AID FOR HOMELESS SHELTERS THAT PROVIDE HOUSING FOR HOMELESS SINGLE MEN THAT SUFFER WITH MENTAL ILLNESS IN RACINE, WI

Approved: ------*JaTawn Pinson*---------------- Date: ------1/12/17-------------

Aid for Homeless Shelters that Provide Housing for Single Men that Suffer with
Mental Illness in Racine, WI

_____

A Seminar Paper

Presented to

The Graduate Faculty

University of Wisconsin-Platteville

_____

In Partial Fulfillment of the

Requirement for the Degree

Masters of Science

In

Education

_____

By

Floyd Harmon

2016

TABLE OF CONTENTS

Chapter One: Introduction

According to the National Alliance to End Homeless, State of Homelessness in America 2016 report, 564,708 people in the U.S. are homeless. The further report that over half a million people were living on the streets, in cars, in homeless shelters, or in subsidized transitional housing during a one-night national survey last January. Of that number, 206,286 were people in families, 358,422 were individuals, and a quarter of the entire group were children. In addition, 83,170 individuals, or 15% of the homeless population, are considered "chronically homeless." Chronic homelessness is defined as an individual who has a disability and has experienced homelessness for a year or longer, or/an individual who has a disability and has experienced at least four episodes of homelessness in the last three years (must be a cumulative of 12 months). Families with at least one adult member who meets that description are also considered chronically homeless. According to the National Alliance to End Homelessness "While people experiencing chronic homelessness make up a small number of the overall homeless population, they are among the most vulnerable. They tend to have high rates of behavioral health problems, including severe mental illness and substance use disorders; conditions that may be exacerbated by physical illness, injury, or trauma" (National Alliance to End Homeless, 2016).

The National Coalition for the homeless reports the following are causes of homelessness:

- **Housing**

  A lack of affordable housing and the limited scale of housing assistance programs have contributed to the current housing crisis and to homelessness. Recently, foreclosures have also increased the number of people who experience homelessness.

- **Poverty**

  Homelessness and poverty are inextricably linked. Poor people are frequently unable to pay for housing, food, childcare, health care, and education. Difficult choices must be made when limited resources cover only some of these necessities. Often it is housing, which absorbs a high proportion of income that must be dropped. If you are poor, you are essentially an illness, an accident, or a paycheck away from living on the streets. According to the 2014 census the poverty rate was 14.5% and there were 45 million people in poverty.

Two factors help account for increasing poverty:

- **Lack of Employment Opportunities** – With unemployment rates remaining high, jobs are hard to find in the current economy. Even if people can find work, this does not automatically provide an escape from poverty.

- **Decline in Available Public Assistance** – The declining value and availability of public assistance is another source of increasing poverty and homelessness and many families leaving welfare, struggle to get medical care, food, and housing as a result of loss of benefits, low wages, and unstable employment. Additionally, most states have not replaced the old welfare system with an alternative that enables families and individuals to obtain above-poverty employment and to sustain themselves when work is not available or possible.

Other major factors, which can contribute to homelessness, include:

- **Lack of Affordable Health Care** – For families and individuals struggling to pay the rent, a serious illness or disability can start a downward spiral into homelessness, beginning with a lost job, depletion of savings to pay for care, and eventual eviction.
- **Domestic Violence** – Battered women who live in poverty are often forced to choose between abusive relationships and homelessness. In addition, 22% of homeless women claim domestic abuse as a reason for their homelessness. (National Law Center on Homelessness and Poverty, 2016)
- **Mental Illness** – Approximately 22% of the single adult homeless population suffers from some form of severe and persistent mental illness (National Law Center on Homelessness and Poverty, 2016)
- **Addiction** – The relationship between addiction and homelessness is complex and controversial. Many people who are addicted to alcohol and drugs never

become homeless, but people who are poor and addicted are clearly at
increased risk of homelessness.

Most homeless shelters provide programming and resources for employment,
educational and skilled training resources, however often times behavioral health
resources are available in some cities. This study reviewed best practices of homeless
shelters that provide housing for single males, who are experiencing homelessness and
suffering from a Behavioral Health Diagnosis.

Statement of the Problem

In a study in western societies, homeless people have a higher prevalence of
mental health illness when compared to the general population, they also are more
likely to be alcoholics and suffer drug dependency. It is estimated that 20 to 25% of
homeless people, compared with 6% of the non - homeless, have severe mental illness.
There are other estimations where one third of the homeless, suffer from mental illness.
Studies have found, that there is a correlation between homelessness and
incarceration. Those with mental Illness or substance abuse problems, were found to be
incarcerated at higher frequency than the general public, (Faze 2008).

Significance of the Study

Even if homeless individuals with mental illnesses are provided with housing,
they are unlikely to achieve residential stability and remain off the streets, unless they
have access to continued treatment and services. Research has shown that supported
housing is effective for individuals with mental illnesses. In addition to housing,

supported housing programs offer services such as, mental health treatment, physical health care, education and employment opportunities, peer support, and daily living and money management skills training. Successful supported housing programs, include outreach and engagement workers, a variety of flexible treatment options to choose from and services to help individuals reintegrate into their communities. Homeless individuals with mental illnesses, are more likely to recover and achieve residential stability, if they have access to supported housing programs, (Hoffman 2013). Better mental health services would combat not only mental illness, but homelessness as well. A 2008 survey conducted by the United States Conference of Mayors, revealed that 20% of cities, listed better coordination with mental health service providers as one of the top three items needed to combat homelessness. Contrary to popular belief, homeless individuals with severe mental illnesses, are willing to accept treatment and services. Outreach programs are more successful when workers establish a trusting relationship through continued contact with the people who are trying to help them, (Folsom 2005).

Definitions

Homelessness**:** Individuals experiencing homelessness can be the result of anyone of the following the circumstances, (Lynen 2016):

- Unsheltered – Living on the streets, camping outdoors, or living in cars or abandoned buildings.
- Sheltered – Staying in emergency shelters or transitional housing.
- Doubled up – Staying with friends or family temporarily.

Chronic homelessness**:** Chronic homelessness is when an individual he or she experiences homelessness for more than a year, or experiences a minimum of four homelessness episodes over a three - year period. The results of a 2014 National Drug Control Policy survey of 578,000 experiencing homelessness, revealed 99,000 were considered chronically homeless. This survey also revealed that approximately 30% of individuals experiencing chronic homelessness, suffer from a serious mental illness, where two – third suffer from a substance abuse disorder, where establishing stable housing, may be the negative result, (Lynen 2016).

Method of research

This paper will use literature reviews that include peer-reviewed journals, articles, government websites, and homeless shelter studies, statistics and data.

Delimitations

This study will limit its research to the best practices of using community resources to help homeless men with behavioral health issues. In addition, with the research found, it will measure its effectiveness with the practices and community resources available to homeless men with behavioral health issues in the county of Racine, Wisconsin.

Chapter Two: Review of Literature

Modes of Homelessness

Nothing can reflect upon our North American and European economically and technologically advanced societies more sadly than the size and misery of our homeless population. Chronically mentally ill people wander from home and congregate in urban areas around the world. It is in the Western developed countries, however that the phenomenon of homelessness and its relationship to mental illness is causing an increasing concern, (Fisher & Breakey 1985).

Homeless people probably always present in the general population, become prominent in times of economic and social stress. During the Great Depression of the 1930's, people were displaced from their homes and deprived of their livelihood, congregated in American and European cities, becoming a symbol of the problem of the times. With postwar prosperity, the ranks of homeless people receded, leaving only residents of urban skid rows, such as New York's Bowery, (Fisher & Breakey 1985), which until the 1970s, contained the majority of the visibly homeless and otherwise marginal individuals, (Gounis 1992), who could be easily insulated from the rest of society. Now it appears that an expansion of a different kind of homeless population, including "bag people", and persons who appear to be mentally ill, is occurring, (Fisher & Breakey 1985). The new visibility of the homeless on city streets, has prompted a great deal of public speculation concerning their characteristics and the reasons for their apparent rapid increase in their numbers.

In the United States, the increase has been attributed to a number of related contemporary trends, such as high employment, decreases in public support programs, changes in the structure of American families, and the unavailability of low cost housing. But the brunt of the blame for increase in the number of the homeless, is often directed toward the deinstitutionalization of individuals who suffer from chronic mental illness (Fisher & Breakey 1985). Therefore, investigation of the causes of homelessness, must go beyond housing markets alone, because of the special characteristics of the population at risk and the public policies that address their needs. Subsides and policies regarding institutionalization of the mentally ill, should be important determinants of the incidence of homelessness, (Honig & Filer 1993).

Treatment of the mentally ill, as measured by the number of inpatients in state mental health facilities, appears to have had an impact on the incidence of homelessness. There has been heated controversy regarding the effect on homelessness of the decision in the 1960s to attempt treatment of the mentally ill in community centers, rather than in state mental hospitals. These findings, suggest that the policy of not institutionalizing the mentally ill has been an important factor in increasing homelessness, (Honig & Flier 1993). As a result, the mentally ill individual faces three possible living situations, in a state hospital, on the street (homelessness), or taken in by relatives (doubling up), (Honig & Flier 1993). With homelessness representing the end of a spectrum of poor housing outcomes, it is estimated, that crowded; where more than one person is living per room and doubled up; where households containing more than one nuclear family, are often cited as causes of homelessness, (Honig & Filer 1993). In addition, non - institutionalizing has resulted in

many people not getting the proper diagnosis needed for treatment. According to

research conducted by the Treatment Advocacy Center, approximately 33% of the

homeless individuals with serious mental illnesses that are untreated, many of these

people suffer from a diagnosis of schizophrenia, schizoaffective disorder, bipolar

disorder or major depression, the homeless population has increased steadily in cities

and small towns since the 1970s, (Treatment Advocacy Center 2016).Since it is likely

that both mental illness and hospitalization rates vary across states, the positive

relationship between hospitalization and doubling up, suggests that many more mentally

ill individuals, are cared for by friends and relatives; than by state institutions, (Honig &

Filer 1993).

In Massachusetts 27% and in Ohio 36% of individuals released from mental

institutions, become homeless in 6 months, (Treatment Advocacy Center 2016). Though

officials believe that they are saving money by releasing patients from mental hospitals,

there is a significant cost to the patient and to society at large. A 2001 study at the

University of Pennsylvania, examined 5000 homeless people with mental illness in New

York. The study revealed a $40,500.00 yearly cost to taxpayers for their use of

emergency rooms, psychiatric hospitals, homeless shelters and prisons, (Treatment

Advocacy Center 2016). As states continue to close down psychiatric facilities, there will

be an increasing number of individuals with serious mental illness, who are homeless.

In 2013, the mayor of Seattle Washington, called the number of untreated mentally ill

people on the street, "an emergency", (Treatment Advocacy Center 2016).

Deinstitutionalization policies designed to maintain people with physical or mental health

problems in the community changed the population, using homeless shelters and

community services. As an example, from 1984 to 1988, the number of people using shelters in New York increased from 5000 to 8000. Most suffered from addiction or mental health problems, (Hurtubise, Babin, Grimard 2009). The definition of a homeless shelter, is no less problematic. In its initial sense, a shelter is a place where one goes to avoid danger, or a place, where people who have no place else to go, can gather, (Hurtubise, Babin, Grimard 2009). In the 1990s, critics of shelters, became harsher. Shelters, were perceived as part of a system that tries to hide the homeless population.

The presence of homeless people in public areas, is seen as an annoyance and a menace, (Johnson et al.,2005 as cited in Hurtubise et al., 2009). The scarcity of alternative housing, coupled with policies that bar homeless persons with histories of psychiatric disabilities or drug abuse from existing housing resources, make shelters, the only available recourse for a significant portion of the homeless population. Also, many mentally disabled individuals prefer shelters over the more regimented, segregating, and stigmatizing option of mental hospitals, and other mental health facilities, (Gounis 1992). Emergency shelters have been the most comprehensive and enduring response to homelessness in the United States, with New York leading the way since the 1980s. Shelters have emerged as a hybrid between a degraded type of "public housing" and a new form of "institutionalization". The persistence of shelter dependency or "shelterization", is a form of adapting to the violent, anomic and generally antisocial environment of the shelter.

This explanation of shelter dependency is theoretically flawed and intentionally leads to suspect practices, because it inverts the causal connection between structural arrangements of a shelter and individual behavior, (Gounis 1992). The long debate on

the connection between mental health policies and homelessness, the role of deinstitutionalization, the prevalence of mental illness among shelter participants and other homeless groups, the need for on sight clinical interventions, the range of obstacles encountered by such initiatives, has produced, along with a fair amount of controversy, a definite mental health agenda for these populations. Both inside shelters and in the streets, a variety of clinical programs have been designed. The stated objectives of such programs, have been to identify, engage, in some kind of treatment, and eventually relocate mentally disabled homeless persons, (Gounis 1992).

Homeless Shelters with Program Resources for Single Homeless Men

Even if it is difficult to determine just how efficient they are, it is obvious that the interventions taking place in shelters often succeed in reaching out to a population considered marginal and fearful of public services, (Levinson, 2004, as cited in Hurtubise et al., 2009). Research tends to focus on the resources and the intervention models that target specific subgroups: women, youths, the elderly, and individuals with mental health problems, there is less research focused on the interventions with adult males, (Hurtubise et al, 2009). Mental health tops the list of problems. Shelters offer basic support, but it is difficult to do so for those suffering from mental health problems, (Hurtubise et al, 2009). Grella, suggests that shelters should offer options related to helping the homeless population suffering from mental health problems, (Grella, 1994, as cited in Hurtubise et al., 2009). A follow up after the initial intervention and long term services are useful when dealing with homeless people suffering from mental health problems, (Hall, 1991, as cited in Hurtubise et al., 2009). Applebaum, Dattalo, and Hall, suggest removing barriers to services, coordinating services, emphasizing patient

participation, modifying rules on the protection of information, lobbying for social and psychiatric services, raising shelter worker's awareness of mental health issues and improving training, (Applebaum, 1992, Dattalo, 1991, Hall, 1991, as cited in Hurtubise et al., 2009). More mental health services are offered inside shelters, than physical health services, (Mosher – Ashley, Henrikson, 1997, as cited in Hurtubise et al., 2009). This fact raises questions about the responsibilities of community organizations relative to public services. The intervention practices developed in shelters, must be analyzed with the content of the transformation of health and social services, (Racine, 1993, as cited in Hurtubise et al., 2009).

Mental illness is a major contributor to homelessness. In a 2008 survey performed by the U.S. Conference of Mayors, 25 cities were asked for the three largest causes of homelessness in their communities. Mental illness was the third largest cause of homelessness for single adults as mentioned by 48% of cities, (Mental Illness Policy.org, 2016). Homelessness is not a steady state for most people who experience it, but the longer it persists, the higher their risk of becoming chronically homeless, (Healing Hands, 2001). Where homelessness is experienced for more than a year, or experiences of a minimum of four homeless episodes over a three - year period, (Lynen, 2016). Rather than episodically homelessness, where homelessness is experienced for less than a year and has fewer than four episodes of homelessness in the past three years, (Healing Hands, 2001). According to Healing Hands (2001), to end barriers that cause single males to become homeless and to overcome challenges they face in moving toward residential stability, will depend on the age of the homeless individual, the cause of homelessness, and where along the continuum of

homelessness, intervention begins, (Healing Hands, 2001). Most studies show that single homeless adults are more likely to be male than female. A 2007 survey by the U.S. Conference of Mayors, found that of the population surveyed, 35% of the homeless people are members of households with children, are male, while 65% of these people are females. However, 67.5% of the single homeless population is male, and it is this single population, that makes up 76% of the homeless population surveyed, (U.S. Conference of Mayors, 2007, as cited in Matlack, 2012). In a broad profile, here is what is known about the men who experience homelessness from a national survey of homeless service users, conducted in 1996, (Healing Hands, 2001).

- Age – 84% of currently homeless men are single adults ages 25 – 54 years, 9% are 55 or older, and 7% are 18 – 24 years. In general, homeless men are older than homeless women, (Healing Hands, 2001).

- Employment – Among homeless men, 41% receive income from employment, compared to 27% of homeless women, although only half expect their job to last at least three months. A higher proportion of single homeless adults, 60%, than of adults in homeless families, 45%, has completed at least a high school education. This helps to explain the fact that more homeless men than women are employed, although in temporary or low wage jobs, (Healing Hands, 2001).

- Ethnicity – Of single homeless adults, who are predominantly male, 41% are White, non - Hispanic, 40%, are Black, non – Hispanic, 10%

are Hispanic, 8% are Native American, and 2% are Asian, (Healing

Hands, 2001).

- Substance Abuse and Mental Health Problems – Homeless men

   report alcohol problems at more than twice the rate reported by

   women, 46% versus 22% for women, and other drug problems at a

   rate half as high, 30% versus 20% for women. The overall incidence

   of Mental Health problems is similar in both groups, 38% of men,

   versus 43% of women, of homeless individuals reporting alcohol, drug

   or mental health problems, 73% are male, (Healing Hands, 2001).

- Habitation – Because homeless men are more likely to have

   uncontrolled alcohol or drug problems, than their female counterparts,

   they are more frequently excluded from emergency shelters, which

   often require abstinence as a condition of admission. This partially

   explains the fact that far more men than women sleep on the streets,

   (Healing Hands, 2001).

This data suggest that single homeless men are at increased risk for chronic

homelessness, higher health risks associated with substance abuse, lack of shelter,

and limited access to needed health services and other resources, partially explain

their enhanced vulnerability, (Healing Hands, 2001).

Resources for single Homeless Men experiencing Mental Health Issues

Homelessness continues to be a major problem in America. The best medical

estimates indicate that about one – third of homeless individuals have a mental illness,

these individuals have difficulties obtaining the treatment and support services they

need to find and keep permanent housing. Research shows that although serving this

population is a challenge, homeless individuals with mental illness, will participate in

services that the view as responsive to their needs, (Psychiatric Services, 1997).

Nontraditional mental health services, such as outreach programs, drop – in centers,

and various types of case management, are successful in engaging homeless persons

with severe mental illness. However, few controlled studies have systematically tested

the effectiveness of programs that include these key elements for improving housing

outcomes in this group. To address this lack of information, beginning in 1990, the

National Institute of Mental Health and later the Center for Mental Health Services

sponsored a series of five research demonstration projects, known as the Second –

Round McKinney Research Demonstration for Homeless Mentally Ill Adults,

(Psychiatric Services, 1997). The studies were conducted in Baltimore, Boston, San

Diego and New York. The duration of the client follow - up ranged from 12 to 24

months, (Psychiatric Services, 1997). Additionally, in New York City, two studies were

conducted, the street study and the critical time intervention study. The street study

recruited mainly persons who were living on the streets, and the critical time

intervention, targeted long term residents of the Fort Washington shelter, (Psychiatric

Services, 1997). Each of the projects focused exclusively on persons with severe

mental illness who were homeless. All participants, were required to have spent a

significant number of nights on the streets, in shelters, or in temporary residences

before enrollment; to have been homeless at admissions to an institution; or to have

no permanent community residence at discharge from an institution. Community

settings, included, a range of housing alternatives, such as living in ones' own

apartment, with friends or relatives, or in a residential crisis in the community, (Psychiatric Services, 1997). During the course of these studies, various case management models were used in the different cities; these models included, rehabilitation, assertive community treatment, and intensive case management. The housing resources and settings in these studies varied. The Boston project compared congregate consumer run housing with independent living. In the New York project, specialized housing for homeless persons with severe mental illness was the housing resource used. The San Diego project tested, the importance of Section 8 Housing Certificate in obtaining and maintaining housing, (Psychiatric Services, 1997). In the New York street study, and the Baltimore project, control groups that received the usual treatment resource were used, while at the other three sites, comparisons were made between interventions that systematically differed in the type and intensity of services provided, (Psychiatric Services, 1997). 894 total individuals took part in the five projects, with an average age of 37.5 years, where 62% were single, 72% were male, 59% were of minority decent, 60% had completed high school and 7% were employed, 90% had a diagnosis of either a psychotic disorder, 57%, or an affective disorder 33%, 27% reported more than five psychiatric hospitalizations, 44% reported having been homeless for more than four years, and 36% reported more than five episodes of experiencing homelessness, (Psychiatric Services, 1997).

The results of the project revealed that individuals in the New York street study, were the least likely to be housed at follow up, this study targeted individuals who were residing on the street at program entry, which was 90% of the individuals targeted. At the final follow up of this project, 38.9% of participants in the street study's

experimental group lived in community housing, (Psychiatric Services, 1997). Control group members in the street study, received no special services. Results for this group represent what may be expected from an untreated street population. Most control group members, 52%, were homeless, and 20%, were residing in institutions at final follow up. At the Baltimore site, 14% of the participants, were living on the street at the program entry, with 31%, living in shelters and 28%, at inpatient programs. At final follow up, more than 80%, of experimental group members in Baltimore were in community housing, compared with 60% of control group members. With Baltimore using a control group that received standard treatment, the results, for this group, indicate what might be expected with ordinary community services and a diverse homeless population, (Psychiatric Services, 1997). In the New York critical time intervention study, all participants resided in the Fort Washington shelter at program entry. These participants had well established relationships with the shelter based treatment team before entering the study. These results may therefore reflect what could be expected from a stable shelter population. 80% of the Boston participants, were also recruited from shelters. Participants in the San Diego study, came from a variety of service settings. Overall, homeless persons who received active interventions attained community housing, (Psychiatric Services, 1997). The increase between the program entry and final follow up in the proportion of individuals living in community settings increased statistically, where a 47.5% increase was found in the proportion of individuals living in community housing, (Psychiatric Services, 1997). Participants were regarded as stably house, if they did not move during the final follow up interval. Those who residing in community housing at the final follow up, were

stably housed, (Psychiatric Services, 1997). The pooled results, from the five housing projects, suggest that offering a range of acceptable housing alternatives, when coupled with case management, treatment, and rehabilitative services, is effective in engaging and stably housing homeless individuals with severe mental illness. These projects have demonstrated that effective methods are available for combining housing and support services to successfully serve homeless persons with severe mental illness, (Psychiatric Services, 1997).

Homelessness in Wisconsin

The Housing and Urban Development (HUD) 2015 Annual Homeless Assessment report to Congress found an overall 11% decline in the number of persons experiencing homelessness since 2010, including a 26% drop in the number of persons living on the streets in Wisconsin. Overall, homelessness declined by 4.4% since 2010. In January 2015, an estimated 6,057 people were homeless, on a given night, 92.7% were staying in residential programs for homeless people and 7.3% were found in unsheltered locations. Chronic homelessness among individuals continued to decline. Since 2010, chronic homelessness declined 50.3%, more than 300 individuals experiencing homelessness in January 2015, were reported as chronically homeless in Wisconsin, (U.S Dept. of Housing and Urban Development, 2015). During the winter of 1984 – 1985, in Milwaukee Wisconsin, interviews with persons staying in emergency homeless shelters and on the streets in order to examine the problems of individuals who are both homeless and seriously mentally ill. A total of 237 interviews were completed with persons who met the study's definition of homeless. Of the total, 185 persons were temporarily staying in shelters and 52 were found to be living in

abandoned cars or buildings, parks, alleys, and similar sites. Symptoms of serious

mental illness were readily apparent in 48% of the persons interviewed. Compared to

a sample of 84 persons enrolled in mental health community support programs,

homeless mentally ill persons were less likely to be from Milwaukee and to have a

family member here. The most recent psychiatric hospitalization reported by homeless

mentally ill persons, occurred longer ago, compared to clients of community support

programs. The interviewing methodology used in this study, suggests that a patient,

non – intrusive outreach effort is a viable means of establishing a therapeutic

relationship with homeless mentally ill persons, (Rosnow, Shaw, Concord, 1986).

Homeless Resolutions in Racine Wisconsin

From 1993 until 2005, a faith based organization almost single handedly sheltered

the increasing homeless population of Racine Wisconsin, a small city south of

Milwaukee. Each year, a network of seven churches agreed to offer shelter to the

homeless each night during the cold weather months. These churches organized

under the direction of the Racine Emergency Sheltering Taskforce (REST), the rest

program, comprised congregations from a wide range of religious perspectives. On the

basis of a census taken in January 2005, at least 276 people were homeless in Racine

County. Of that number, 66 people were classified as chronically homeless. According

to the executive director of the United Way of Racine County, there is an estimated

1,200 homeless people in the county on a regular basis. When asked in the 2005

survey to identify their most pressing needs, Racine's homeless prioritized basic

requirements, such as, "meals, access to mainstream resources, bus tokens/program

transportation, emergency medical care, transitional housing, emergency shelter,

bathing facilities and utility assistance, (Tunkieicz, 2003, as cited in Djupe and Olson, 2007). As an outgrowth of their work with local food pantries, Racine residents, Donna Bumpus and Pat Liesch, founded the REST program in 1993, (Bumpus,2003, Danielson 2001, as cited in Djupe and Olson, 2007). They became aware of a network of locally run homeless sheltering programs in Southern Wisconsin and Northern Illinois, known as the Public Action to Deliver Shelter (PADS), which operated out of churches in small towns in Illinois, (Gardner, 2003, as cited in Djupe and Olson, 2007). Racine's neighboring city, Kenosha, recently had established a faith based homeless shelter, the Interfaith Network Nightly Shelter (INNS) Program. In 1970, Louise Hunter, a women, whose Christian beliefs moved her to work toward the mending of poverty in Racine, founded Love and Charity homeless mission for men, (Woods, 2005, as cited in Djupe and Olson, 2007), due to Louise Hunter's retirement, Love and Charity closed in June, 2016, (Schaaf, 2016). From the start the REST Program was intentionally a faith based program. REST guests, were a cross section of Racine's poor population, roughly half of REST'S guests, from 1998 – 2003, were African American, 5% were Hispanic, (Bumpus, 2003, as cited in Djupe and Olson, 2007), and the remainder were white. A majority of REST'S guests were between the ages of 31 and 50 years, very few were under the age of 21, or over the age of 60, (Bumpus 2003, as cited in Djupe and Olson, 2007). Roughly 85% of REST'S guests were male, (Danielson, 2001, as cited in Djupe and Olson, 2007). Over the twelve years of REST'S existence, its shelters gradually found themselves serving larger numbers of homeless guests. In the 1990's, REST sheltered an average of thirty guests per night, (Danielson, 2100, as cited in Djupe and Olson, 2007). After 2000, that number climbed to more than fifty

guests per night, and eventually REST Congregations also began hosting an overflow

of homeless people from nearby Kenosha, (Killackey, 2003, as cited in Djupe and

Olson, 2007). In 2005, REST'S, last year of operation, its shelters were serving an

average of seventy guests per night, (Tunieicz, 2005, as cited in Djupe and Olson,

2007). As early as 1998, REST'S executive director, and its board of directors, began

appealing to the city of Racine for assistance in establishing a year round single site

homeless shelter. Their aim in establishing a single site shelter was to remove the

burden from local congregations, (Djupe and Olson, 2007). The city government,

however, was slow to respond. It commissioned an Ad Hoc Committee of its Human

Services Board to consider REST'S request, in 1998, that committee seemed to have

never reach a concrete conclusion. For four years, REST advocates continued

occasionally to ask for the city's support for a year round, single site shelter,

(Buttweiler, 2002, as cited in Djupe and Olsen, 2007). As REST Board President

explained from the programs perspective "at some point, it needs to be a community

buy in, it can't just be the churches", (Thomas 2003, as cited in Djupe and Olson,

2007). Many concrete reasons, were cited for the need for a single site shelter. In the

REST Board President's words "we are a fragile organization, we are a band aid, we

are a pseudo agency, that's what we've evolved into", (Thomas, 2003, as cited in

Djupe and Olson, 2007). One specific concern was the difficulty inherent in asking

untrained volunteers to deal with the special needs of the portion of the homeless

population living with mental health challenges, serious illness, and substance abuse,

(Thomas 2003, as cited in Djupe and Olson, 2007). As one REST Congregation

Pastor stated bluntly "we are not equipped to handle schizophrenics", (Djupe and

Olson, 2007). The program established a policy that participants would not be admitted to the shelters after 10:00 pm, unless they were accompanied by a police officer, and beginning in the fall of 1998, the shelters refused to accepts individuals under the influence of drugs or alcohol, (Pfau 1998, as cited in Djupe and Olson, 2007). Another concern, was the REST program operated only during the cold weather months of October through April, leaving the homeless to sleep on the beach or in the city parks in the summer months. Advocates for the homeless, redoubled their efforts of the establishment of a single site shelter in 2003. After years of inaction by the city government, the United Way of Racine County, took matters into its own hands by convening a Community Task Force; The Transition Advisory Council, to assess the needs of Racine County's homeless population. The task force was charged analyzing "needs and social service gaps", and helping with fund raising and planning efforts, (Rest Shelter News, 2004, as cited in Djupe and Olson, 2007). It quickly set a primary goal of identifying tenable solutions to the problem of chronic homelessness and decided that a centralized effort to fight homelessness would be necessary, (Djupe and Olson, 2007). It had become clear, however, that a permanent single site shelter was needed, (Burke 2003, as cited in Djupe and Olson, 2007). Around the same time as the announcement of the single site shelter plan, the formation of a new homeless assistance was also announced. The organization, which would be called the Homeless Assistance Leadership Organization (HALO), would take the REST program and Homeward Bound, a shelter that served homeless women exclusively, (Sides, 2004, Tunieicz, 2004, as cited in Djupe and Olson, 2007). A HALO board member said "as we look to the future, we can say there are ways we

can do this better, by not duplicating resources and really address the cause of chronic homelessness together, not just as individual groups addressing pieces of it", (Tunieicz, 2004, as cited in Djupe and Olson, 2007). HALO envisioned improving service delivery for the homeless and putting them on the path to self - sufficiency. Two separate shelters would be housed, one for men and one for women and children, with a total of 120 bed space. The HALO Shelter formally opened its doors to homeless men on November 4, 2005, (Djupe and Olson, 2007). Since opening in 2005, HALO has never had to turn down a qualifying client and serves an average of 92 people nightly (Halo, 2015). HALO'S mission is to provide a pathway to self - sufficiency for those experiencing homelessness in Racine County. This is accomplished through a variety of programs and services offered at HALO or through partner provider associations and organizations. HALO'S case management team, works closely with program participants in order to create a clear and comprehensive plan of success, (Haloinc.org, 2013). Included in HALO'S programming is,

- The journey to Self – Sufficiency Program – an accountability based program for adults wishing to return to stable housing.
- Family Program – a program for assisting homeless families in shelter.
- Permanent Housing Program (PHP), a housing program for individuals or families experiencing disability, including mental illness, this housing program is offered on a permanent basis, (Haloinc.org, 2013).

HALO offers extended shelter resources, for participants who desire to work with a case manager to create their own Individual Success Plan (ISP). ISP'S pair participant dedication with community support services, such as mental health counseling,

vocational training, financial planning, budget counseling, addiction recovery, and tutoring. HALO collaborates with community area agencies to provide support services needed to assist HALO participants to succeed in resolving homelessness, (Halo, 2015). HALO'S Permanent Housing Program (PHP), is a program that provides housing resources to individuals or families, who are ready to leave HALO'S shelter program, but because of mental illness or another disability, are not prepared to live on their own. In HALO'S Permanent Housing Program, clients have the opportunity to start over in a respectable apartment, and are in turn required to attend groups, budget monthly, maintain sobriety. Besides an apartment, HALO'S Permanent Housing Program, offers other resources, which include;

- Financial help, such as monthly budgeting, workshops and training

- Payee Services

- Assist in coordinating Dr. appointments

- Education through classes held at HALO and referrals to classes at community resources

- Mentoring and support through mental health crisis

- Volunteer and employment opportunities

- Legal referrals

- Assistance in signing up for health care/food stamps

- Assistance for disabled participants in obtaining SSI/SSDI benefits

- Assistance in becoming active in their community

Additionally, in the Permanent Housing Program, participants are required to;

- Participate in a continuing Individual Success Plan (ISP), including monthly meetings with their case manager

- Attend groups as dictated by their ISP

- Remain sober – random drug testing is administered by HALO Staff case managers

- Maintain hygiene

Monthly housing inspections are done to ensure homes are maintained, cleaned and in order, as well as to check on the well - being of participants. HALO'S Permanent Housing Program (PHP) has been in existence since 9/2008, with a main - criteria of providing housing resources for homeless individuals who suffer from mental health issues. HALO'S PHP program is a limited lifetime permanent housing program based on the severity of a participants' mental health disability. (Haloinc.org, 2013). A participants' disability must impede an individual from living a functional life style. HALO'S PHP program is an accountability program, where a participant must be able to function on a day to day manner, where case management to observe compliance and progress made on a participants Individual Success Plan (ISP), and a total of 60 community support resources are offered. An individual must be have a source of income such as Social Security or be able to maintain employment with employment resources in the community, that comply with their disability, participants also work with Good Will, and the Department of Vocational Rehabilitation (DVR), as employment resources. Participants in this program, have their rent paid by the Housing and Urban Development program (HUD), a participant not receiving Public Benefits, must obtain income, to pay utility bills and to offset services provided, which

is 30% of their monthly adjusted gross income. PHP offers 5 levels of housing

programs, with PHP 1 and PHP 2 address housing issues with single individuals with

mental health issues. PHP 3, PHP 4, and PHP 5, address housing issues for a mixture

of single individuals and families who may have a family member that suffers from a

mental health issue, where chronic homelessness is also a factor, (Halo.org, 2013).

HALO'S PHP Housing program has a total of 45 participants, with a total of 20 single

males, where the age range is from 19 to 64 years. HALO'S PHP program, has a total

of 8 single males advance from the PHP housing program, to obtaining their own

housing through HUD, (Haloinc.org, 2013).

Chapter Three: Conclusion and Recommendation

Research provides that addressing the matter of available community support resources for single males experiencing homelessness with mental health issues, is of major concern. The literature exposes the challenge this population encounter, as a result of the lack of available resources paired with social condemnation. The research also provides knowledge, that when homeless shelters combine their resources with community support resources the partnership provides a constructive avenue in resolving homelessness issues and establish a means where a relationship to address mental health issues are possible. In addition, the research expresses this collaboration will also provide the benefit of providing an opportunity for case management, community support interventions, mental health support groups, single male support groups, lifestyle workshops, housing resources and legal resources.

Based on this study, homeless shelters in Racine, WI will greatly benefit from forming partnerships with community agencies to leverage their resources. The research has shown that this partnership is vital in helping homeless single males who suffer with mental health, gain community assistance toward resolving homelessness. The appendix list of community agencies in Racine, WI available for potential collaborations.

Based on research and best practices, successful collaborations establish a referral process that includes a release of information and an accountability policy. This process helped to ensure when viable community and homeless resources are available, accountability standards are in place. Research shows the successful programs which

held individuals accountable to rules and policies produced compliant participants that

were able to successfully address their homelessness and mental health issues.

References

Fazel, S, Khosla, V, Doll, H, Geddes, J (2008). "The Prevalence of Mental
Disorders among the Homeless in Western Countries: Systematic Review and
Meta – Regression Analysis". *PLoS Med* **5** (12): e225. doi: 10.
1371/journal.pmed.0050225.

Folsom, D.P., Hawthorne, W., Lindamer, L., Gilmer, T., Bailey, A., Golshan, S.,
Garcia,P. Unutzer, J., Hough, R., and Jeste, D.V. (2005). "Prevalence and Risk
Factors for Homelessness and Utilization of Mental Health Services among
10,340 Patients with Serious Mental Illness in a large public Mental Health
System". American Journal of Psychiatry, 162: 370 -376. Feb 2005.

Hoffman, Piper (2013, May 6). More Mentally Ill Becoming Homeless Because States
Won't Help. Retrieved from http://www.truth-out.org/opinion/item/16193-more-
mentally -ill-becoming-homeless-because-states-won't-help.html.

Lynsen, Ann. (2016, April 4) Homeless and Housing. Retrieved from
http://www.samhsa.gov/homelessness-housing.

National Alliance to End Homeless. (2016). The State of Homelessness in America.
Retrieved from
http://www.endhomelessness.org/page/files/2016%20State%20Of%20Homeless
ness.pdf

Statistic Brain (2016)/ National Law Center on Homelessness and Poverty. Retrieved
from http://www.statisticbrain.com/homelessness-stats/

Fisher, Pamela J., Breakey William, R., "Homelessness and Mental Health: an
overview". International Journal of Mental Health 14.4 (1985) 6-41.web

Honig, Marjorie., Filer, Randall K., "Causes of Intercity Variation in Homelessness". The
American Economic Review, Vol.83, No. 1 (Mar., 1993), 248-255.
http://links.jstor.org/sici?sici=0002-
8282%28199303%2983%3A1%3C248%3ACOIVIH%3E2.0CO%3B2-9

Gounis, Kostas. (1992) "The Manufacture of Dependency: Shelterization Revisited",
New England Journal of Public Policy: Vol. 8: Iss.1, Article
60.http://scholarworks.umb.edu/nejpp/vol8/iss1/60

Hurtubise, Roch., Babin, Pierre–Olivier., & Grimard, Carolyne., "Shelters for the Homeless : Learning from Research". In: Hulchanski, J. David; Philippa; Chau, Shirley; Hwang, Stephen: Pardis, Emily (eds.) Finding Home: Policy Options for Addressing Homelessness in Canada (e-book), Chapter 1.2. Toronto: Cities Centre, University of Toronto. 2009. www.homelesshub.ca/Finding Home

Treatment Advocacy Center. (2016) "How Many People with Serious Mental Illness are
    Homeless". Retrieved from http://www.treatmentadvocacycenter.org/problem/consequences-of-non-treatment/2058

"Homeless Mentally Ill Facts, Figures and Anecdotes - MENTAL ILLNESS POLICY Org". 2016." 250,000 Mentally Ill are Homeless, The number is increasing". Retrieved from http://mentalillnesspolicy.org/consequences/homeless-mentally-ill.html

Matlack,Tom.," Why Are Men More Likely to Be Homeless? - ." The Good Men Project, 28 Jan. 2012. Retrieved from http://goodmenproject.com/good-feed-bloog/why-are-men-more-likely-to-be-homeless/

Healing Hands, "Single Males: The Homeless Majority". Health Care the Homeless Clinicians' Network, National Health Care for the Homeless Council, Vol 5, No. 3, June 2001

Shern, David L., Felton, Chip J., Hough, Richard L., Lehman, Anthony F., Goldfinger, Stephen, Valencia, Elie., Dennis, Deborah., Straw, Roger., Wood, (1997). "Housing Outcomes for Homeless Adults with Mental Illness: Results from the Second -Round McKinney Program".   Psychiatric Services, Vol. 48. No. 2. February 1997

Djupe, Paul., Olson, Laura., "Beyond the Culture Wars". Intrests in Community Conflict, 2007, by Baylor University Press, Waco Texas 76798

Schaaf, Mark, "Love and Charity to close", May 18,2016. Retrieved from http://journaltimes.com/news/local/love-and-charity-to-close/article_dbedf2b8-a747-5f62-9f7c-aeb7f71e1ee.html

Halo – Homeless Assistance Leadership Organization Shelter and Services – Racine WI. "Racine Treatment Center", 10 - 20 - 2015. Retrieved from http://www.homelessshelterdirectory.org/cgi-bin/id/shelter.cgi?shelter=9806

HALO Inc. (2013), "Permanent Housing Program (PHP)". Retrieved from
http://www.haloinc.org/programs/php

HALO Inc. (2013), "Programs and Services". Retrieved from
http://www.haloinc.org/programs

Homelessness in Wisconsin Remained Stable in 2015. U.S. Department of Housing and
Urban Development – Nov 19th, 2015. Retrieved from
http://urbanmilwaukee.com/pressrelease/homelessness-in-wisconsin-remained
stable-in-2015

Appendix

Available community agencies in Racine, Wisconsin include:

- Legal Action of Wisconsin – assistance with Legal Matters
- HOPES Center or Racine Inc. – Mental Health and Social Service Resources
- Racine Vocational Ministry – Employment Training
- Behavioral Health Services of Racine – AODA and Mental Health Services
- Housing and Urban Development (HUD) – Housing Resources
- Harvest Consulting – AODA – Mental Health – Family Counseling
- Moore and Associates – AODA Treatment
- Family Service of Racine – Outpatient Mental Health Counseling Resource
- National Alliance on Mental Health (NAMI) – Mental Health Referral Resource