest hit by the economic crisis, focused on exploring the association between socio-demographic variables and economic stressors with mental disorders. This study analyzed the effects of the economic crisis in a representative sample within the general population of Murcia, Spain (49). The study was particularly important, because at the time of the study, there was still a lack of population-level research on the relationship between the economic consequence of recession and specific mental disorders (49).

The study mentioned above has shown that unemployment and economic crises have detrimental effects on mental health. Murcia was analyzed using a cross sectional survey based on a representative sample of the adult and non-institutionalized general population. The survey was preformed using a highly structured interview designed by WHO which included information about mental illness, severity of the disorders, symptoms, disability, quality of life, use of services and medication and several risk

factors. The study explored the association between socio-demographic variables and economic stressors with mental disorders during the economic crisis in the general population of Murcia, Spain (49). Since Murcia was one of the places that was hardest hit by the economic crisis it was an excellent candidate to analyze the crisis's effect on mental health (49). In the representative sample, it was found that those exposed to multiple and recent economic stressors had the highest risk of anxiety disorder (49). It was also found that major depression, alcohol abuse with or without dependence, and specific phobia were the three most common psychiatric disorders (49).

Economic crisis brings a reduced sense of security due to higher financial stress and unemployment rates. It has been found that unemployed individuals have poorer mental health than their employed counterparts (49). Economic crisis affects people from all population subgroups, regardless of social standing and occupational status. It is critical to understand the implications that economic crisis has on individuals, especially when relating to the mental health of individuals. In Spain, economic individuality is highly important to the culture, and thus economic fragility plays an important role on the mental stability of a person. Thus it is important that during recessions, physicians should be especially mindful of the psychological impact of patients' economic situation and work environment when diagnosing and treating mental health concerns. Especially due to the significant economic crisis in Spain in 2007, which still lingers, leaving the unemployment rate in Spain at 22.7%. Intervention programs for unemployed people and for those affected by financial problems should be considered as these programs may ameliorate economic-related distress among people. Economic crisis might be a window of opportunity to reform and strengthen mental health services in Spain. In history,

periods of crisis offer a possibility for better collaboration between professionals from different areas to develop more efficient approaches to prevent and alleviate the negative impacts of financial crisis on mental health (49).

Many countries surrounding Spain are also dealing with economic crisis. Spain is known as the door from Africa to Europe, as such, it has many immigrants. Immigrants generally come from Northern Africa, specifically Morocco. The financial crisis left many immigrants in dire situations as well. Mental illness amongst immigrants is an additional concern. In a study done analyzing mental illness amongst immigrants found that the prevalence of mental illness in immigrant populations is similar to the rest of the general population in Spain. However, immigrants have much more limited access to health care and medical services which increases the frequency of mental illness affecting immigrants lives more significantly than the general Spanish population. Immigrants with mental health problems in Spain have increased frequency of disability, incur more social cost, and often have increased human suffering and a decrease quality of life (28). The implications of economic crisis spread farther than the general population, and often have increased negative impacts on immigrants.

Familial Dynamic in Spain

As mentioned previously, the familial unit in Spain is very defined and is one of the most important aspects in Spanish society. In Spain, family is central. Often, young people remain living in their parent's house until the age of 28.9 compared to the age of 18 in the United States. This tradition is encouraged as many youth can benefit by lessoning the financial stress of living on one's own. Living with family for a longer period of time also provides pillar of support for young people. This practice has been

found to be very beneficial for the youth. Often times youth, especially in the United States, leave the house at age 18 which adds additional pressure and stress to young individuals. Having the additional time at home gives more time to gain control of finances, thus reducing the stress as they attend school. In this way, the custom contributes greatly to the mental health of youth. Young adults are not the only group of people that remain at home with their families. Many people suffering from mental illness also benefit from this cultural and social practice. Most of the people with a severe and persistent mental illness live with their families with low level of work integration (47). Having the mentally ill live in their familial house provides them with better support which leads to better health. It has been shown that by living with persons that the mentally ill are familiar with, they have better chance of living a fulfilling life (47). It also is beneficial for society because the mentally ill are being taken care by their loved ones instead of the state. This reduces the amount of severely mentally ill left to their own devices which normally leaves them either on the street, in the hospital, or in shelters that could potentially not have the services to treat the mentally ill (47). Spain is thus able to care for a large percentage of the mentally ill by way of their families. However, care for those with mental illness still needs to include all the persons' areas of function, including that of their family (47).

Caregivers for the Mentally Ill

The societal structure of Spain is family oriented. Thus, those who suffer from mental illness are rely heavily on the care of their family, and families see taking care of their kin as an obligation. In 80% of the cases of the mentally ill or those suffering from substance abuse, the family members are the caregivers of these patients (25). Many

families directly suffer from the impact of mental and addictive disorders of the members within their family (25). The familial role in mental illness is critical, as the quality of life for those with mental illness is greatly increased by having a strong family dynamic. Although this social structure is extremely beneficial to the mentally ill and to the Spanish society as a whole, it does not come without its costs. Family caregivers must undergo significant changes; 65% of family caregivers undergo substantial changes in their lives. Family caregivers have a significant reduction in their physical and/or their mental health (25). Compared to the general population, 40% of caregivers may suffer depressive symptoms or disorders and up to 15% have anxiety symptoms (25). Those with mental illness as well as their caregivers also suffer from victimization. Those with mental illness and their families suffer violent victimization to a greater extent than the general population (27). The addition of victimization to the already stressful circumstances causes the mentally ill and their caregivers to suffer further. In Spain, the burden of caregiving primarily falls upon the women of the family. When the stress of caregiving and the victimization of the mentally acts congruently with the additional issues mentioned above, many women suffer an extraordinary amount. Thus while there is a need for more therapies and services for the mentally ill, there is also a need for their families as well.

Most therapies in Spain offer help for those with mental illness, however, there is an increased category of mentally ill caregivers that are arising in Spain. The burden of being solely responsible for the wellbeing of the mentally ill has taken its toll, and many caregivers are now finding themselves with mental health disorders as well. As this is a relatively new phenomenon, most therapies are aimed to help the person with the mental

illness and the therapy focuses on reducing the emotion distress of the person with the mental disorder. Rarely do these therapies focus on developing strategies that will help decrease the caregivers' burden and emotional stress. In a study done of the mentally ill and their caregivers in 2015 it was found that 83.3% of caregivers for mentally ill sought help (25). In this study, researchers utilized cognitive behavior therapy to help those caregivers. At the 12 month follow up of this study, the cognitive behavioral therapy helped 82.7% of the participants. These participants felt less anxious and less depressed for the 12-month period after the study (25).

Homelessness and Mental Illness in Spain

Many of those suffering from a mental health disorder have difficulty maintaining normal societal lifestyles and thus find themselves on the streets. Homelessness and mental illness go hand in hand in Spain. Even with increased mentally ill living with their family, there are still many mentally ill that end up on the streets. The homeless population in Spain is similar to other European countries (38). However, Spain's society has only recently begun to tackle the increasing problem of homelessness, and in the past has not put nearly enough consideration into mental illness and homelessness. Until the year 1999, there was no official definition of homelessness. This deficit had severe implications for the homeless, especially with regard to their relationship with society and to the law (38). The concept of a formal definition of homelessness is a simple notion in theory, but provides great help in organizing the many services aimed at improving the situation of the homeless. Spain now has such a has a clear definition of homelessness. By addressing the problem head on, Spain can continue to reduce the number of overall homeless individuals, and especially those with mental illness.

In Spain, many homeless persons undergo an extraordinary number of stressful events in the course of their life (38). On average, the homeless population in Spain faces on average nine important stressful life events that can often be detrimental to the physical, emotional, and mental health and wellbeing of those individuals. It has been found that the higher number of stressful life events also leads to weakened social networks, which further alienates the homeless and mentally ill from mainstream society (38). Stressful life events severely affect those with mental disorders, but even more so with people with severe mental disorder, such as schizophrenia. Homeless persons with schizophrenia have an even more negative impact from traumatic life events (38). Homeless persons are more likely to undergo an increased amount of difficult life events which also are increasingly more likely to influence their mental health.

Within homeless populations there are large percentages of mental illness. A study analyzing homelessness and mental illness found that homeless persons with schizophrenia range between 4% and 28.4%. There is also high incidence of severe depression, which ranges from 15% to 20%. These statistics are incredibly high compared to the general population, however, those living in homelessness have suffered a significant amount more than the general population. Often, the homeless have a lifetime prevalence of extreme poverty, poorer overall health, emotional and/or physical abuse, and lack of social networks, which explains the increased frequency of these mental illness disorders compared to the non-homeless population (38). The same study analyzing mental health and homelessness found that 18% of homeless persons had been previously admitted to psychiatric hospitals, which was surprising to researchers, as many experts thought the number was lower than they had expected. This could be due

to many factors, including the negative association of psychiatric hospitals, homeless persons not being able to access care, and lack of resources (38). The most prominent finding in this study was the significant prevalence of consumption amongst the homeless. In homeless populations, abuse and dependence with the consumption of any one drug, including alcohol, affected almost 50% of the homeless population (38). The average age of onset for a substance abuse disorder was 21 (49). Amongst this incredibly high statistic were many women. Researchers are finding an emerging group of drug-dependent young women in their thirties which is very similar to that of their alcoholic male counterparts. Many of these young women have children to support and end up turning to prostitution for survival (44). Homelessness and substance abuse are each strongly mediated by social, cultural, and situational factors. Alcohol and drug use continue to figure heavily in the experience of the contemporary homeless population (29).

In 2002, a study was done comparing alcohol and drug use in homeless populations in Madrid, Spain and Los Angeles, California in the United States (29). Comparisons between Europe and North America can suggest how national policy, differing social and economic context, and cross-cultural variation may influence the profile of the homeless population and the dynamics of homelessness (29). Overall, the study found that 36.5% of homeless persons living in Madrid had a lifetime prevalence of any substance abuse (29). Homeless persons living in Los Angeles had a 73.6% prevalence of any substance abuse (29). Of these persons, 28.3% of those in Madrid had an alcohol dependence compared to the 60.3% of persons in Los Angeles (29). In both cities, 80% of alcohol dependent homeless persons experienced symptoms of alcohol

dependence before having experienced their first episode of homelessness (29). The study also found that 12.8% of homeless persons in Madrid had a substance abuse problem of any drug except alcohol compared to 49.0% of persons in Los Angeles (29). In Madrid, all drug dependent homeless persons experienced drug dependence before their first episode of homelessness. In Los Angeles, 70% of homeless persons experiences their drug dependence before their first episode of homelessness (29). Lastly, the study found that persons suffering from dependence of marijuana, stimulants, PCP, and cocaine were higher in Los Angeles compared to Madrid (29). In each category, drug and alcohol substance abuse was significantly lower in the population studied from Madrid compared to the Los Angeles population. Also, the sample from Los Angeles had a significantly higher lifetime and 12-month prevalence of substance abuse, which could be due to the availability and popularity of particular drugs. Overall, persons in Los Angeles had more significant health problems, while in Madrid persons had more significant emotional problems. This could be due to the popularity of wine in Mediterranean countries, which has been found to be healthier and less damaging to one's health than other substances (29). This study was one of the first of its kind in Spain to compare substance abuse within homeless populations to another country. The study was extremely valuable as Spain differs greatly compared to the United States in many ways, including a national healthcare system, more familial support when it comes to those living with mental illness, and many other differences.

This study gave great insight into substance abuse amongst the homeless in Spain and the United States, however, there are many other factors that play into this study including national policy, social and cultural aspects thus the data of homelessness and

substance abuse cannot be assumed to correlate exactly between the United States and Spain (29). However, even with these differences, the data is still very useful because it gives insight into how substance abuse affects the homeless in each country.

Summary

Spain's focus towards the mentally ill and homeless is a relatively new campaign compared with that in the United States. However, Spain has already made great leaps in understanding the mental health of its citizens, in caring for those with severe mental illness, and in extending study further to understand the demographic completely. Although the programs in Spain are very strong in caring for the mentally ill, Spain has been lacking in informative campaigns about mental health in general and specifically directed toward correcting mistaken stigmatization of the mentally ill. The media in Spain very rarely feature stories regarding the mentally ill, and little work has been done to reduce the stigmatization of the mentally ill within the media (47). Spain is also lacking in promoting work integration for the mentally ill. As in other countries, the measures for the work integration and independent life of people with disabilities rarely reach the people suffering from mental illness (47). People in Spain make a tremendous effort to maintain familial relations for those with mental illness and persons with mental illness benefit greatly from having the support of their family, but often times these people have a low level of work integration which burdens the family. Having a higher level of work integration for those with mental illness would greatly benefit Spanish society. Overall, however, Spain is making great progress to support those with mental illness.

Stigma Toward Mental Illness and Homelessness in Spain

The World Health Organization and many other international organizations have identified mental illness stigma as one of the most important problems related to mental health in contemporary society (48). Currently, there are four main types of stigma identified. The first of which is public stigma, which is the process by which members of a population apply mental illness stereotypes and behave discriminatorily toward persons with mental disorders. Public stigma can make it difficult for persons with mental illness to get and/or keep employment, to have access to education, or to social and/or health services. The second main type of stigma identified is self-stigma. This occurs when those suffering from a mental disorder internalize public stigma, and begin to feel a lowered self-worth. The third type of stigma is label avoidance. Label avoidance refers to the way in which the psychiatric diagnosis determines the labeling of a person to society, for instance the labels "crazy", "useless", or "dangerous". The fourth type of stigma is structural stigma; this refers to the discrimination or lack of promotion by social structures towards persons with mental illness. Stigma also influences the potential of risk behaviors associated with social exclusion, self-punishing, etc (48). These four types of stigma all cause additional suffering to those suffering from mental illness.

Stigma is observed in three aspects of social behavior. One of which is stereotypes, which represent a general agreement about what characterizes a certain group of people, such as the beliefs of that group. Stereotypes are knowledge structures that are usually inappropriate or incomplete that are shared by most members of society, this is a cognitive facet of stigma. When stereotypes are applied, and one experiences negative emotional reactions, then social prejudices are manifested. Prejudices are

expressed in the form of attitudes and values that ultimately, can lead to effective discrimination. Discrimination is explicitly using action to follow through with stereotypes and prejudices. If stereotypes and prejudices are applied to those with mental illness, it places these persons in a situation of social disadvantage. This often happens in all societies, but especially in western societies. In western societies, research has revealed that stereotypes usually include information about the mentally ill's dangerousness and relation with violent acts. Negative stigma can also be attributed to society thinking that persons suffering from mental illness are responsible for the illness itself or for not having been capable of curing it by treatment, their weak character, their incompetence and/or incapacity to carry out essential tasks such as self-care, their unpredictable character and reactions, and their lack of control (47). This information is misguided and adds to the negative stereotyping, prejudice, and stigma associated with mental illness, as often times persons suffering from mental illness are incapable of doing any of the actions mentioned above (47).

When prejudices are activated, these beliefs can lead to reactions of fear, concern, and distrust which can trigger various forms of discrimination. This discrimination could lead to the mentally ill person having to cope with other difficulties in addition to their illness. Difficulties could include trying to obtain a job or trying to find independent housing. Discrimination can also lead to restriction in the mentally ill's social relations, such as limiting their social sphere to other persons with mental illness, or the deterioration of their access to judicial and health care systems (47). Stigmatization places people in situations of exclusion that obstruct social integration. This especially affects people with mental illness and their families, and also may be associated with

other psychological risks produced by the social exclusion such as self-excluding behaviors, risky behavior, cognitive problems, self-punitive behaviors (47). Stereotypes, prejudices, and discrimination associated with mental illness may deprive these people of the opportunities that may be essential for them to achieve their vital goals, especially those goals that involve their economic and personal independence (47).

In 2014 a study done by the Foessa Foundation reported that there are five million people in Spain affected by severe exclusion. This is 82.6% more than in 2007, the year before the lingering economic crisis broke out (40). The increase of those experiencing social exclusion Is a result of multiple factors in Spain, which makes determining the cause of stigma towards those people causing social exclusion difficult to pin-point exactly. Although, the homeless are part of the day-to-day landscape in Spain, most people have no idea what their lives are like or how they got there. Many homeless in Spain sleep rough or in shelters, ending up there after the result of numerous social, structural, economical, and personal factors (40). The 'traditional' homeless people now share their condition with new and diverse types of homelessness forming a continuum of processes and trends of social inclusion vs social exclusion (44). Amongst the homeless population, homeless women especially suffer from extreme cases of social exclusion, which are often caused by stigma. These women's life circumstances are the result of a complex intertwining of experiences, deficiencies, failures, frustrations, and difficulties which lead them into a tunnel of vulnerability at the end of which they find themselves living on the street (44).

In Spain, women hold a high role as the main familial component. The stigma associated with not filling this role, takes a devastating toll on the emotional and mental

health of women. Both conceptually and analytically, the problem of homelessness among women falls within the logic of social exclusion processes and the emergence of a 'second-class' citizenship (44). Homelessness among women involves a condition of social isolation and uprooting which is representative of the paradigm of negative individualism (44). Many Spanish women when forced into social isolation feel unable to regain their place in society as well as in their family. Homeless women are left outside of their normal social realm, they are linked to elements of social deviation, victims of social segregation and associated with a strong component of social stigmatization (44). Stigma is a huge contribution to social exclusion, as many individuals feel the hardships of the physical aspects of homelessness as well as the emotional aspects of social exclusion that homelessness brings.

Part of social exclusion is derived from the language used towards those that are homeless and/ or suffering from mental illness. Homeless persons in Spain use to be referred to as 'vagabonds' and 'idlers', however, many advocates have considered it necessary to redefine these terms in order to suppress the element of social stigma. Many advocates for the homeless populations throughout Spain emphasize that in order for stigma to lessen, the negative connotation of the word 'homeless' must also be reduced. Some advocates prefer the word transúnte, 'transient', which is equivalent to vagrant in English but without the negative connotation (38). The term 'transient', it is defined as a man or woman who roams from place to place, from one institution to another, with no possessions other than those he or she carry with themselves, and who keeps looking for work or help with the only aim of short term survival. However, after the most recent economic crisis in 2007, homelessness began to rise and those suffering from

homelessness became more than ‘transient’ persons, the population now has new characteristics and new profiles. Thus a new conceptualization of the phenomenon became imperative, and the terms ‘homeless’ and ‘roofless’ were introduced to refer to the new types of marginalized social groups. (44). The significance of the word transúnte refers now to people who are poor and marginalized that either use services such as hostels or live without roofs (sin techo) or homes (sin hecho) (38). In the past, many words have been used to describe the reality of homelessness, but do not actually define a homeless person. These words include: mendigo (beggar), vagabundo (bum), and carrilano (traveler) (38). These descriptors all have negative connotations and many organizations throughout Spain have begun campaigns against the use of these types of disparaging and humiliating terms in this context (38). Private businesses have also reached out towards the homeless in the forms of hostels. Hostels in Spain provide living arrangements which include showers, hot meals, and clean clothes (39).

Using negatively connoted words not only increases stigma, but it also restricts the help that organizations and society can give to these people. If homelessness is looked at as strictly lacking a home, then the issue is being analyzed in an extremely restricted fashion. Solely viewing this as lacking a house relates to housing prices, fiscal policies, home rental policies, income distribution policies, pensions and other types of social benefits, and to welfare regulation which provide access to housing (24). However, the issue is much more complicated than that. Other structural factors must be taken into consideration, such as employment policies, equal opportunity policies, social policies for vulnerable groups, educational policies, vocational training policies, immigration policies, etc. Homelessness is a multidimensional problem. Using structural

factors, family/relational factors, personal factors, and cultural factors it is possible to see how homelessness reflects with social inequality as well as relational elements and personal matters (44).

Stigmatizing attitudes may vary depending on the situation in which stigma is being used. For example, it was found in Spain, that psychosis seems to show more stigma attitudes than cancer and depression, but less than cocaine addiction and AIDS (47). Both the Attribution Theory and The Responsibility theory models are important explanation of the stigma present towards those with mental illness in Spain (48). The attribution theory is the perception of the dangerousness of those with mental illness. The attribution of dangerous behavior to a person leads to the emotion of fear, which leads to apprehensive or avoidant behavior towards persons with mental illness (48). The responsibility model identifies two pathways of functioning. The first is as follows: if it is thought that the person is responsible for or has some control over the disease, then the person observing facilitates attitudes of anger and punishment, or repression. If the attribution considers the person as a victim of the disorder, or deems the disorder uncontrollable, then the main attitude towards that person will be of pity (48). A study done in Italy, the United States, and Spain showed that the perception of dangerousness of people with mental illness is directly and positively related to fear, and thus the avoidance of persons with mental illness (48).

An outcome of societal stigma towards the mentally ill and homeless is internal stigma. Internalized stigma is considered a risk factor for poorer mental health prognosis (46).

Higher levels of internalized stigma are associated with higher levels of depression and psychiatric symptom severity and lower levels of self-esteem and recovery oriented mindset (46). Internalized stigma, also referred to as self-stigma, is characterized by a subjective perception of devaluation, marginalization, secrecy, shame, and withdrawal from society. Internalized stigma has a variety of adverse effects including: profound psychological adversity, demoralization, hopelessness, lowered self-esteem, reduced self-efficacy, impaired social adaption, unemployment, income loss, reduced psychiatric medication adherence and limited social support. (46)

Mental illness like other human conditions, involves a process of stigmatization (47). This stigma can significantly reduce utilization of mental health care services, reduce quality of life and increase avoidant coping. People with mental illness may also suffer from a series of social reactions that have a negative effect on their well-being, adaptation, and social integration. These consequences derive from the connotations associated with the term mental illness and from the attitudes it arouses in the general population. These consequences are especially seen in people who should be at the forefront of collaboration in the integration of those with mental illness, or those dealing with homelessness. These people include, but are not limited to: landlords, employers, educators, neighbors, etc (47).

Most of the stigma relating to those with mental illness are associated with a lack of knowledge about the mental illness. A study done in Madrid in 2004, "Schizophrenia Opens the Doors", revealed that only 17% of people served from the general population had heard of or read some news about schizophrenia in the last 6 months, while 83% knew nothing about the illness and one third of the surveyed people did not know the

origin and cause of the disordered thinking and 44% thought that schizophrenia was not a curable illness (47). Stigmatization of people with mental illness is found more in people with lower education level (47). The most revealing fact about knowledge of mental illness is the high degree of confusion between this type of disorder and mental retardation in the general population, which suggests that educational and informative campaigns about this topic should focus specifically on the differentiation between mental illness and mental retardation (47). There is a need to widen the attention of the public towards the mentally ill by not only considering the symptom of mental illness, but their social needs as well (47)

Spanish society is very well integrated. This can be seen by the high rate of inclusion towards homeless populations. Studies from a few autonomous regions of Spain suggest that the percentage of socially excluded is around 4% of families and 3% of people in the country as a whole (38). It would therefore appear, that Spanish society by comparison with Europe in general, is relatively well integrated. There are many reasons and factors that can explain why poverty and homelessness in Spain are not reflected by high indices of marginalization. One of the factors is the stigma towards the family seems lower in the Spanish general population than in the American sample found from a study done in Spain in 2006 (47).

Many of the factors relating to the integration of the poor in society revolve around the familial and social dynamic in Spain. There is a high value of family serving as a coping mechanism and resource to those undergoing difficult times. Thus many families take in homeless family members. Normal familial traditions also favor children staying at home, with their parents, until an advanced age. This tradition allows many

youth to become financially stable before they move out, and does not pressure youth to leave the house at a premature age which could lead to economic hardship, emotional issues, or mental illness. Many people throughout Spain co-inhabit, 2 out of 3 unemployed persons live in family settings where at least one other person is working. This is the highest proportion of unemployed persons living with others in all of the European Union (38). Very few persons in Spain live alone, thus this reduces societal stigma, as the more people living with others due to economic or other circumstances, the less stigma associated with these conditions. In Spain, only 10% of homes are single-occupant (38). Of those homes, only 3.6% of single occupant homes is there an adult under 65, which indicates that most people that live alone are the elderly (38). To compare, the United states has about 23% single occupant homes and France has 25% single occupant homes (38). Familial ties contribute largely to the reduced social stigma of homelessness and poverty.

Summary

Housing, education, and employment are the most important factors of social integration/exclusion (38). When someone does not have access to these factors, a stigma from society often exists. The stigma that goes with people without home makes a communication strategy necessary in which the means of communication have a decisive role, carrying out a relation based on positive concepts, and introduction of centers and services to help those suffering from homelessness (39). The director of Shelter Sostre, Gloria Garcia, in Barcelona believes that everyone has set principles, the homeless too, and that only through a personal friendly relationship can you grant concessions on these principles, and out of it learn another dimension of reality. Garcia

explains, “Let’s say you are certain you would never in your life spend money upon going to the opera. But if your mother’s greatest dream is to take you to the Opera House you would dress up and go. With a homeless person something similar happens. When there is a mutual friendly relationship built they become more cooperative. Gradually, they drink less because you ask them to do so, and end up realizing they are living better lives, which enhances their self-esteem” (41). Only once stigma and negative emotions are removed and instead replaced with compassion and empathy then the can the homeless reenter society with a sense of purpose and self-esteem. Homelessness constitutes both a social and a personal problem embedded in the dynamics of social exclusion and linked to the interplay among structural, family/relational, personal and cultural elements (44).

Homelessness and Housing in Spain

Number of Homeless in Spain

"On the street I feel vulnerable, so inferior. You lose your dignity and it's hard to get back. I want out of this" – Miguel Arregui, a homeless man waiting to go into a shelter in downtown Malaga, Spain for the night (40).

The most recent count of homeless people in Spain, such as Miguel, was done in 2012 by the National Statistic Institute (INE). This was the first great effort made by Spain to determine how many people were homeless, other efforts have been done since, but this estimate was the first of its kind to collaborate with all autonomous in Spain to obtain the most detailed count. In 2012, 22,929 homeless people in Spain were counted, which corresponds to 0.05 percent of the population (45). However, it is extremely difficult to determine the exact amount of homeless living in Spain, as many social organization that work with and provide services for the homeless put the number of homeless more at 40,000 (40). These numbers refer to the true homeless in Spain, however many people in Spain are suffering from housing insecurity and are at risk of becoming homeless. In 2014, approximately 20.4-27.3% of the population of 47.2 million live below the poverty line, depending on what European Union parameter for the poverty line is being measured (40). Spain has only very recently began looking at the population dynamics of the homeless, and the country is still determining the best method for estimating the number of people living in homelessness within their country, and how that statistic compares to other countries in the European Union.

The different methodologies used to determine these estimates and the diverse definition of homelessness currently in use make determining the amount of homeless

difficult. Thus the low numbers of homelessness in Spain is due to the methodological factors and not the social reality (45). Collaborating with other European countries and their methods adds to the difficulty of determining the homeless. For many countries, it is very difficult to determine how many homeless persons exist, and thus many countries result to easier methods of determining the homeless. Some countries do not count those 'sleeping rough' and just count those housed in shelters, whereas other countries try to include everyone, even those precariously housed in abandon buildings and under bridges (45). There are ongoing obstacles to determining the extent of homelessness in member states within the European Union (45). Literature on homelessness in Europe is only recently beginning to emerge despite growing recognition that homelessness is an increasingly troublesome social problem in European countries (29). Spanish government's interest, although recent, has gained valuable insight into the homeless populations.

The interest in the homeless population in Spain began in 1999. Before 1999 there were no statistics or even estimations on how many homeless were in Spain (38). This interest started the documentation of those living in homelessness as well as the services they used. In 1999, they began estimating how many people were suffering from housing insecurity and homelessness. It was found that 11,000 people used hostels each year (38). In Spain, when someone is unable to afford a house, hostels are a cheap alternative. This is similar to hotels and motels in the United States that homeless people sometimes use, but at an average of 7 euros a night compared to 60 dollars a night in the United States (38). This original study also found that over a 150,000 people in Spain had urgent housing needs, but were not considered truly homeless (i.e. living with friends

or family) (38). The study also estimated that in 1999, 80% of the current homeless population had been so for more than a year, and between 30% and 40% had been for more than 5 years (38). This research was the pilot for even more studies to come in Spain.

Overview of the Homeless

Like the United States, homelessness in Spain is a complex issue. The situation of the homeless is the result of multifaceted interactive factors such as large scale socioeconomic factors, housing policies, unemployment, social welfare policies, and immigration policies. The situation of homelessness is also the result of personal vulnerability, such as traumatic or stressful life events, support network variations, critical situations, illness, and mental health, that may make some individuals more susceptible to becoming homeless than others (38). Poverty is not the only outstanding factor for homelessness. In Spain, it is incredibly important to look at more factors than poverty, as poverty is not the only determinant. There are many extremely poor people in Spain, that appear to have a similar level of economic resources as the homeless. A small portion of the severely poor actually become homeless, approximately 6.5 persons per 1000 persons in extreme poverty become homeless (38). A huge factor for the poor is that if they do lose their economic security, and lack the familial support or the emotional and mental support in which to cope, they are at risk for homelessness. Thus, although poverty and high unemployment are large factors in becoming homeless, they are only some of the determinants for becoming homeless, with larger issues being found within social relationships and one's own health. It is apparent that homelessness is the result of

the cumulative effect of financial stress, economic downfall, and many other critical issues.

The Working Poor; Road to Homelessness

David Cerezo, a homeless man waiting to be served lunch by a humanitarian organization in Malaga, Spain, writes: "It is easy to end up on the street. It's not because you led a bad life; you lose your job and you can't afford to pay rent" (40). However, Cerezo also mentions the other factors that contribute to many people's lives on the streets, "some of those who ask for food at Malaga Angels of the Night (Angeles Malaguenos de la Noche) have ended up on the street because of drugs or alcohol, but there are also parents coming for food for their kids, and very young people who need help" (40). In this statement, Cerezo makes an excellent observation, there is not one aspect of society that creates homelessness; it can happen to anyone, via many different routes. There are many people in Spain on the verge of homelessness, or on the verge of poverty. Having a job in Spain does not guarantee a life free of poverty (40). In 2007, the proportion of working poor in Spain was 10.8% which rose in 2010 to 12.3% of the population according to Dossier de Pobreza EAPN España (40). Dossier de Pobreza EAPN España is sponsored by the European anti-poverty network, and conducts reports on poverty in Spain (40).

The line between homelessness and poverty in Spain is a point of study for researchers in Spain. The poverty gap in Spain is defined as the percentage difference between the poverty risk threshold and the average income of homes under this threshold (45). The poverty gap in Spain rose from 26.4 to 31.4 between 2006 and 2012, whereas in Europe it rose from 22.1 to 23.4 percent (45). The amount of the children also living

on the verge of poverty has increased, 27% of the country's children (more than 2.3 million) live in or on the verge of poverty according to the United Nations Children's Fund, UNICEF (40). This reflects how deeply Spain was affected by the economic crisis. With the poverty gap growing, there is a greater likelihood of losing access to housing. There is a close relationship between access to housing and the risk of social exclusion (45). Once someone is exposed to severe poverty they are more at risk for homelessness, which lessens their social access and leads to other difficulties.

Common causes of homelessness

Homelessness is a multi-causal phenomenon, and it is far from being a solely economic factor, even though for many people economic crisis and financial instability contribute greatly to their hardships (38). The most common causes of homelessness in Spain fall into four groups, material, affective, personal, and institutional. The material group relates to economic variables and the factors that relate to poverty. Spain's severe recession and high unemployment rate have impoverished many people within the population. Spain's unemployment rate is approximately 25%, according to the National Statistic Institute, compared to approximately 5% in the United States. A high unemployment rate not only directly impoverishes those struggling to stay off the streets, but it also reduces government budgets for social services for the poor (40). The second, the Affective Group, associates variables related to loss of social support and breakdown of social networks (38). The loss of social networks has a huge impact as a cause of homelessness. There is evidence that deterioration of social structures is worsening, as residential exclusion increases. The strong impact of the recession on living conditions in Spain, especially for those with lower incomes, and the stream of mortgage foreclosures

over the last few years suggest that Spain will be facing increasing homelessness (45). The third major predictor of homelessness is physical ailments. This grouping of physical and/or mental illnesses is generally intertwined. Having a disability or an addiction causes many to become homeless, which further increases their risk for mental illness, or furthers the progression of their already existing mental illness or physical illness. Many homeless persons tend to have many occurrences of stressful life events in the period either before or in the transition to the first situation of homelessness, which then worsens their mental health (38). The final grouping is institutionalization: if someone has been in any type of institution during their lifetime, they are more likely to end up in a homeless state (38). These groups contain the main causes of homelessness, each contributing in a unique manner to the homeless population.

Surveying the Homeless

It is only recently that Spain has developed an interest in learning the demographic of their homeless population. As elsewhere, it is a challenging problem. Currently, Spain uses the National Institute of Statistics (INE) to collect information on the homeless. The INE is the only body that produces quantitative data on homelessness. The INE conducts The Survey of Homeless People and the Survey on Support Centers for Homeless People in Spain. For example, these surveys collected data from care facilities in towns of more than 20,00 inhabitants from February 13 – March 25 in 2012, . These dates were chosen because they correlated with the highest demand for housing and food services (45). A similar approach is taken in the United States in conducting a yearly count of the homeless during the last week of January. In the Spanish survey of 2012, persons 18 years or older were asked if they had stayed at a support service within

that week, or the week prior to the survey, with a support services being defined as a shelter or residence, women's refuge for victims of sexual violence, center for refugees or asylum seekers, a flat provided by the public, an NGO or other organization, occupied flat, hostel or hotel paid for by a public body, a public space or non-conventional dwelling not meant for human habitation (45). This method is, again, very similar to the techniques used in the United States. By surveying shelters and other organizational housing for the homeless, it is easier to determine their demographics. However, by their nature, these surveys underestimate the actual number of homeless persons living in the country because they do not account for those that do not have any contact with the services provided above (45). The United States also struggles with the problem of not reaching all of those living in homelessness. Nonetheless, the INE studies have given the Spanish government invaluable working information on the approximate number of homeless (in larger cities), and the demographic of these individuals.

On a smaller level, the city of Barcelona conducts its own study of the local homeless population annually. For this reason, Barcelona has the most accurate and detailed data of the homeless in Spain. The city chooses March 11 to do a single night count, a method very similar to the 'single count' technique in the United States. In this manner, the city of Barcelona found that between the years of 2005 and 2012, there was an increase from 10,632 to 14, 681 in the number of people using support services. This increase in number implies an increased pressure on the local organizations and social services agencies tasked with responding to this need (45). It also relevant to note that because this time coincided with the financial crisis, more people were in need of social services at precisely the time that there was less government and private funding

available. For now, the points to be made are first, the need for sequential surveys, in that, for example, the 2014 national and Barcelona studies showed a decrease in the number of homeless people, and second, the importance of cities learning from each other to determine the most efficient and accurate survey methods. As an example here, the city of Madrid also conducted a survey of its homeless population in 2012. Like Barcelona, Madrid utilized the method of relying on services already being provided, however, they went one step further. In an effort to reduce the underestimation of homeless people inherent in this method. Madrid organized nearly 1,000 volunteers to walk through the streets of the city to survey and interview the homeless. This study was important because it was the first of its kind to actually count those who were sleeping/living in public areas and thus identified those who were not being helped by support services. Of those found on the street, 43% were found awake and 69% of these people agreed to be interviewed concerning the common services that they used. The most common service identified was soup kitchen, however, only 26.8% of people interviewed actually utilized any social services. Thus this survey clearly demonstrated how markedly social services are failing to reach those actually living rough on the streets, with the survey method itself suggesting ways in which social services in Spain could effectively reach all those without a home. The survey also demonstrates that if the most popular service was only used by 26.8% of people, then the INE's survey cannot possibly quantify the true extent of homelessness in Spain (45). Clearly, there needs to be a more efficient and accurate way of assessing homelessness in Spain, a finding congruent with the experience in United States where our surveys as well consistently underestimate the amount of homeless in the country.

Profile of the Homeless in Spain

In Spain, as in the rest of Europe, homelessness has been an essentially masculine phenomenon. For example, the majority of the homeless in Spain between the ages of 31-45 are male (38). In the last decade, however, new social groups have appeared among the homeless, notably young and middle aged women (44). Garcia, a supervisor for an extremely successful homeless shelter in Barcelona, describes the demographic of the homeless in Spain: "The average Spanish homeless person has no family ties, a poor education, a certain psychological profile of emotional instability, and is a victim of unemployment. Most are young or middle aged men, although more and more women are entering this group now, as well as immigrants from North Africa". This definition of the profile of the homeless in Spain is extremely vital as it emphasizes causes of homelessness other than drug dependence or poor life choices (41). Garcia emphasizes the relatively new phenomenon of homeless women in Spain, and describes the wide variety of sociological profiles in this group. In 2014, the predominant sub-types of homeless women in Spain were the following: young and middle-aged divorced or separated women; victims of abuse; young or middle-aged drug-dependent or previously drug-dependent women; women who had been institutionalized in closed facilities, including prisons and/or hospitals; young university students; squatters; women suffering from mental illness, personality disorders, and/or other mental disability; and immigrant women (44). In recent years, increasingly more young people are being drawn into homelessness as a result of the new dynamics of employment and difficulty in gaining access to housing (44). Thus there is an increase in young university students becoming homeless due to the lack of opportunities in Spain for them following university. There

is also an increasing presence of women amongst the excluded, marginalized population (44). Thus, although, the main demographic of homeless in Spain remains middle-aged men, more and more, women are included as well.

Homelessness in Women

In 2014, homelessness affected approximately 3,000 women in Spain (44), representing between 11% to 19% of the total homeless population in Spain. These numbers represent a rise in women living in homelessness. This has deeper significance because homeless people are not only affected by the lack of a fixed place of residence, but also suffer from their lack of participation in society. These shortcomings particularly include the lack of involvement in community relations that are constituted within the framework of a household (44). In Spain, women are the essence, the vital core of the household. The household is centered around the woman. The household constitutes the main source of strong feelings of a woman's feelings of confidence and appreciation (55). The experience of homelessness is thus even more devastating for her.

Both for cultural and ideological reasons, the situation of homelessness gravely affects woman as they have lost their emotional refuge within the household. The home is a social niche for women, a place where they can take haven and organize their network of interests and relationships. This niche allows women to build their own identity both as women, and as a vital aspect of society (44). Homelessness strips women of this identity.

Spain, like many Mediterranean countries, has a strong association with family. Family tends to intervene more frequently when a member becomes homeless, especially in the case of women. Families intervene more frequently with women becoming

homeless than they do in the case of men because of the basis of the Spanish family dynamic. Also, families tend to intervene more frequently because women do not enjoy full political, social, and civil rights compared to men, and often may be categorized as 'infra-citizens' (44). This is especially seen when women fall into homelessness. The increased rise of women living in homelessness and serious implications that coincide with this situation are a definite concern; indicating a grave unraveling or failure of social ties.

Social Exclusion of the Homeless

As noted above, homeless people suffer from severe deficiencies stemming from lack of participation in the community relations established within the framework of a household (44). This is manifested clearly in the studies above of homeless women in Spain. However, lack of social relationships also affects homeless men as well. A study done in 2010 in Barcelona revealed that the homeless who were suffering severe forms of social exclusion had faced repeated obstacles throughout their lives. These obstacles include problems in accessing dignified housing throughout their lives because of their low financial capacity and lack of family support and patrimony (45). For women, the female path to social exclusion is most often associated with previous household violence and conflicts with their former partner. For men, social exclusion is often most related to lack of resources, unemployment and poor health (44). Although the cause of social exclusion may differ, the outcome of social exclusion remains the same – poorer mental health.

Many factors add to the social exclusion of the homeless, such as education level, lifestyle choices, and societal factors. Homeless persons tend to have a low educational

level, equivalent to the primary level that is obligatory in Spain (38). Lower educational level adds to social exclusion: the homeless are not likely as well informed, and have less access to good jobs. Without this access to information and good jobs, because access to housing often is difficult without proper resources (39). With regard to lifestyle choices, many homeless tend to live alone; many have undergone experiences of institutionalization in prison and/or psychiatric hospitals. Some studies have found that as high as 30% of homeless in Spain have undergone some sort of institutionalized experience. After these experiences it is especially difficult to get back into society and thus social exclusion is seen even more. Thus there are multiple reasons and origins for homeless persons becoming social excluded.

Social exclusion also plays a role in health care. Although Spain has universal health care, it is apparent that access for the homeless is not as comprehensive as it could be (38). This is seen by the high indices of many diseases within the homeless population. Incidence of both AIDS and tuberculosis is very high, compared to the normal Spanish population and to that in the homeless populations in other countries (38). A possible explanation for this phenomenon is the large immigrant component within the homeless population in Spain; immigrants do not have access to Spain's universal health care. It can be seen as an extension of social exclusion into health care.

A poignant description of the impact of social exclusion on the life of the homeless again comes from Garcia, a supervisor of a successful homeless shelter in Barcelona (mentioned above) She explains that one of the main reasons that they cannot reach the primary public network is precisely because they have slipped so low on the social ladder. "The homeless have moved so far to the margins of society that they have

more or less ceased to exist in bureaucratic terms, are not registered as citizens, and therefore do not, or cannot, receive help from social services. If they do get help, it is limited and short-term. They don't receive long-term follow-up assistance" (41). Thus one of Garcia and this shelter's largest concerns is to restore this sense of social dignity. Garcia wants to "restore [the homeless] not only to nourishing food, hygienic habits, and better health, but also socializing skills so that they can enter a wider society" (41). This concept is extremely important in order to give the homeless integrated into society.

Comparison of the Homeless Between Madrid and Los Angeles

Studying homelessness in different countries provides valuable information. Such comparisons can be difficult because of differences in sampling methodologies and levels of intensity. Conceptually identical issues can be measured with a number of different research instruments, and the definitions of homelessness, mental health, substance abuse, exit from homelessness and other variables can differ from country to country. (29). Nonetheless, it remains a worthwhile endeavor, as seen in a 2002 study of homelessness in two large metropolitan cities in the United States and Spain, namely, Los Angeles and Madrid. In this study, the researchers wanted to analyze different aspects of homeless using identical definitions of homelessness. Researchers of both cities defined homelessness as: an individual having spent at least one night in the last 30 days in a setting either defined as a temporary shelter, an uninhabitable shelter, or an institution providing temporary living accommodation (29).

The study found many interesting differences between the homeless population in Los Angeles and the homeless population in Madrid. The study found the percent of homeless living in Madrid on any given day was 0.07%, and 0.65% in Los Angeles (29).

In the Madrid sample the average age was five years older than in the Los Angeles sample, being 42 years old as compared to 36 years old (29). The Los Angeles sample was found to be better educated, with an average of 11.5 years of schooling in Los Angeles compared to 8.4 years in Madrid (29). The lower average years of schooling in Madrid could be attributed to the compulsory age of schooling in Spain being 14, compared to that of 18 years in the United States (29). Also found was that more of the Los Angeles population were employed at the time of study: 30% employed in Los Angeles compared to 7.5% in Madrid. The higher level of employment in Los Angeles can be attributed to the unemployment rates in each city. In 2002, the unemployment rate in Madrid was 20% compared to 8% in Los Angeles. The study also found that the age of the first episode of homelessness was lower in Los Angeles at an average age of 28.9 compared to an average age of 34.9 Madrid (29). The higher age in Madrid can be attributed to the stronger familial ties within Spain and can also be attributed to youth staying in their parent's house for a longer period of time in Spain compared to the United States. People in Madrid could be experiencing homelessness at later ages because the age at which young adults are expected to be living independently of their parents and supporting themselves is much older than in the United States. The average age of emancipation of Madrid is 28.5 years old (29). The comparison between these two highly populated countries is extremely interesting. Many of the differences such as average years of education, employment rates, and average age of first episode of homelessness are heavily correlated to each country's national policies and societal expectations.

Housing First/RAIS Model

Similar to the United States, many organizations throughout Spain promote the Housing First model. The RAIS Foundation is one of largest organizations in Spain to help the homeless, this organization also supports the Housing First model in Spain. This approach focuses on moving homeless people immediately from the streets or shelters into their own apartment based on the concept that their first and primary need is stable housing (40). The RAIS Foundation especially targets those who have spent at least three years living on the streets, or those suffering from mental illness, drug use, alcoholism, or who have disabilities (40). Jose Manuel Caballol, the director of the RAIS Foundation speaks to the benefits of the Housing First model, and the goal of the foundation. "The results of [Housing First] are spectacular, the people are so happy, they take care of their house and of themselves because they don't want to lose what they have" (40). Caballol also mentions the struggle that those with mental illness face when trying to obtain housing. "Those with severe problems have a hard time gaining access to homeless shelters, supportive housing, or pensions, and that even if they do [obtain services] they fail to move forward with their rehabilitation or end up being expelled from the system once again" (40). The Housing First model that is used by the RAIS Foundation and many others was is modeled after the United States. Caballol states that the Housing First model "offers a definitive solution to the problem of homelessness and spells out significant savings in costs for the State, such as Hospital care, for example" (40). The RAIS Foundation also stresses the importance of the role of social workers, psychologists, and experts in social integration who listen, support, and assist the beneficiaries of the Housing First project (40). The integration of many different professionals is critical in order to help the homeless not only transition to stable housing,

but keep such housing. The model also focuses on determining what the homeless themselves want and need and the RAIS Foundation promotes a cohesive effort.

Potential Solution to Housing for the Homeless

As many countries struggle to find a solution to housing their homeless population, Spain has found a potential answer in vacant houses. In 2014, 3.4 million homes were vacant in Spain, which is about 14% of the total housing stock in Spain. This is enough houses to provide homes for every single homeless person in the entire European continent (42). Spanish officials are looking into using vacant houses as a potential solution to house the homeless. Currently, hostels play a large role in helping the homeless, they service as rehousing centers. Spain takes advantage of this cheap housing solution. All hostels include at least canteens and washrooms, and possibly clothes or first aid. Some hostels even provide legal and/or social services (38). However, Spain would like to transition into a more permanent solution than hostels. Caballol, the director of the RAIS foundation stated that "the system could use a turn of the screw, to provide permanent and unconditional housing, in the first place", advocating for this transition (40). Using vacant houses and transitional teams to help the homeless reenter society is the current idea being promoted by Spanish officials and service organizations.

Summary

The problem with homelessness in Spain remains, and is being critically looked at by many Spanish officials, even though the problem is significantly less than many European countries and especially compared to the United States. Miguel Arregui, a 40 year-old homeless man describes homelessness in Spain in this manner: "you find

yourself in the street because you don’t have anyone to turn to, and once you’re there it’s really hard to take flight again” (40).

Incarceration and Criminalization of the Homeless in Spain

The phenomenon of incarceration and criminalization of the homeless in Spain has both similarities and differences to comparable policies in the United States. Like the United States, Spain has laws against public intoxication, begging, and occasionally, camping. However, these laws are generally more lenient, and rarely result in incarceration; when prison sentences occur, the length of stay is significantly less. Unlike the United States, loitering laws are practically non-existent. Thus, although there are still instances of the homeless being sent to jail or fined, it far less common than in the U.S. There is a similarity in the form of laws which target specific groups, albeit indirectly. Thus, Spain also struggles with criminalization of the poor and homeless.

In the years following the "Dictator Rule" under Franco, Spanish society seemed to make every effort to distance itself from this mode of conduct. Spain became one of the freest countries in Europe. For example, The 'Law of Social Dangerousness', that criminalized homosexuality, political dissidence, homelessness, as well as other social groups, was abolished (50). Since Franco's regime, policing for the cause of 'public order', which generally affected the poor, homeless, and socially different, ceased (50).

However, as a result of the financial crisis, there has been a significant increase in the number of homeless people in Spain (52), and increased strain on Spain's social institutions. Hence, many of the once valiant Spanish laws, have slowly changed back to stricter sanctions against the homeless. In summer of 2012, as part of the 'Poverty is Not a Crime' Campaign, the Housing Rights Watch conducted a survey of national laws that penalize and/or criminalize the behavior the homeless. Legal experts prepared reports by country describing the nature of anti-social behavior laws, as well as other regulations

that affect homeless people (52). This data can support the view that the increase in the number of homeless people brings with it a need to provide better protection to people in such vulnerable situation, rather than more penalizing consequences (52).

The Homeless and Incarceration

Under Spanish Criminal Law, there is not any provision that prevents people from begging in public spaces, because homelessness is not directly criminalized from a strictly criminal law perspective by the Spanish National Government. However, the Spanish Criminal Code prohibits the use of minors or disabled people to beg. The prohibition on using minors (children) or disabled people to beg is intended to prevent the exploitation of children and the disabled (52). This has been a controversial law, because it can be unclear whether the child is being used, or whether the child is simply with his or her parent while the parent attempts to beg for money. This is the only national law in Spain, however, that directly affects the homeless.

The majority of the criminalization of homelessness in Spain comes from local regulation, namely ordinances. Many municipalities in Spain are very concerned about the issue of the visual homeless (52). Examples of these ordinances can be found in large cities such as Madrid or Barcelona, as well as many others. A Municipal Ordinance of Madrid bans camping within the city and establishes the obligation of taking the homeless to municipal shelters (52). According to a Municipal Ordinance of Barcelona, any conduct or appearance of homelessness in organized forms or associated with harassment that can impede the free transit of people within the public spaces is forbidden (52).

Municipalities do not forbid homelessness, but instead criminalize homeless

people indirectly. Certain municipalities can directly criminalize homelessness by preventing homeless people from begging in public spaces and imposing a fine that is disproportionate to their economic status (52). Many municipalities, such as Madrid and Barcelona, use nuisance ordinances to regulate the homeless. The Nuisance Ordinance of Madrid has a clause that prohibits the manipulation, rummaging and extraction of leftovers within containers of supermarkets located at the streets. This entitles the Local Police to remove the belongings of homeless people and fine them. Similarly, in Barcelona, the Municipal Ordinance of Use of Public Areas of Barcelona contains provisions similar to that of Madrid. Barcelona's ordinance also prevents people from being in public spaces without fulfilling minimum conditions of personal hygiene (52). These ordinances are specifically discriminatory to the homeless, in that the homeless are the most likely to be unable to access showers, etc.

It has been shown that homeless people are overrepresented in both arrest rates and prison population statistics (51). However, there is still minimal data as to whether these high arrest rates and prison population statistics reflect the effect of previous incarcerations, or if they are the direct result of simply being homeless. There are many factors contributing to this statistic. Some researchers believe that these high incarceration rates are the result of the homeless having a criminal disposition and that this disposition is also a cause of their homelessness. Other researchers disagree and have evidence that this high rate is demonstrably the result of the action of legislators! These researchers have found that the condition of homelessness may result in homeless people engaging in "strategies of survival", which are often illegal (because of the ordinances mentioned above) and hence generate higher arrest rates amongst homeless

people (51). Although the causes of high incarceration rates of the homeless remains unclear, it is apparent that many laws in Spain specifically target the homeless population: as such, they raise questions with regard to both justice, and with regard to their own effectiveness.

Incarceration of Homeless Immigrants

The largest group incarcerated in Spain are immigrants, and a large number of these are homeless when they are incarcerated (51). In the 2005, the Homeless People Survey was conducted by the Spanish National Center for Statistics which found that 48.2% of homeless people in Spain were of foreign origin, while the foreign population accounted for only 8.46% of the total population in the 2005 census (51).

One of the largest and most controversial issues in Spanish society pertains to immigrants, especially the homeless immigrants (51). The 2003 survey of Services for Homeless People determined the population group that was most frequently assisted were immigrants. This survey found that services for homeless immigrants accounted for 58% of the total services in Spain (51). In 2008, the same survey of Services for Homeless People found that this percentage grew to 62.7% of total services (51). The demographic of homeless foreigners is very diverse. The 2005 INE survey found that of the homeless foreigners, 43.6% came from Africa, 37.5% from Europe, 14% from South America and 4.6% from Asia (51). The largest groups in Spain however, are from Romania, Morocco, and Poland. This diversity of homeless immigrants makes it extremely difficult to find appropriate services, as each person has different needs, and each culture has different priorities and customs. According to the same survey, 59.4% of homeless foreigners have been in Spain for less than three years (51), demonstrating that there is a constant

influx of new immigrants into Spain. In the 2008 one night-time count of homeless people, foreigners accounted for 53% of the total homeless population in Madrid and for 62.2% in Barcelona (51). Therefore, it can be concluded that there is an increasing number of immigrants to Spain among the homeless. In that this group of people are excluded from social resources, because they are considered non-persons under Spanish law, they do not have access to many of the rights of the Spanish people (such as health care).

Effect of Prison on the Homelessness

Homeless people are at increased risk for incarceration and release from jail or prison leaves a person particularly vulnerable to an episode of homelessness (52). Thus, homelessness can be seen as a cause and/or consequence of incarceration, since release from incarceration, together with eviction and family disintegration, are key causal factors in homelessness. Long periods of incarceration can be the precursor to evictions and the breaking of family or spousal ties (52). There are a number of pathways into homelessness and a variety of complex relationships between homelessness and the commission of a crime, and between release from prison and entering a cycle of homelessness, crime and re-offending behaviors. For some, homelessness contributed to their offending behavior through the criminalization of certain behaviors such as public order offences, like being drunk and disorderly and begging. The adoption of criminal behavior for street survival, and the development of addictions to cope with the isolation, insecurity and difficulties of being homeless cause many homeless to be incarcerated. For others, it was criminal behavior that led to homelessness, most crucially because the nature of the offences for which they were imprisoned led to a break-up of their

relationships and their time in prison led to a loss of accommodation. In addition, drug and/or alcohol addiction and mental health problems enhance the likelihood of incarcerations, exacerbate the problems of homelessness and, in turn, have an in increase on the probability of reoffending (51). It is necessary to establish protocols with the public offices and the police to take part in the lives of the homeless, to ensure that they receive effective legal protection, as many of these people have an extreme deterioration of social or health resources, and thus are less likely to receive adequate legal help.

Life After Incarceration

The risk of homelessness increases after incarceration (51). A study in 2005 of those incarcerated in Spain found that 30% of people released from prison will have nowhere to live, and between the years of 2005 and 2006, 12,000 prisoners were released with nowhere to go (51). This problem has been going on for some time, in 2002 The Revolving Doors Agency found that 49% of prisoners with mental health problems had no address to go to upon leaving prison (51). Finding oneself in a situation of homelessness increases the risk of reoffending, ex-prisoners who are homeless upon release are twice as likely to reoffend compared to those with stable accommodation (51). This statistic is extremely critical as not only are there significant economic consequences for the State, but instead of helping those released finding a position back in society, it is continuing the unproductive and dangerous cycle of criminalization.

Many people in Spain undergo cycles of homelessness and imprisonment, as many people who have been in prison have more complex needs and thus are more likely to become homeless. In 2009, the organization Homeless Link found that 18% of their clients had spent time in prison (51). On the other side of the cycle, in 2003 a study of

prisoners in Spain found that 51% of prisoners had some type of housing problem prior to imprisonment, and l5% were sleeping rough before they were sent to prison (51). This cycle affects all ages, in 2008, a study of young offenders, ages 16-25 found that 35% felt a lack of accommodation was the factor most likely to make them re-offend (51). It can be seen from the data that incarceration and homelessness in Spain is a repeating cycle.

Life in Spanish Prisons

Given that there is a high likelihood of becoming homeless after prison, and that the homeless are more likely to become repeat offenders, it is interesting to look at what life is like in Spanish prisons. There have been several reports by the Spanish Society for the International Human Rights Law which denounce Spanish prisons, especially centers of detainment for immigrants (51). These reports focus on the conditions of the facilities, access to health and social services, irregularities in procedures for effective legal protection, and mistreatment and other abuses by security staff. In 2009, there were reports of lack of privacy in dormitories and bathrooms, deficiencies in the hygiene conditions and cleaning of the premises, and overcrowding (51). There are also problems with medical attention for inmates, especially those with special needs, such as those with withdrawal symptoms or psychiatric conditions. Moreover, in 2009, about 30% of interviewed internees from the prisons in Madrid, Malaga, and Valencia reported weight loss or weakness, and hunger, physical, and/or mental discomfort. It was also found that about 75%, at some point, felt sad while 10% report having considered suicide (51). Since many homeless people end up in prison, it can be seen that Spanish prisons are not an appropriate location for the homeless who often have many mental health problems.

Housing to Reduce Offending Rates

Due to the high rates of prisoners not having proper housing after being incarcerated, and the high rates of homeless being incarcerated, there is an obvious need for housing to end this disastrous cycle. It can be seen that the centrality of housing is a key factor in reducing homelessness and re-offending rates. In 2011, Spanish officials indicated that there were 7,000 homeless people in prison, who currently have a roof (the prison roof), but who had nowhere to live when they get out. Thus, it is essential to ensure their right to housing in order to enhance their quality of life and prevent them from reoffending when they are released from prison (51). It can be suggested from statistics mentioned above that housing has a huge impact on the likelihood of prisoners re-offending. A study done by Crisis in 2011 showed evidence that having stable accommodation reduces the risk of re-offending by 20%. Accommodation can provide the stability necessary to enable individuals to address their offending behavior and to access a range of other services such as community mental health services and to gain employment (51). Spanish researchers are not the only people to have discovered this phenomenon; in New York, supportive housing has been documented to reduce criminal justice involvement drastically, reducing jail incarceration rates by up to 30% and prison incarceration rates by up to 57% (51).

In addition to humane reasons, there are also economic reasons justifying the centrality of housing in interventions with homeless people. Numerous studies in different countries show that providing emergency supports such as homeless shelters are actually costlier than providing the supports to assist homeless people in permanent housing (51). For example, in the United States, prisons and jails are among the most expensive settings to serve people who are homeless. In 2004, a nine-city study

calculated median daily costs for prison and jail at $59.43 and $70.00 respectively, compared to $30.48 a day for supportive housing (51). Moreover, the United States' Housing First model emphasizes placement of homeless individuals in permanent housing, where they have access to services necessary to stabilize them and keep them housed (51). Consequently, Housing First users also make less use of emergency shelters, less use of emergency medical services, and are less likely to get arrested than when they were homeless, all of which produce savings for the taxpayer (51). In recent years, many policy-makers and service providers in Spain and other European Member States have become interested in Housing First concepts. Housing First has been incorporated in homelessness strategies in Denmark, Finland, Portugal, The Netherlands, Ireland, and France (51). The Housing First model is a practical and effective way in reducing incarceration and criminalization of the homeless in Spain.

Summary

Overall, the Spanish case shows how the homeless, and especially the foreign homeless, can be unfairly and unproductively incarcerated, and that incarceration and homelessness can be described as a vicious cycle in Spain. Those living in homelessness can be caught up in administrative procedures of arrest, and, in the case of immigrants, detention in internment centers and deportation from the country (52). The Spanish government uses policies as instruments of control. However, empirical data demonstrates that this approach is not an effective way to manage irregular migration, and causes many individuals harm. The administration of such laws and policies could be seen as unfairly targeted the poor, the homeless, and immigrants. Thus, reform in

Spanish policy towards immigrants and the homeless is needed, as well as reform within Spanish prisons.

Finally, there is evidence to demonstrate how access to housing helps to break the institutional circle, guaranteeing human rights and saving public expenditure (51). Strategies to help the homeless have developed and implemented Housing First Models, as a means of addressing homelessness across Spain to counterbalancing with an inclusionary approach the punitive strategies currently in place (53).

National Policy in Spain

Definition of Homeless

The governmental focus on homelessness is a relatively new topic of consideration in Spain. Spain often joins the European Union's efforts on strategy, especially on issues of social policy. The European Federation of Services for homelessness unites all members of the EU to share ideas on how to assist the homeless. The Federation wanted all members of the EU to have a common definition of homelessness to work in synchrony and to determine how many homeless are actually in each country (38). This goal stemmed from the McKinney Homeless Assistant Act in which the United States defined a homeless person as any person who lacked adequate accommodation, resources, or links with the community (38). After analyzing the United States' definition, the European Federation of Services for homelessness agreed on a broad definition of a homeless person as one who is incapable of acceding to and maintaining an adequate personal dwelling through his/her own means or incapable of maintaining a dwelling with the aid of social services. This definition includes economic poverty that impedes access to housing in the market context, and social exclusion and personal marginalization which impede access to housing through community assistance channels (38). Homelessness has also been more specifically defined as persons or families that are socially excluded from permanently occupying a personal and adequate home. This includes persons who have no roof over their head and are condemned to live on the street as vagrants, temporarily housed in hostels or centers for the homeless (especially those created by public authorities or private sectors), are temporarily housed in the private sector (in hostels or with friends or relatives), occupy legal or illegal unsafe

housing (shacks, abandon houses etc.), live in institutions (hospitals, prisons, psychiatric units, etc.), or those who live in a dwelling that cannot be considered adequate or social acceptable (38). With a consensus on the definition of homeless, the European Union, and more specifically Spain, can more easily tackle this problem.

Defining homelessness enables European countries to work together to determine how many homeless are living in Europe and in each member country. In 2013, The European commission estimated that 410,000 people sleep rough on a random night through the European Union. The commission also found that more than 5 million people are exposed to a situation of homelessness each year (45). These numbers give government officials an estimate for the size of the homeless population, but as mentioned earlier, these estimations significantly miscalculate the actual number of people living in homelessness, especially underestimating those physically living on the street.

Autonomous Communities in Spain

Spain is broken into 17 different autonomous communities. These communities are analogous to states within the United States. Local governments are accountable for the social care of homeless people through the help and guidance of the national government (45). However, data regarding the homeless and services provided for the homeless depend in large part on the political will of the local administration and their priorities (45). The national government requires social guidelines for local communities and provides support to local communities in order to ensure the needs of the homeless and poor are being met without total burden falling on the autonomous community. National legislation requires all municipalities with more than 20, 000 residents to have

social services for homeless persons (39). This is difficult for many smaller communities, thus smaller cities rely heavily on private initiatives, such as religious organizations. Spanish society is mostly Catholic, making up a large portion of the population and the Catholic Church helps provide incredible services for those in need, such as shelters and food. Overall, local communities within Spain rely on leadership within the community, help from the national government, and help from private organizations.

There is huge variety among the Spanish Autonomous, in terms of resources and available services. The Attention Network was developed to aide in sharing information about resources available to homeless people. This local network is driven and supported by the Autonomous Communities and the General Administration of the State. It is critical in establishing continuity amongst the communities to provide the best services possible for the homeless. The network also helps ensure that a majority of homeless live in one Autonomous community and that the support services are distributed across Spain (39). Thus, although Spanish Autonomous communities are highly varied, local communities share a common goal of providing satisfactory services for the homeless.

Dynamics of Spain's economy

As mentioned previously, Spain was hit hard by the economic crisis, with an unemployment rate in Spain of 25% of the population in 2005 (42). Of those employed, 13% are still classified as the working poor, or those with full time employment still living in poverty (42). The impact of crisis was magnified for the poor and the homeless. The European Observatory on Homelessness published the report "Extent and Profile of Homelessness in European Member States", detailing the impact of decreased funding for

social services and for the increase in unemployment (45). Many people in Spain find it difficult to obtain a job, and it is even more difficult for the homeless, especially if a person is young (41). Private sector positions are extremely difficult to obtain because companies do not accept that homeless persons can be "competitive" (41). Thus, many homeless turn to self-employment opportunities and co-operatives. These two employment options have been the traditional occupational outlets for the homeless (41). As such, it is imperative that national policies work to prevent more repercussions from the economic crisis, particularly for those most vulnerable in the population.

According to the Platform for Mortgage Victims, there have been 569,144 foreclosures since 2007 (40). Poor families, many of whom were evicted for failing to pay their rent or mortgage, are now living together in squats known as "Corralas" in empty buildings owned by banks or construction companies (40). The pattern of evictions continues, with many are still being kicked out of their homes due to inability to pay rent. According to Judicial Sector Statistic, within the first 6 months of 2014, there were 37,241 evictions in Spain (40). Hence, there is still a need for the government to take a role in the area of affordable housing.

Welfare System in Spain

Spain has an excellent social welfare system, which includes social security, health care, education, unemployment insurance, housing support and social services (38). These programs have made a strong impact on Spain's residents and have made considerable advances over the years (38). Foundational to Spain's welfare programs are integrated plans based on collaboration between public and private organizations. These collaborative efforts result in comprehensive action from all types of social welfare

services and on many levels of need. These include prevention, attention, rehabilitation, and social reintegration. The goal of Spain's national policies is to make intervention within the lives of those in need both comprehensive and globally coordinated. Many of the Spanish national policies go beyond coverage of basic needs and promote active personal and social rehabilitation with programs that offer effective opportunities for participation and integration into the community. This is critical for any society to become more cohesive, and particularly important for family centered Spain (38).

It is a conscious focus of Spanish officials to integrate the needs of the homeless into national policies, and to promote intervention styles that are active and flexible to the homeless person's needs (38). Spain's national policies have become more proactive, looking at different methods of helping the homeless, to become involved early on in their needs rather than waiting for the homeless to come for help in crisis. National policy makers are looking to identify more with those in need within the community and use local community participation to improve policies (38). Ideally, Spanish government would actually like to see participation and involvement of those affected to ensure that available services are being used successfully and that the development of future services leads to and focuses on the social integration of the homeless (38).

Social Services and Current Programs

Spanish social services and current programs for the homeless are derived from a collaborative effort to do the best for those in need. These programs aim to establish integral strategies with activities of intervention in all areas to favor the rehabilitation and progressive social incorporation of vulnerable groups such as homeless people (39). The Ministry for Health, Policy, and Social Equality make annual calls for proposals for NGO

to finance activities for social inclusion; these funds come from the contribution of the citizens through the tax system. Autonomous Communities and the Spanish Federation of Town Councils and Provinces (FEMP) work closely with The Ministry for Health, Policy, and Social Equality (39). The Ministry for Health, Policy, and Social Equality's aim is to design a model of social participation with Public Administration and Autonomous Communities (39). With the collaboration of national and local governing bodies, these programs are very successful in helping those in need. Within this integral program, homeless people are included as beneficiaries (39).

Data and literature shows that these integrative programs were truly defined by 2009. In 2009, there were four basic provisions of social services within the Spanish National Government's system: Information and Guidance, Family Support and Aid at Home, Alternative Lodging, and specific activities of Prevention and Insertion. It was also complemented with the financing of centers for social services, centers of welcome, and hostels (39). In 2009, the plan agreed upon by the Spanish national government, The Lodging Alternative, was to finance 12 hostels which would have 653 different locations and the potential to lodge 14,000 persons as well as provide 13,600 food, blankets, and other necessities, including maintenance (foods). 100,000 other persons benefited from the provisions made by the Lodging Alternative (39). In 2010, The Ministry for Health, Policy, and Social Equality had 9,235,265 euros to subsidize the activities of 25 organization with corresponding programs. These programs were intended for those in need. 36.09% of this funding in 2010 went to those without a home and were dedicated to programs fostering social inclusion (39). A sign of the success of these efforts can be seen in the findings of the Association of Directors and Managers of Social Services

within the Spanish National Government, which reported that public spending on the neediest in the year of 2014 was 18.98 billion, fully 2.78 billion *less* than in 2012 (40). In other words, less and less money needs to be allocated towards providing homes for the homeless, with more of the current focus going towards social integration of those who now have a home. Like all national policies, change is a slow progression; however, the Spanish government is moving forward to incorporate many services and innovative changes in its policies, to best provide for those in need.

Programs lacking in Spain

The main need still within Spanish national policy is in the coordination of the many nation-wide services, services within autonomous communities, and the coordination between the two. Existing services do not function in a coordinated and complementary way (38). Without coordination between these services, there is an uneven distribution of resources across cities or regions, which can lead to homeless persons moving from one city to another (38) with loss of support. This situation has negative effects, as many of the cities do not have the resources to handle large influxes of people, without the funds beforehand to deal with the situation (38). When there is a large gap of funding due to an uneven distribution of resources, much of short fall is taken up by religious organizations (38). These organizations help sponsor Realidades Centers, which are often located in smaller cities that are hit the hardest by the uneven distribution of resources. These centers are able to help upwards of 100 people at a time in a comprehensive way, helping to secure housing, work, pensions, and so on (38). Another area for potential enhancement in Spain's care for the homeless is in case management. In Spain, centers for case management are especially scarce (38). Thus,

two large problems in Spain are coordination between national and local policies and better case management of those experiencing homelessness.

In sum, there remain a number of areas for policy improvement in Spain. It is fundamental to develop an integrated plan based on collaboration between public and private organizations. It is also necessary to develop a comprehensive action plan for all types of social welfare services and with a consideration of all action levels: prevention, attention, rehabilitation, and social reintegration. Social integration should involve a globally coordinated and comprehensive plan. This plan should go beyond the mere covering of basic needs, and thus promote active processes of personal and social rehabilitation. Ideally, this program would also offer effective opportunities for participation and integration into the Spanish community (38). It is important to promote orientation and intervention styles that are active, flexible and responsive to the homeless person's actual needs, rather than simply deciding what the homeless need and thus potentially missing what would have been the most useful services to them (38). It is critical for the development of effective future policies that their authors become involved in the actual needs of the homeless, and that they create plans that favor the participation and involvement of the homeless themselves within policy creation. If Spanish government leaders continually improve their policies in this manner, then they stand the best chance that available services will be properly used, and that the paths of individuals through these programs will lead increasingly to social integration/reintegration. (38).

Future Programs

Future programs within Spanish National Policy are focusing on the prevention of homelessness. There needs to be an agile and flexible response permitting appropriate intervention once people start to experience housing marginalization, and other early risk factors for homelessness. By having such intervention, marginalization of the homeless can become less chronic, and these persons can integrate back into society faster (38). It is necessary to establish a homogenous model to guarantee a protection of the people most at risk for homelessness. It is essential for local organizations have to have the economic and technical support of their Autonomous Community and of the general administration of Spain. Although each government entity will have diverse responsibilities within these plans, it is imperative to have articulate networks that permit action with the specific needs of each homeless person (39).

Spanish government is actively building comprehensive and participative strategies on homelessness. The following programs have been made with the support of the respective city councils within Spain. Local governments along with private organizations have developed plans for programs. These programs will be subsidized by the government in addition and complementary to those already established by Autonomous Communities and/or City Councils and must have the support and collaboration of social services of the territory or action area (39).

This plan includes a variety of programs operated by local administrations. For example, there are programs of welcome and lodging that develop activities of social engagement. These programs will exceed the basic needs of lodging and maintenance, with the additional capacity to carry out social and labor integration functions. Additionally, programs in the area of housing will consider mediation with the private

sector in order to reduce the number of persons evicted due to inability to pay rent; his plan will also work with the private sector and help those in at- risk situations in terms of their ability to rent. The plan includes programs to provide temporary lodging and support while promoting personal development. In the category of personal development are included social skills and abilities that will enable communal integration (39). This plan is reliant on collaboration with local communities, and on the integration with many structures within the community, such as a center of welcome. The referential element in each city, The Center of Welcome, acts as a hostel did in the past. Centers of Welcome for homeless will cover the needs of lodging, food, clothing, and health in an immediate and transitory way (39). These centers will provide services by breaking needs into the following themes, and distributing the services accordingly: Drop-in, Units of Insertion, Lodging for Families, Lodging for Emergencies, Specific Centers, and Intervention of Street. All of these categories are specific areas in which the Spanish government has found to be critically important to get the homeless off of the streets. These focuses provide help with basic needs, social integration, help with workforce integration, and many other services (39). Drop-in needs will be centered for people who have been permanently on the street and who have not found any viable alternative. Units of Insertion are services and locations such as hostels and Centers of Welcome which offer private lodging and make possible a personal coexistence. Lodging for families provide housing for families. Family is extremely important within the society of Spain, thus it is imperative that this is respected and promoted in centers for homeless persons. Lodging for emergencies will be provided by city councils. These spaces must accommodate all people in a situation of need in which it is necessary to spend the night off of the street.

Specific centers are centers that are focused on the specific needs of the homeless. These centers will provide resources and become an integrated part of society to avoid the stigmatizing situation of becoming homeless. Intervention of street involves the entire community to end homelessness. It is important to not only have the coordination of services working together, but also to have the help of those throughout the community. The main focus of this plan is to have a 'ceiling for everyone', the Spanish government believes that there are enough resources throughout Spain, that no person should have to spend the night in the street against his /her will (39).

Summary

Spanish policy uses important sources of insights into their homeless population. By knowing the significant factors that go into homelessness, policy can be tailored accordingly. These insights are essential to design effective preventive strategies that address the economic, social, and psychological problems of those at risk and that reflect the specific cultural context in which these problems occur (29).

5. Research Questions

The Literature Review provides the basis for the following research questions.

1. **To what extent does mental illness affect the homeless, and what solutions could significantly help the homeless who are suffering from mental illness in the United States and Spain?**
2. **How are the homeless perceived in the United States and Spain, and what is the effect of stigma towards the homeless and mentally ill?**
3. **Is there a strategy to successfully house the homeless in the United States and Spain? And how could appropriate housing improve the mental health of the homeless?**
4. **What is an alternative more humane, economically sound solution to incarceration of the homeless in the United States and Spain? How do social disturbance ordinances affect the homeless in the United States and Spain?**
5. **Which current national policies in the United States and Spain promote the health of the homeless, and which national policies negatively affect the homeless in the United States and Spain?**

1. **To what extent does mental illness affect the homeless, and what solutions could significantly help the homeless who are suffering from mental illness in the United States and Spain?**

Mental illness in homeless populations is an extremely delicate issue. Homelessness escalates mental illness, and mental illness in returns escalates the condition of being homeless and the time spent in homelessness. Many homeless people are significantly affected by previous mental health issues, and homelessness also exacerbates mental illness (15). It is critical to include mental illness when providing services for the homeless, and it is important to understand that not all mental illnesses can be treated the same. In order to help the homeless with mental illness get off of the street it is important to provide mental health services as part of housing programs, because it is one problem to get the homeless off of the street and into housing, but it is a completely different challenge to house them in a stable environment (29). There is a lack of treatment facilities and housing options available for those suffering from different mental illnesses in the United States (27). Individuals are not receiving the treatment they need or in some cases are not receiving treatment at all. Over half of the individuals suffering from mental health disorders such as schizophrenia or bipolar disorder are receiving no treatment for their mental illness at any given time in the United States, and many of those suffering from mental health issues are not being treated in Spain as well (3). However, due to Spain's universal health care, many more people are being treated for their mental illness (43). Mental health is critical to look at when considering how to help the homeless.

Many researchers in Spain are working to understand the dynamic of major mental illnesses, in the hope of reducing the stigma of mental illness by offering factual information (39). Researchers also hope that their work will lead to the better care to those whose mental illness has reduced the quality of their lives. Many homeless undergo stressful events in their lifetime (44). Many of these events are the result of stigma against the mentally ill and homeless. On average, the homeless population in Spain faces nine important stressful life events that can often be detrimental to the physical, emotional, and mental health and wellbeing of those individuals (38). It has been found that the higher number of stressful life events also leads to weakened social networks, which further alienates the homeless and mentally ill from mainstream society (38). Mental illness, that is exaggerated by stressful events can have an even more painful impact on the homeless (38). When analyzing solutions to help the homeless, it is important to keep in mind the mental health issues of that individual.

To understand the importance of mental health issues, it is important to look at a study that compared Madrid and Los Angeles shows how incredibly rampant substance abuse amongst the homeless, and how these mental illnesses can severely affect the homeless. Overall, the study found that 36.5% of homeless persons living in Madrid had a lifetime prevalence of any substance abuse (29). Homeless persons living in Los Angeles had a 73.6% prevalence of any substance abuse (29). Of these persons, 28.3% of those in Madrid had an alcohol dependence compared to the 60.3% of persons in Los Angeles (29). In both cities, 80% of alcohol dependent homeless persons experienced symptoms of alcohol dependence before having experienced their first episode of homelessness (29). The study also found that 12.8% of homeless persons in Madrid had

a substance abuse problem of any drug except alcohol compared to 49.0% of persons in Los Angeles (29). Mental illness and substance abuse causes individuals to ignore financial responsibility, lose connections with society, and cause individuals to become unable to take care of themselves. Solutions to significantly help the mentally ill suffering from homelessness must be focused on the demographics of the homeless living in each region. It is important to include help and education in regards to substance abuse in order to help the mentally ill get off of the streets.

When looking to house the homeless, mental health services must be an active part of this arrangement. It is critical to get the homeless off of the streets and into safe housing, and the housing must also be aligned with the mental health needs of the homeless. This is thus why Housing First models that promote mental health services, caseworkers, and active programs are far more successful (15). When a Housing First program has other services available to the homeless, especially directed towards their mental health needs, the homeless are inclined to stay in the housing, and incorporate back into society, as well as maintain their mental health status (23). There is a large need for mental health services among housing services for the homeless, which can be seen with the large number of persons with untreated mental illness both in the United States and Spain (43). In the United States, people with untreated serious mental illness comprise an estimated one-third of the total homeless population (4). These individuals make up a very large percentage of the homeless, and are the most vulnerable and at risk. People with serious mental illness are reported to be 10-20 times more likely than the general population to become homeless (4). The mentally ill are at an extremely high risk for ending up on the streets, which can further increase their disease. Mental illness

comes in many forms and is represented in varying degrees on the streets. Most represented among the homeless are illnesses such as schizophrenia, bipolar disorder, major depressive disorders, and PTSD (especially from those who have served in the military) (10). Many of these individuals have had trauma or other abuse in their lives. A large percentage of homeless mentally ill had difficult upbringings and have frequently experienced direct forms of abuse, which has been defined as verbal, emotional, physical, and sexual, which later continue to be problematic once they are on the streets (10). Abuse such as the kind many of these people experience while they are younger can negatively affect psychosocial and behavioral outcomes in adulthood, and thus typically leads to homelessness or uncontrolled mental illness. This issue is rampant in both the United States and Spain, as a large portion of both countries' homeless population has had some form of abuse (49). It is imperative to understand the degree and type of trauma experienced in order to provide adequate assessment and treatment of those who have been victimized and now are suffering with a mental illness. The addition of a lack of a home to these emotional issues causes mental illness to further increase. Thus, in order to maintain the mental health of those living in homelessness, more mental health services must be provided in addition to stable housing

2. **How are the homeless perceived in the United States and Spain, and what is the effect of stigma towards the homeless and mentally ill?**

Many people have an idea as to what they understand homelessness looks like. This idea is generally negative, and thus a stigma is directed towards the homeless. However, not all homeless display the same characteristic traits that people believe. And often, many homeless walk among society, completely unseen (14). The same goes for the mentally ill. Many harsh stigmas are associated with the mentally ill. The public still believes that many mentally ill people are dangerous, making their symptoms up, or are lying about the severity of their symptoms (13).

Stigma towards mental illness has intensified over the past 40 years, even though understanding of mental health has improved (1). Much of the public believes that people with serious mental illness are, by far, more dangerous than the general population. This thought is intensified by the media (1). The media often negatively portrays the mentally ill with stories of violence, destruction, and the adverse implications of homelessness. There have been many studies tracking the increase of stigma towards the mentally ill in the United States. The mentally ill homeless are commonly characterized by the society as disheveled and dirty; wearing clothes inappropriate to the season', pushing their possessions in a shopping cart; urinating and defecating in public; shouting and gesturing animatedly to trees, store windows, or passersby; or remaining mute and withdrawn when approached (2). This type of person can often be seen in every city, but it does not characterize the population as a whole. Stigma can be detrimental for the mentally ill and homeless (3). Stigma stereotypes and dehumanizes these populations which can inhibit their ability to obtain a job, acquire a

loan for a house, maintain relationships, or adjust to societal conceptions. Public figures and mental health professionals have found that stigma consistently hinders the mentally ill's ability to live as well as inhibits the homeless from obtaining a more stable life (5). Both countries are affected by the stigma associated with homelessness, however, is making significant advances in the understanding of the homeless and mentally ill, and is actively working to reduce stigma (50). Stigma intensifies many of the issues that the mentally ill and the homeless are faced with.

In Spain, here has been a decrease in the stigma towards the mentally ill and homeless, as the society gradually pushes towards fewer negative connotations towards the mentally ill and homeless (49). Many advocates for the homeless populations throughout Spain emphasize that in order for stigma to lessen, the negative connotation of the word 'homeless' must also be reduced. Some advocates prefer the word transúnte, 'transient', which is equivalent to vagrant in English but without the negative connotation.

The effect of stigma is significant for the homeless and mentally ill. An outcome of societal stigma towards the mentally ill and homeless is internal stigma (44). Internalized stigma is considered a risk factor for poorer mental health prognosis. Higher levels of internalized stigma are associated with higher levels of depression and psychiatric symptom severity and lower levels of self-esteem and recovery oriented mindset (45). Internalized stigma, also referred to as self-stigma, is characterized by a perception of devaluation, marginalization, secrecy, shame, and withdrawal from society. Internalized stigma has a variety of adverse effects including: profound psychological adversity, demoralization, hopelessness, lowered self-esteem, reduced self-efficacy,

impaired social adaption, unemployment, income loss, reduced psychiatric medication adherence and limited social support (44). Opportunities for the homeless and mentally ill are reduced significantly with increased stigma in the United States and Spain, as many homeless and mentally ill are unable to be active parts of society due to the negative connotation their wellbeing, as well as the lack of self-esteem associated with higher stigma. The views of the homeless in the United States and Spain are still heavily threaded with stigma, however, both countries are working to reduce the negative association with the homeless. Spain however, seems to be making more progress, as the society as a whole is working to reduce stigma (44).

3. **Is there a strategy to successfully house the homeless in the United States and Spain? And how could appropriate housing improve the mental health of the homeless?**

Being homeless can cause detrimental outcomes in a person's life that can often be so severe that that being homeless can be fatal (5). Some homeless live in severely dangerous and unhealthy living conditions, are forced to forage for food and shelter, and do not receive adequate medical care. The mortality rate of the homeless is 4-9 times higher than the general population (7). These people need a practical solution that enables them to get off of the street. Many programs that have been developed so far often fail as they are very difficult for the homeless to adhere to (8). Thus a successful way to house the homeless is needed. Much of the difficulty for the homeless to adhere to problems is related to access, many homeless have difficulty adhering to programs due to lack of access to professional centers, food services, and housing opportunities (9). This is especially so for the mentally ill homeless, and for those living in the United States, as many programs are much farther away from each other, and it is not as easy to walk to different centers, or use public transport (10). People with serious chronic mental illness constitute less than one-fourth of all admissions to community mental health centers (11). This could be due to this inherent lack of trust, stigma towards mental health, or inability to obtain access. Thus a housing program that incorporates mental health services as well as housing opportunities is the most vital solution towards successfully housing the homeless.

A strategy that has been found to be extremely successful for the homeless is the Housing First method in the United States and in Spain. The Housing First model

complemented with a communal focus in which there is congregated housing with on-site support is an incredible example of the harm reduction approach (12). By having this communal approach, housing is enabling the homeless to have a secure place to stay, and is also providing the homeless with beneficial programs in order to improve their mental health, social skills, and overall integration into society (16). At its most basic, and in a majority of cities, Housing First method is providing the homeless with scattered housing, case management, and services, which is still beneficial if a city does not have the means of providing more communal housing. Ideally, the Housing First method should have a central base, where the homeless are able to get their services close to home (17). Housing First treats formally homeless persons as normal citizens rather than as clients or patients.

Housing first is also beneficial for the economy. A study done in Spain in 2012, which can be found in the Literature Review, found that support housing units halves the use of social and health care services compared to service-use during homelessness. This equates to 14,000 euros of savings per resident/year in Spain (51). In this study, the greatest savings were gained from the decreased use of institutional care and special health care (51). Overall, the Housing First method is an extremely viable option that has benefits for the wellbeing of the homeless and for the economy. Housing first offers stable housing without requiring treatment adherence or sobriety, thus practicing harm reduction policies regarding substance use and consumer choice (15). The Housing First approach aims to use the method of harm reduction to help reduce substance abuse amongst homeless populations.

Programs similar to the United States' 'Housing First' are also being developed in Spain. The RAIS Foundation, one of largest organizations in Spain to help the homeless, also supports the Housing First model (40). This approach focuses on moving homeless people immediately from the streets or shelters into their own apartment based on the concept that their first and primary need is stable housing. Spain's Housing First model also uses "Centers of Welcome" in order to coordinate a central and community based housing situation (41). Those with severe mental health problems have a hard time gaining access to homeless shelters, supportive housing, or pensions, and that even if are able to obtain services they fail to move forward with their rehabilitation or end up being expelled from the system once again. The RAIS Foundation stresses the importance of the role of social workers, psychologists, and experts in social integration who listen, support, and assist the homeless (40). It is critical to integrate many different professionals in order to help the homeless not only transition to stable housing, but keep such housing.

Appropriate housing with services specific for the homeless population can improve the mental health of the homeless. Many homeless have been found to prefer Housing First, especially the central housing model because many homeless fear isolation and loneliness (16). Also having housing benefits those with mental health issues and substance abuse issues because until they feel the sense of security and safety that comes with being housed, it is very unlikely that they will be able to start working on their mental health. The Housing First type approach to ending homelessness demonstrates the viability of inclusion, rather than exclusion, as a response to homelessness and marginality (40). The Housing First approach to addressing substance abuse in homeless

populations is rooted in Abraham Maslow's hierarchy of needs (15). According to Maslow's hierarchy of needs, one's basic needs of shelter, food/water, safety, and friendship must be met before one is able to reach self-actualization (15). Without having one's basic safety and security needs met, a person will not have an adequate platform for which to successfully address other challenges, such as psychiatric symptoms, addiction, or employment. For those that are suffering from mental illness, self-actualization is the desired goal. Those that promote Housing First often describe the model as oriented towards recovery (41). Promoting this strategy enables the homeless to be able to be successfully housed while treating mental health issues. By having communal living situations within Housing First the homeless are able to increase their social integration. This housing solution is beneficial in both countries, as centrality is key when providing services. This solution would be especially beneficial in the United States, as many centers of services are scattered around cities, and often difficult to navigate. When programs come together and work in synchrony to help, the homeless benefit greatly (7).

4. **What is an alternative more humane, economically sound solution to incarceration of the homeless in the United States and Spain? How do social disturbance ordinances affect the homeless in the United States and Spain?**

Many of those living in homelessness in the United States and Spain are incarcerated unfairly and would be better served by other means, such as mental health services or housing. This is a huge problem for many homeless in both the United States and Spain (29, 48). The United States unfairly targets the homeless by making certain actions, which are significantly related to being homeless, illegal (29). Spain uses similar methodology as well. This treatment of the homeless is not only inhumane, but it does not benefit society in the best way possible.

Homelessness and incarceration comes in cycles (30). Many people in Spain undergo cycles of homelessness and imprisonment, as many people who have been in prison have more complex needs and thus are more likely to become homeless (51). As well as many people who have been imprisoned have had housing problems or were sleeping rough prior to being sent to prison (51). This phenomenon affects all ages, and many homeless feel that the lack of accommodation is the greatest factor in the possibility of them reoffending.

The centrality of housing is a key factor in reducing homelessness and re-offending rates (40). In 2011, Spanish officials indicated that there were 7,000 homeless people in prison, who currently have a roof (the prison roof), but who had nowhere to live when they get out (51). Thus, it is essential to ensure these people have housing in order to prevent them from reoffending. It is clear that an alternative solution that is more humane and economically sound is necessary (51). Instead of putting the mentally ill and

homeless in jail, it is more important to provide them treatment, and actually help deal with the underlying issue instead of bandaging the wound. Both the United States and Spain have many laws that inhibit the quality of life of the homeless, and also cause more economic stress on society (50).

Social Disturbance Laws are active in both the United States and Spain. Social Disturbance Laws make daily living of the homeless illegal and are incredibly cruel to the homeless (51). These laws further instigate the stigma of the homeless and mentally ill. Many cities who make it illegal to camp, beg, or loiter, specifically target the homeless (33). The efforts spent fining and dealing with these small crime cases could be instead focused on providing services for the homeless (33). These ordinances are unfair, and cause the homeless to feel like second class citizens. Time and money could be better spent providing mental health services and shelter, rather than incarcerating the homeless unfairly (34). Social ordinances further separate the homeless from mainstream society which can exaggerate the hardships that the mentally ill and homeless already suffer from.

5. **Which current national policies in the United States and Spain promote the health of the homeless, and which national policies negatively affect the homeless in the United States and Spain?**

There are many national policies that are contributing healthfully in the United States and Spain, but still others that do not. An organization that takes huge responsibility for the homeless in the United States is HUD (13). HUD's mission is to create strong, sustainable, inclusive communities and quality affordable homes for all (36). HUD strives to meet the need for quality affordable homes, and to utilize the platform of housing to improve quality of life for those in the United States (36). HUD serves over 1 million people through emergency, transitional, and permanent housing each year (36). HUD's Office of Special Needs Assistance Programs supports the nationwide commitment to ending homelessness by providing funding opportunities to quickly rehouse homeless individuals and their families (36). HUD advocates self-sufficiency and promotes the effective utilization of national resources to help those suffering from homelessness. Another program that does incredible work for the homeless is PATH. PATH is a national grant to the States, and provides assistance to those, especially with mental illness, trying to find stable housing (34). PATH works hand in hand with other homeless service providers in every state to make sure people with severe mental illness are identified and getting services they need (34). PATH helps communities implement housing first approach. SAMHSA is another agency doing good for the homeless within the United States Department of Health and Human Services (32). SAMHSA leads public health efforts to advance the behavioral health of the nation (32). SAMHSA's mission is to reduce the impact of substance abuse and mental illness

on America's communities (33). SAMHSA helps provide treatment and services for people with mental and substance abuse disorders, helps to support the families of those suffering, and build stronger communities (33).

Another significant program in the United States are sliding scale daycares (34). There are many single parents in the United States that are affected greatly by the many laws and regulations in providing a day care (34). Thus sliding scale day cares that reflect income are truly beneficial for the homeless. Another beneficial national policy is through housing vouchers, but these vouchers are being funded less and less and are often extremely difficult to get or the waiting period is incredibly long (35).

Spain has an excellent social welfare system, which includes social security, health care, education, unemployment insurance, housing support and social services (47). These programs have made a strong impact on Spain's residents and have made considerable advances over the years. These focuses provide help with basic needs, social integration, help with workforce integration, and many other services (47). Additional drop-in needs for those that are permanently on the street and who have not found any viable alternative are provided by the Centers of Welcome (39). By having national policies that direct care for homelessness through the use of case managers and housing, it is possible to end homelessness. Spain is making great strides using national policy to help those on the street (39).

6. Summary and Conclusion

Cross national comparisons of homelessness are critically important to explore how homelessness and the profile of the homeless population varies in contexts affected by different economic, political, social, and cultural influences (29). It is incredible to see and understand the different difficulties that the homeless endure in each country. It is also critical to look at how stigma plays a role in the life of the homeless. By comparing each country, it can be shown that contrasts between Spain and the United States can suggest how national policy, differing social and economic context, and cross-cultural variation may influence the profile of the homeless population and the dynamics of homelessness (29). The homeless in the United States are especially limited by their access to services such as health care, mental health services, and case workers. By comparing the United States to Spain, it can be seen how much benefit the homeless of Spain receive from universal health care and the centrality of social services.

In each country there are obvious areas that need improvement, especially within the legal system. In many cases the cities do not have adequate care resources to meet the current profiles and problems among homeless. It can be seen in both countries the importance of having a location for the homeless to be at all times of the day, by having Centers of Welcome, and locations where services can easily be accessed there will be less homeless on the street thus reducing stigma, less homeless using emergency services by getting the appropriate mental health care, less homeless incarcerated due to unfair social ordinances, and less people living precariously. By having locations where the homeless can receive the services they need, countries can ensure that this issue is not

being overlooked. Having centrality in services is critical for cities, states, and national governments to work closely and smoothly, which can be seen by the programs in Spain.

The United States has one of the largest homeless population for a developed country, estimated to be 6.2%, approximately 20 million people (2). In the United States many homeless have some form of severe mental health issues, 20% to 25%, and face the difficulties of stigma. Most homeless, instead of being treated with mental health services, are unfairly treated or incarcerated. The homeless are incarcerated and criminalized because of their poverty and untreated mental health, and national policies would do well to reform in order to treat the homeless more humanely and more adequately. Homelessness is a very difficult issue to tackle, and it will only be solved with the cohesive effort of social services and the help of the community by providing more support and compassion towards this group and less stigmatization.

7. Personal Viewpoint

I have been passionate about providing services for the homeless since my time studying abroad in Granada, Spain. While working in Spain I had the opportunity to volunteer for an organization called Solidarios. Solidarios, a national program throughout Spain that strove not only to give food and other necessities to those living on the streets, but also, in typical warm Spanish fashion, to share conversation and human contact. Despite the urgency of meeting needs for food and shelter, we were conscious of the equally important need for conversation and human contact. I saw that this social connection was particularly critical for those suffering with mental illness. I saw that for people suffering from homelessness, mental health issues are often a more pressing problem than the lack of a home. I have for years had in my heart the determination to help the homeless; in Spain, I realized that my particular contribution would be through the practice of medicine with a focus on mental health issues. I have continued to work with the homeless at Community Outreach Incorporated as a Spanish translator in the medical clinic as well as a tutor for the local youth homeless shelter, Jackson Street Youth Shelter Incorporated. I recently obtained a position working for Community Services Consortium as the Point in Time Count Coordinator for Linn, Benton, and Lincoln Counties. Through my experiences I have been able to meet many homeless persons, social workers, directors of homeless shelters, government employees and many more. From these experiences I have been able to gain an opinion as to what is the best option we can provide for the homeless in the United States.

I believe that there is no one solution to help the homeless, nor the mentally ill, but this problem takes an accumulation of good ideas with a network of passionate people. Homelessness and mental health are issues that need to be looked at from a societal viewpoint, it is imperative in order to help these people that society is also in agreement to help. Thus, eliminating stigma and discrimination of the homeless and mentally ill is one of the most critical first steps. When the viewpoint of the homeless and the mentally ill changes, more services can be provided towards these groups, and these services can be provided in a way to provide the most help for these people. The homeless are some of the most misunderstood people in society, they are often the most honest, intelligent, and warm individuals, and it is imperative our society treats them as such.

A story I found extremely inspiring, and an ideal way to treat the homeless through community action, can be seen by the project 'Shelter', in Barcelona. Shelter provides the homeless with a safe and healthful environment. Shelter, is a progressive project which serves the bridge between the homeless and public services. A community neighborhood in Barcelona saw the problem of homelessness and decided to take it upon themselves to house the homeless. This is done through a community effort. This group brings homeless people to the shelter where families cook the dinners, others help with cleaning, while another team helps them get an allowance. There is a physician on the team as well that helps with their immediate health needs as well (41). The idea that keeps the project Shelter running so successfully is the notion of having all the needs of the homeless met in one central area. The homeless receive their shelter, food, and mental health services within one roof. They are taught that they are an important aspect of society and they are treated with respect. The Shelter program allows the homeless to

stay in the house in the same way that they would stay on the street. The house does not have many rules, so the homeless do not have to wash themselves, they can sleep on the floor, and even can get drunk. One of the only rules is that the shelter does not allow violence. The director of Shelter explains "somebody who has lived in the streets for a long time has a different mental structure. He cannot grasp, for example, that having to shower is a social habit. They lead very isolated lives, they don't organize themselves to claim their rights, and find it difficult to relate to others because nobody relates to them, or relates to them badly, so it is critical to gain trust and mutual respect for one another first before moving onto other social issues" (41).

In conclusion, I believe that the best way to help homeless people will not be achieved through a single plan or idea, but through a congregated effort by society as a whole. To help the homeless is far more complicated than a plan developed by the national government or even local communities. True help for the homeless will come from an accumulation of government support, local efforts through organizations such as advocacy groups and churches, and personal efforts from society as a whole to help others. In order to help the homeless, an understanding must be made that homelessness is mostly the product of personal circumstance, treatment of society, and mental illness.

8. Recommendations

Homelessness is an extremely difficult social issue. One of the most difficult issues regarding homelessness is categorizing those living in homelessness under one umbrella. Homelessness is complicated, and there are many factors that contribute to those becoming homeless. So many factors, that homelessness cannot be solved with throwing money, housing, or other services at the issue. People become homeless through a variety of factors, including housing insecurity, food insecurity, mental health issues, generational poverty, lack of familial/social support, incarceration, and many other issues. Homelessness is not a disease of society, but in-fact a symptom. "I always feel frustrated using the word homeless, like it is one population" (Appendix A). By looking at homelessness as a black and white issue we are not addressing the root cause of homelessness, we are just giving people shelter.

1. We as a nation need to quit calling people homeless, this is circumstance not a characteristic of who they are. If we start looking at each difficulty, or circumstance individually it would change the conversation entirely and we would start focusing on route causes. It is impossible to blanket homelessness solely as having a lack of a home. Homelessness is far more complicated. Simply giving people homes without any support for their mental, emotional, financial, or physical help is why there is so much difficulty in housing the homeless. Thus it is imperative for society to stop calling people homeless, homelessness is just an

address, the route of their problems lies much deeper. It is necessary that the end goal of providing services for the homeless is to get someone from crisis to self-sufficiency.

2. Having an access point for the homeless and a shared database within cities is critical for services to have a centrality and to provide the best care. It is necessary that all organizations work together to meet the needs of each individual person. It is necessary to have a place in each city where people can go and get a shower and get clean. Human dignity and basic needs have to be at the forefront of everything that is done for the homeless.
3. It is evident that the United States needs to increase the capacity for mental health services and treatment services, and by treating each individual uniquely, as everyone is different, and solutions to homelessness need to be aware of the differences within the homeless population.
4. There is a huge need to reform the penal system in both the United States and Spain. Too often, the homeless are treated as criminals, when in reality they are just trying to survive. National and State laws should not deprive the homeless of their right to liberty because of their social status. States should consider the negative consequences and there needs to be an adoption of criminalization approaches that focus on basic human rights. It is clear that this penal system is aimed to criminalize poverty. Instead the system should work to promote the overall health of those who suffer the most.
5. Health care services coverage is an important element of social cohesion in most European countries, and the United States would do well to see how well

European countries, including Spain, provide health care. Having better health care not only improves the physical and mental health of the homeless, but it implements the idea that the homeless are part of society, and as such they deserve health care too.

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Appendix A: Interview with Kari Whitacre, Executive Director of Community Outreach Incorporated

Whitacre is the executive Director of Community Outreach Incorporated (COI) in Corvallis, Oregon. COI is an organization that provides transitional housing for families experiencing homelessness, drop-in services for the homeless which provides services such as food, blankets, and showers, a free medical clinic, and a sliding scale daycare facility. COI is a central organization in helping the homeless in the city of Corvallis, and Whitacre is an experienced professional who has seen the difficulties of being homeless in the United States. Whitacre is an expert in social services and case management and describes many of the real, day-to-day challenges when helping the homeless.

Many people who suffer from chronic homelessness suffer from mental illness and substance abuse. Kari Whitacre states that there is an argument among providers as to whether the "people try to self-medicate with alcohol because they're not having the mental health needs met or does mental illness become co-occurring based on the drug or alcohol abuse." She believes that alcohol and drugs don't necessarily "calm the demons." At her organization, COI, Whitacre is able to see the effects of mental illness on the homeless first hand. She states that about half of the people they serve at COI are

"suffering from mental illness or drug abuse, or some other issue in their past, like trauma". She describes trauma as extremely prevalent in the homeless population, and that many people who are unable to maintain housing have difficulty because of the trauma in their past. She states "about 85% of the folks [at COI] suffer from trauma in their lives, many people suffer more from previous trauma than generational poverty". She explained that this is especially prevalent in women and "about 90-95% have had some sort of sexual or physical trauma in their past and then the victimization escalates". There are many ways in which mental illness affects the homeless, some of the most significant ways include: being unable to retrieve social services due to mental illness, excluding oneself from social communities and distances oneself from family, and many others. Mental illness is an extremely significant issue that many homeless must face, and it plays a large role not only for the first episode of homelessness, but it remains an issue throughout one's life, which can be seen first-hand by Whitacre.

There is not one grand solution that will help the mentally ill homeless, but there are many smaller ideas that could help with this problem. Whitacre states that the most important underlying issue is by providing more mental health services. She states that "we [The United States] do not have adequate mental health services. We don't have enough providers; I think a big problem is in regards to medications. People can't afford to fill them or don't know how to fill them." This is an extremely important example, as many people with mental health issues are in need of medication. This problem also has a viable solution. "We also don't enough beds available at the mental health hospital. It's happening all around the US. So you have a ton of people who are really suffering from mental illness and can't even get what they need to stay whole and get on the right

track. It's a whole cycle. The system is fractured." By expanding knowledge to more providers and hospitals about mental illness in homeless populations it can be possible to distribute medication in a way that the homeless can afford it and are aware of the instructions.

Whitacre also states that a large aspect of helping those with mental illness is providing care in a compassionate way. She explains that "you'd be surprised what people are willing and able to do if we say 'we believe in you and we expect this of you' -that's huge. By asking them 'how are you feeling today' goes incredibly far when you are speaking with someone who has been isolated or abandoned."

Whitacre states that at COI, they serve "the hidden homeless, those that walk among us, that work at grocery stores, and whose kids go to schools with our kids. We would never deem them that misconception of what we perceive homelessness to be because they don't fit the part; they don't play the role. And there's a definite benefit to someone who is chronically homeless to look that way and act that way because that's how they get their basic needs met. But the reality is, nobody needs to look that way based on the services we have in this community available to them. Most homeless find that they are just having a hard time getting that first and last month's deposit met or are having trouble making the day care payment needed so that they can full time. It's not that they're free loaders as the system sometimes portrays them to be, it's just that the system is broken." Much of the stigma associated with homelessness in the United States is due to the expectations of society, society expects people to be able to pay rent, send their kids to daycare, and afford a meal on the table, but when someone loses support systems, and falls into poverty, it is very difficult to be able to manage all of those costs.

Thus, the stigma associated in homeless is often very skewed from the reality of homelessness. Whitacre states that "people on the street are unable to advocate themselves, and not everyone can work through the system. There are so many clients out there that don't have advocates. Without social and familial ties, it is so hard to work through issues. People feel embarrassed, stigmatized. That's an unfair expectation of society to say 'pick yourself up, get over it' as this is often more difficult done than said." Whitacre describes the incredible difficulties in being an unseen homeless person in the United States.

Whitacre expresses her own feelings about why the homeless in Spain may be stigmatized less. She explains that "the homeless in America are more likely more predatory, they feel more unsafe than the homeless in Spain. The healthcare in Spain is obviously working better to help those with mental illness, because the health care is better, there is a lower stigma." Whitacre states that the effects of stigma towards the mentally ill is huge and apparent. "we are

not giving the homeless dignity and not giving them opportunity. Especially the mentally ill. The mental health system in The United States is so unbelievably broken and hurtful towards the people that need it most. And I don't know how we as a society expect someone who is experiencing homelessness can also take care of their mental health needs when they're alone and out on the street." Due to stigma, many of the homeless are discouraged and unable to navigate back into society, "people try so hard, but the system and the people in the system are not responsive to the needs of individuals. The people experiencing [homelessness] know that they don't have the tools to help

themselves, they need advocates, they need compassionate people that care." Helping the homeless is more than logistics, it is necessary to have concern and empathy for others.

Often many services have insufficient cooperation between the institutions responsible for the care of homeless people. An example of this disconnect can be seen in a narrative by Whitacre of COI. She describes a story that encapsulates the mental health problem in the United States' system. She states that COI has a partnership with a local hospital that if someone is in need of services when they are released from the hospital they can be brought to COI if they have no other place to go. Whitacre describes that "a few weeks ago we got a call from the hospital regarding somebody who had overdosed on heroin. She came into our services fresh-off of heroin, she had past sexual trauma, the whole nine yards. She was too high level of care for our services, and she would not have made it in our organization as we do not have the appropriate resources for her. Her withdrawal was too much and she really needed impatient care. The hospital ended up having her check out. It was incredible that our system did not have a place to put this person suffering from addiction and mental illness. We eventually took her into our services, and she was here for about 3 days before she relapsed. We were able to get this woman into a detox facility, she was detoxed, but then released because there was no impatient bed available for 2 weeks. Which started a slew of questions, such as why would you ever detox somebody with a serious heroin overdose with no place for her to go afterwards. You're just setting her up to fail. By the time we had reached out to her again, she was arrested for a parole violation and put in prison. And this is a story that happens every day in the world of social services." Whitacre's narrative shows an everyday occurrence in the United States, it also shows the disconnect

between many organizations. If the United States wants to be successful in providing help for the homeless it is imperative that these services are fluid and work corroboratively. Whitacre witnesses this occurring regularly and would say that the "majority of people who come from jail have been there have been there because of a mental health or substance abuse related crime. There is story after story of people who should have received treatment."

Whitacre's personal viewpoints and experiences in the life of social services gives valuable insight into what it is like to treat the homeless and mentally ill under the current services being provided.