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## 23

# THE MEDICALIZATION OF HOMELESSNESS

*Tom Baker*

Health and homelessness are strongly inter-related. Clinical and demographic studies have long shown that poor health can be a contributing factor to homelessness, can be an effect of homelessness and can impede an exit from homelessness (see Hodgetts et al., 2007; Hwang, 2001; Institute of Medicine, 1988). Poor physical and mental health puts people at greater risk of becoming homeless and, once homeless, they are at increased risk of premature death, are more likely to experience a wide range of physical and mental illnesses and are more likely to be assaulted (Hodgetts et al., 2007; Hwang, 2001). However, beyond the *empirical* connection between health and homelessness, health geographers and other critical social scientists have documented the emergence and expansion of *medicalized understandings* of homelessness. As political interest in addressing the structural causes of homelessness has waned, individualized therapeutic interventions have become a central focus of efforts to address homelessness (Gowan, 2010; Lyon-Callo, 2000; Weinberg, 2008). For several decades now, therapeutic interventions have been commonly positioned as a fundamental cure for homelessness, rather than a topical treatment for the symptoms of structural phenomena, such as housing deprivation.

While the medicalization of homelessness is a transdisciplinary research topic that spans academic disciplines including geography, sociology, anthropology and urban studies, this chapter emphasizes the contributions of health geographers. One of the most significant contributions made by health geographers has been to examine the role of *homeless service spaces* in the medicalization of homelessness. The chapter initially outlines the historical development of medicalized homelessness, drawing on sociologist Teresa Gowan's (2010) key text *Hobos, Hustlers and Backsliders*. The chapter then discusses how homeless service spaces have been a key part of the promotion and reinforcement of medicalized understandings and interventions. Synthesizing the work of a range of health geographers, the chapter highlights how homeless service spaces have enabled two distinct styles of medicalization: first, *authoritarian* medicalization typical of mainstream shelters and transitional housing programs; second, *assertive* medicalization typical of supportive housing programs. Following this, the chapter discusses how recent research within health geography suggests that homeless service spaces serve two key functions in the medicalization of homelessness. On one hand, homeless service *systems* allow for the *objectification* of homeless people as members of a (sub-)population with distinctive health characteristics and therapeutic needs. On the other hand, homeless service *sites* allow for members of those populations to be *subjectified* in accordance with social and political norms relating to the healthy individual. The chapter concludes by identifying research opportunities related to the rationales behind, and resistance to, medicalization and the ways in which medicalized understandings and interventions are reconciled with non-medicalized alternatives.

## Systems, sin and sickness

Efforts to address homelessness, such as policies and services, reflect particular understandings of homelessness as a problematic social condition. These understandings or problematizations are historically and geographically variable: there is no universally accepted, timeless understanding of homelessness. Within Western nations, Gowan (2010) claims that homelessness has been understood as a problem of sin, systems and sickness.

The first and oldest of these understandings positions homelessness as a problem of individual sin – or moral deficiency – to be addressed with strategies of exclusion and punishment. The origins of this moral problematization stretch back to the Protestant Reformation of the 16th century when, for “the first time, begging and impoverished wandering were primarily understood as indications of moral weakness or criminality and as major social problems” (Gowan, 2010, p. 31). This remained the dominant understanding of homelessness until the early 20th century, when a rival understanding began to emerge, positioning homelessness as a problem of systems that ought to be addressed with systemic regulation or transformation. In the United States, the Roosevelt Administration’s package of New Deal reforms in the 1930s – including job creation, enhanced labor rights and cash assistance to vulnerable people – was an early example of such an understanding being put into practice. As was the case in many countries at the time, the combination of Keynesian economic management and (what later evolved into) the postwar welfare state dramatically reduced the incidence of homelessness for several decades. Systemic understandings of homelessness became normalized, and arguments about the moral deficiency of homeless individuals began to subside.

From the 1980s, Keynesian economic management and the postwar welfare state began to be rolled back with market-based, neoliberal reforms. The economic and social upheaval associated with these changes translated into a widely acknowledged homeless crisis (Mitchell, 2011). With systemic change placed beyond the pale of state intervention, the problem of homelessness was increasingly located within the individual. On one hand, historically enduring moral understandings of homelessness reemerged, and homeless people were exposed to a widening array of civil and criminal sanctions. Urban geographers, in particular, have conducted extensive research on the application of such sanctions and their implications for the rights and lives of homeless people (for an overview, see Mitchell, 2011; von Mahs, 2011). On the other hand, a new understanding of homelessness based on individualized pathology began to emerge with the growth and maturation of specialized homeless services. Given its apparently *medicalized* framing (Lyon-Callo, 2000), health geographers have been primary contributors to a growing geographical literature on this approach to homelessness (for early research, see DeVerteuil, 2003, 2006; for more recent research, see Evans, 2012; Evans, Collins and Anderson, 2016). Across the Anglophone world, the 1980s saw activist groups and charitable organizations create stopgap responses to the homeless crisis, in the form of soup kitchens and basic shelters. “While much immediate hardship was mitigated,” Gowan (2010, p. 46) notes, “the soup kitchen or emergency shelter tended, as ever, to institutionalize the problem of homelessness.” Initially uncoordinated and localized, these efforts became formalized into the homeless service sector through the introduction of specialized public-funding streams. What were conceived as remedial services offered in anticipation of systemic reform, over time, became focused on therapeutic reform of the homeless themselves. “Somewhere along the way,” Gowan (2010, p. 51) concludes, “systemic [understandings of homelessness] . . . had become lost in a sea of practices that implied very different ways of understanding the problem.” Homelessness was understood less as a disorder of systems and more as a disorder of the self (Lyon-Callo, 2000), with variously moral (a problem of poor behavior) and medical (a problem of poor health) dimensions.

## Styles of medicalized homeless governance

Where the justice system focuses on transforming the moral character of the homeless through enforcement of civil and criminal sanctions, the homeless services system has come to focus on transforming their

medical character through therapeutic interventions that address individualized mental and physical pathologies. By medicalizing a state of housing deprivation, Evans (2012, p. 188) notes, “unhoused individuals are politicized, not simply as ‘homeless’ citizens but as living beings with biological ‘pathologies’.” The research of health geographers and other social scientists suggests that there are two distinct but coexistent *styles* of medicalization practiced by homeless services, which stem from two different treatment philosophies: First, the treatment-led philosophy typical of mainstream shelters and transitional housing programs is associated with an *authoritarian* style of medicalization. Second, the housing-led or Housing First philosophy typical of supportive housing programs is associated with an *assertive* style of medicalization. Each of these will be briefly explained.

As localized, volunteer-based, and often radically motivated responses to the homeless crisis became folded into a formalized and professionalized homelessness service sector, “mission creep” set in. The guiding philosophy of service provision transitioned from one based around meeting material needs, such as housing, to one based on producing self-sufficient and housing-ready individuals with the aid of therapeutic interventions, such as addiction treatment, counseling and psychiatric treatment. With the prospect of access to permanent housing made contingent on clinical stabilization and treatment adherence, the treatment-led philosophy of homelessness services translated into an authoritarian style of medicalization (Gowan, 2010). Health geographers such as Geoffrey DeVerteuil and Robert Wilton are key contributors in this research area (DeVerteuil, 2003, 2006; DeVerteuil and Wilton, 2009; Wilton and DeVerteuil, 2006), demonstrating how such therapeutic interventions reflect a host of different intentions relating to care and control (for related contributions from urban geographers, see Cloke, May and Johnsen, 2010; Johnsen, Cloke and May, 2005; Johnsen and Fitzpatrick, 2010). Mandated by specialized government funding streams, treatment-led philosophy and practice saw an “army of social work professionals trained in the language of disease and dysfunction . . . examining and categorizing their clients’ capacities in terms of mental health, substance use, life skills, parenting, budgeting, and overall ‘housing-readiness’” (Gowan, 2010, p. 49). In the United States, treatment became embedded in federally funded *continuum of care* programs, while in Australia, Canada, France, New Zealand and Sweden the terms “staircase,” “linear” and “step-wise” are among those used to describe the underlying treatment-led focus of the homeless services system (Evans, 2015; Houard, 2011; Johnson, 2012; Knutagård and Kristiansen, 2013; Laurenson and Collins, 2007).

While treatment-led approaches remain the orthodoxy for homelessness services in Western countries, since the late 1990s an alternative philosophy of housing-led service provision has gained momentum. Commonly called Housing First, this philosophy, which health and urban geographers have begun to research in recent years (Baker and Evans, 2016; Evans, 2015; Evans, Collins and Anderson, 2016; Hennigan, 2016; Klodawsky, 2009), is associated with supportive housing programs that target chronically homeless individuals (for an overview, see Baker and Evans, 2016). The “chronically homeless” – a term with strong medical suggestions – are a statistically small portion of the overall homelessness population who are unable or unwilling to submit to the authoritarian medicalization of treatment-led homelessness services but unable to independently overcome their homelessness. Contrasting with the authoritarian style of treatment-led service programs, these programs engage in assertive medicalization, using persistence and persuasion to *convince* their clients of the need for treatment. Permanent supportive housing programs require that homeless individuals be housed “as quickly as possible with ongoing, flexible and individual support as long as it is needed, but on a voluntary basis” (Busch-Geertsema, 2013, p. 4). Rental lease agreements between clients and landlords allow clients to maintain their accommodation without abstaining from alcohol and drugs and without necessarily engaging in treatment. Rather than mandating treatment uptake as a condition of housing retention, case workers assertively offer treatment services and suggest ways to reduce mental and physical harms associated with problematic alcohol and drug use (see Aubry et al., 2016, regarding the central place of assertive community treatment in Housing First programs). The homelessness services system has thus become bifurcated: authoritarian, compulsory medicalization is applied to the non-chronic, majority homeless population, and assertive, voluntary medicalization is applied to the chronically homeless.

These ambivalent styles of medicalization align with a broader sensitivity, within geographical scholarship, to diverse practices and motivations implicated in homeless interventions (see May and Cloke, 2014; Murphy, 2009; Sparks, 2012). To understand how these two styles of medicalization have been enabled, the next section draws attention to the role that spaces of homeless service provision play in objectifying and subjectifying homeless populations.

### Homelessness services as objectifying and subjectifying spaces

In both authoritarian and assertive modes, the medicalization of homelessness is achieved through spaces of homeless service provision. Indeed, health and urban geographers have advanced the broader field of homelessness research by providing detailed accounts of the ways in which homeless service spaces are implicated in medicalizing homelessness (Evans, Collins and Anderson, 2016). Their work also provides insights into the impacts of homeless service spaces at a number of scales – from the scale of the individual homeless person through to city-scale and national-scale apparatuses of poverty management (May and Cloke, 2014). Homelessness services are impacted by a diverse range of understandings, agendas and motivations, including those of government, service organizations, practitioners and service recipients. As spaces of “regulatory richness,” argue DeVerteuil and Wilton (2009), social services may act, variously, as “a platform for operators’ therapeutic aims,” while at the same time they “may act to contain and control people deemed disruptive and unproductive” by society at large, and, for service recipients, they “may act as a critical node of survival” (p. 463). Even a single homelessness service program “can be read as an entanglement of strategic policy efforts, therapeutic impulses, and personal hopes and desires, all invested in a very unique socio-spatial intervention” (Evans, 2012, p. 186). In order to illustrate how homeless services have been crucial spaces within and through which the medicalization of homeless has been enabled, health and urban geographers tend to distinguish between (1) the roles of homeless services *systems* in governing homeless (*sub-*)populations as political *objects* with distinctive health characteristics and therapeutic needs and (2) the role of homeless service *sites* in governing homeless *individuals* as political *subjects* to be reformed in accordance with social and political norms relating to the healthy individual. In some research accounts, an analogous distinction is made when authors refer to the political and personal dimensions of social service spaces (e.g., Evans, 2012) or to technologies of power and technologies of the self (e.g., Wilton and DeVerteuil, 2006). The chapter will now briefly discuss how spaces of homeless service provision have been instrumental to the medicalization of homeless governance insofar as they have facilitated the objectification and subjectification of the homeless on medicalized terms.

Individual sites of homeless service provision are joined together – formally and informally – as part of a homeless services system, which itself is a crucial component of municipal and national poverty-management apparatuses (DeVerteuil, 2003). Knowledge produced within the homeless services system shapes understandings of the homeless population – its features, its needs, its impacts – which helps turn that population into an object to be governed (Evans, 2012; Hennigan, 2016; Willse, 2010). In the early decades of the formal homelessness services system, it became possible to aggregate administrative data collected from individual homeless clients across the system and, using those data, represent the homeless as a coherent, knowable population that was demographically distinct from the general public, particularly in relation to their health characteristics and needs. In the United States, for example, a prominent report titled *A Nation in Denial: The Truth about Homelessness* (Baum and Burnes, 1993) used administrative data to advance a medicalized understanding of homelessness, arguing that the “primary issue is not the lack of homes for the homeless; the homeless need access to treatment and medical help for the conditions that prevent them from being able to maintain themselves independently in jobs and housing” (p. 3). Data collected by newly formalized homelessness services were crucial in objectifying the homeless as a population in need of therapeutic intervention. Using administrative data from homelessness

services, researchers “turned out hundreds of studies of the pathologies of the homeless, establishing their high levels of addiction, depression, and family dysfunction” (Gowan, 2010, p. 50). These findings began to shape and reinforce the views of health professionals, political decision-makers and the public. An authoritarian, treatment-led approach to homelessness was not only feasible and logical but seemingly necessary.

Health geographers and other critical social scientists have shown that, in the late 1990s, analysis of administrative data collected by homelessness service providers suggested a new way of understanding the homeless population as a governable object (Baker and Evans, 2016; Evans, 2012; Hennigan, 2016; Willse, 2010). Applied research began to discern differences in the length of time spent homeless and the extent of poor health within the homeless population (see Culhane and Kuhn, 1998). They found that approximately 10% of the homeless population – termed the chronically homeless – consumed approximately half of the financial resources available to the shelter system, and that same small proportion of the homeless population were disproportionate consumers of public services, such as emergency medical services and psychiatric services (Culhane and Kuhn, 1998; Kuhn and Culhane, 1998).

These findings have had at least two impacts on the way in which the homeless population is understood and governed. First, they suggested that the chronically homeless were fundamentally different from the remaining 90% of the homeless population and, therefore, in need of a different type of homelessness service intervention. Second, the findings provided an economic justification for new interventions that addressed the chronically homeless segment of the homeless population. As the chronically homeless were resistant to authoritarian, treatment-led homelessness services, room was made for assertive, housing-led homelessness services to emerge as a more effective and economical way of addressing the chronically homeless (see Baker and Evans, 2016; Evans, 2015; Hennigan, 2016). In recent years, an expansive literature has developed on the topic of housing-led services for chronically homeless people, including large-scale randomized control trials (e.g., Goering et al., 2011), which has allowed for more fine-grained understandings of the chronically homeless population as a medicalized object to emerge within health and urban geography (see Evans, 2015; Hennigan, 2016; Klodawsky, 2009).

Although homelessness service provision plays an important role in constituting the homeless population as a governable object, service provision activities have individualized “subject-making effects” (Lyon-Callo, 2000, p. 328). Homelessness services, in this sense, are engaged in attempts to produce particular kinds of people – in particular, people who align with social and political norms relating to the healthy individual. “The social relations that exist between staff and clients and among clients are not neutral or devoid of power,” argue Wilton and DeVerteuil (2006, p. 660); they are “designed to shape the conduct of individual clients.” In the context of the treatment-led shelter system, Lyon-Callo (2000, p. 328) notes how “[t]reatment focuses on reforming and governing the self,” such that homelessness service activities “produce homeless subjects who learn to look within their selves for the ‘cause’ of their homelessness.” Housing-led services are also engaged in subject-making. Commenting on a housing-led program for chronically homeless people with alcohol-abuse problems, Evans (2012) observes a “continuous and intense type of medicalized, micro-logical supervision of drinking and daily living.” He describes how “residents are invited to problematize their lives in terms of alcohol dependence. . . [which] provides a new grid of intelligibility for individual desires and actions” (p. 196). Yet, unlike treatment-led services, where clients are required to engage in treatment, housing-led service providers must convince their clients of the need for self-reform. Case managers “must ‘sell’ participation,” Hennigan (2016, pp. 14–15) points out, because the “rehabilitative techniques of [Housing First programs] . . . become considerably (if unevenly) obstructed by the contractual relationship” between the client-cum-tenant and the landlord. The tenant-landlord relationship, while offering protection from compulsory treatment, applies a subtle form of compulsion to participate in treatment: clients must learn to budget effectively on minimal income, lest they fall behind on their rent and bills and find themselves homeless again as a result (see Hennigan, 2016).



## Summary and future research

This chapter discussed how homelessness has been medicalized as a social problem, focusing in detail on the insights of health geographers (often in conversation and/or collaboration with urban geographers and critical social scientists from other academic disciplines). It has shown that, in recent years, health geographers have been part of efforts to trace the emergence of an assertive style of medicalized homeless governance, associated with housing-led services for the chronically homeless, alongside the longer-standing authoritarian style, associated with treatment-led services for the general homeless population. Synthesizing the insights of health and other critical social scientists, the chapter suggested that the spaces of homelessness service provision are crucial to the medicalization of homeless governance in general, and to its authoritarian and assertive variants in particular, insofar as they enable the homeless to be objectified as an unhealthy population and subjectified as unhealthy individuals in need of therapeutic reform. Although the chapter has emphasized the contributions of health geographers to a better understanding of the medicalization of homelessness, it is worth noting that research debates have generally occurred outside the formal venues (such as specialized journals) where health geography, as a sub-discipline, is made and remade. This (sub-)discipline-spanning characteristic of homelessness research, combined with the continuing prominence of medicalized understandings and interventions, puts health geographers in a strong position to steer and make key contributions to the transdisciplinary research agenda on homelessness. With the issue of health occupying a central position in contemporary transformations to the global landscape and localized spaces of homeless governance, there are opportunities for health geographers to explore (1) the potentially diverse *rationales* behind medicalized intervention, (2) the ways in which homeless people, advocates, service providers and others *resist* or augment medicalized intervention through a range of practices and (3) the *reconciliation* of medicalized intervention with alternative understandings of homelessness – based, for example, on structural injustices. Studies that address these topics would enable researchers to advance beyond the factual, empirical nexus of homelessness and health – something that health researchers have long grasped – to better appreciate the *political* nexus of homelessness and health that is increasingly implicated in decisions about the availability and type of support provided to those experiencing housing deprivation.

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