Topics in Social Psychiatry
Series Editor: Ellen L. Bassuk, M.D.

HOMELESSNESS

A National Perspective

Edited by
Marjorie J. Robertson, Ph.D.
and
Milton Greenblatt, M.D.

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TOPICS IN SOCIAL PSYCHIATRY

Series Editor: Ellen L. Bassuk, M.D.
The Better Homes Foundation
Newton Centre, Massachusetts
and Harvard Medical School
Boston, Massachusetts

ANATOMY OF PSYCHIATRIC ADMINISTRATION
The Organization in Health and Disease
Milton Greenblatt, M.D., in collaboration with Paul Rodenhauser, M.D.

HOMELESSNESS
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RESPONDING TO THE HOMELESS
Policy and Practice
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Marjorie J. Robertson, Ph.D.

Alcohol Research Group
Institute of Epidemiology and Behavioral Medicine
Berkeley, California

and

Milton Greenblatt, M.D.

Olive View Medical Center
Sylmar, California
and University of California, Los Angeles
Los Angeles, California

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Contributors

THERESE ANDRYSIAK, St. John's Hospital, Santa Monica, California 90404

HIDA AVENT, Stepping Stone, 1833 18th Street, Santa Monica, California 90404

ELLEN L. BASSUK, Department of Psychiatry, Harvard Medical School, Boston, Massachusetts 02115, and the Better Homes Foundation, 181 Wells Avenue, Newton, Massachusetts 02159

GARY BLASI, Legal Aid Foundation of Los Angeles, 1550 West 8th Street, Los Angeles, California 90017

WILLIAM R. BREAKEY, Department of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine, Baltimore, Maryland 21205

PHILIP W. BRICKNER, Department of Community Medicine, St. Vincent's Hospital and Medical Center, New York, New York 10011

M. AUDREY BURNAM, Social Policy Department, the RAND Corporation, Santa Monica, California 90407-2138

ROBERT J. CALSYN, Departments of Psychology and Gerontology, University of Missouri–St. Louis, St. Louis, Missouri 63121

MARTIN D. COHEN, the Robert Wood Johnson Foundation Program on Mental Illness, Boston, Massachusetts 02115, and Massachusetts Mental Health Center, Boston, Massachusetts 02115

PATRICIA DOHERTY, Department of Community Medicine, St. Vincent's Hospital and Medical Center, New York, New York 10011

RICHARD J. FIRST, College of Social Work, Ohio State University, Columbus, Ohio 43210

PAMELA J. FISCHER, Department of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine, Baltimore, Maryland 21205

TONI FLYNN, Salvation Army, San Luis Obispo, California 93401

GERALD R. GARRETT, Department of Sociology, University of Massachusetts at Boston, Boston, Massachusetts 02125

MILTON GREENBLATT, Department of Psychiatry and Biobehavioral Sciences, and San Fernando Valley Program in Psychiatry, University of California, Los Angeles, Los Angeles, California 90024, and Department of Psychiatry, Olive View Medical Center, Sylmar, California 91342-1495

JOEL F. HANDLER, School of Law, University of California, Los Angeles, Los Angeles, California 90024

RENÉ I. JAHIEL, Graduate School of Management and Policy, New School of Social Research, New York, New York 10011

PAUL KOEGEL, Social Policy Department, the RAND Corporation, Santa Monica, California 90407-2138

SUSAN LADNER, National Academy Foundation, 660 Madison Avenue, New York, New York 10021

JACQUELINE LEAVITT, Graduate School of Architecture and Urban Planning, University of California, Los Angeles, Los Angeles, California 90024

JOHN MCADAM, Department of Community Medicine, St. Vincent's Hospital and Medical Center, New York, New York 10011

KAY YOUNG MCCHESNEY, Department of Sociology, University of Missouri–St. Louis, St. Louis, Missouri 63121

ESTHER S. MERVES, Department of Sociology, Kenyon College, Gambier, Ohio 43022

GARY A. MORSE, Department of Psychology, University of Missouri–St. Louis, St. Louis, Missouri 63121

SARA PETRY, Olympic Mental Health, 4526 Federal Avenue, Everett, Washington 98203

JAMES PREIS, Mental Health Advocacy Services, Inc., 650 South Spring Street, Los Angeles, California 90014

JULIA M. ROBERTSON, Seven Counties Services, Inc., 137 West Muhammad Ali Boulevard, Louisville, Kentucky 40202, and Department of Psychiatry and Behavioral Sciences, University of Louisville School of Medicine, Louisville, Kentucky 40202

MARJORIE J. ROBERTSON, Medical Research Institute of San Francisco, Institute of Epidemiology and Behavioral Medicine, Alcohol Research Group, 2000 Hearst Avenue, Berkeley, California 94709

DEE ROTH, Office of Program Evaluation and Research, Ohio Department of Mental Health, Columbus, Ohio 43266-0414

RUSSELL K. SCHUTT, Department of Sociology, University of Massachusetts at Boston, Boston, Massachusetts 02125, and Department of Psychiatry, Harvard Medical School, Boston, Massachusetts 02115

MILES F. SHORE, Department of Psychiatry, Harvard Medical School, Boston, Massachusetts 02115, and Massachusetts Mental Health Center, Boston, Massachusetts 02115

NAOMI SIEGEL, Private Practice, Santa Monica, California 90025

ANDREA L. SOLARZ, American Psychological Association, 1200 Seventeenth Street, N.W., Washington, DC 20036

AMY SOMERS, AIDS Foundation San Diego, 4080 Centre Street, San Diego, California 92103

DERRELL TIDWELL, Outreach Team to the Homeless Mentally Ill, St. John's Hospital, Santa Monica, California 90404

BEVERLY G. TOOMEY, College of Social Work, Ohio State University, Columbus, Ohio 43210

J. THOMAS UNGERLEIDER, Neuropsychiatric Institute, University of California, Los Angeles, Los Angeles, California 90024

WILLIAM J. VICIC, Department of Community Medicine, St. Vincent's Hospital and Medical Center, New York, New York 10011

MARY BETH WELCH, Urban Studies Program and Women's Studies Program, California State University, Northridge, Northridge, California 91331

JUDITH WILHITE, InfoUse, 2560 Ninth Street, Berkeley, California 94710

Series Editor's Preface

During the 1980s, we witnessed remarkable advances in medical knowledge along with skyrocketing health care costs. The explosion in information coupled with pressing economic considerations have resulted in dramatic changes in the health care industry. These have included privatization, increasing specialization, and the growth of consumerism. As an outgrowth of these changes, physicians are now regulated and controlled through new practices and policies such as managed care and legal statutes (accompanied by the threat of litigation).

Although some of these changes have improved the quality of care and access to services, these trends have spawned a growing medical technocracy. By adapting to financial imperatives, concentrating on the creation of new administrative systems, and focusing on ever-smaller fragments of human physiology, providers have shifted their views of the origin and treatment of illness. For example, psychiatrists have become more biologically entrenched, at times needlessly sacrificing context and circumstance. Despite the critical importance of a biological approach to patient care, we cannot condone the diminishing emphasis on the patient as a whole. Such an approach includes patients' families; the quality of their lives and experiences; and the personal, social, and political structures that may have contributed to their illnesses.

We are introducing a new book series, *Topics in Social Psychiatry,* in an effort to reintroduce the importance of context to the welfare of our patients. Just as we are reawakening to the fragility of our environment and its immediate and long-term effect on our lives, this series attempts to refocus on the psychosocial, spiritual, and political contexts that affect our patients. Without understanding our connectedness to other people, groups, and cultures and the natural world, we cannot understand the fundamental needs of patients and appropriate methods of care.

It is fitting that *Homelessness: A National Perspective* heralds the series. Disenfranchised, disadvantaged groups have been particularly hard hit by the technological morass afflicting our medical system; the desperate plight of homeless persons suffering from chronic mental illness is a case in point. Moreover, the issue of homelessness highlights the importance of understanding the effects of structural and systemic forces on individuals and families. This tragic social problem illustrates the complex interplay of macrolevel factors on individuals, especially those who suffer from disabilities.

Marjorie Robertson and Milton Greenblatt have edited a comprehensive volume

that discusses the heterogeneous nature of the homeless population, their diverse needs, and strategies for change. An encyclopedic reference about homelessness, this book strongly conveys the problem's complexity and the importance of context. The editors have covered the causes of homelessness; mental health, health, and substance abuse issues; needs of special populations such as veterans, the elderly, women, and children; and policy-related issues. Health care providers, researchers, and policymakers alike will benefit from reading this book. *Homelessness: A National Perspective*'s grounding in thorough research and compassionate insight ensures its status as a standard text in the field.

ELLEN L. BASSUK, M.D.

Preface

September 28, 1983, was my first day in skid row, Los Angeles. I parked outside an old trailer that housed the Innercity Law Center, behind the Catholic Worker Hospitality Kitchen at Sixth and Gladys. In the cold drizzle, hundreds of people stood quietly in a line that curled around the old structure housing the Hospitality Kitchen (or the "hippie kitchen" as it was fondly called). One could go inside and sit down to eat a hot if modest meal, and there was no preaching. It was considered the second best "free meal" in skid row. People lined up around the building, through the parking lot, out to the next street, and up a block or two. Since it was the end of the month, more than 1,000 meals would be served that afternoon, mostly to people who were homeless. Those serving the soup that day would ladle constantly for 2½ hours without pause. I was shocked. I kept returning to the trailer window to look out at the line (Robertson, field note).

That was a long time ago. Almost a decade later, seeing homeless people in our urban and suburban areas is a common experience. They have become such a "normal" part of our popular culture that they are increasingly portrayed in situation comedies and movies, in the comic strips of the newspapers, and even as toy dolls. None of us is shocked any more.

In 1986 we began to organize this volume because we believed that homelessness was an important social crisis that was advancing faster than our knowledge and understanding of it. The United States in the 1980s and early 1990s was characterized by multiple political and socioeconomic changes that contributed to the "social construction of homelessness." These structural factors included the scarcity of low-cost housing, recessions, a changing labor market, seriously reduced social welfare and educational programs, and consequent increases in the size of poverty populations. The massive deinstitutionalization of those in state and county mental hospitals also contributed to the problem. In their attempts to understand and "solve" the problem of homelessness, however, researchers focused more on the individuals who were homeless than on public policies, social and economic factors, and service delivery systems.

This book is designed to provide a broad perspective on homelessness in the United States during this era by looking at both individual homeless persons and the context in which they experienced homelessness. We take the perspective that homelessness is a product of the dynamic interaction between structural conditions

and individual vulnerability. Several chapters analyze the more general context in which widespread homelessness has occurred. Others detail the heterogeneity of the population along with strategies for intervention on behalf of specific target populations.

This volume is intended for a broad audience, including students and colleagues in many fields. It reveals many myths and stereotypes about homeless persons and their situations, and it paints a picture of a complex social problem that must be addressed at the broadest social and economic levels. This work is also designed for policymakers. It outlines local and national perspectives, points out promising avenues of progress, and emphasizes elements that should be considered in fashioning a national plan.

A unique contribution is the cross-disciplinary perspective drawing from anthropology, architecture and urban planning, law, medicine, psychiatry, psychology, social welfare, and sociology. In many respects, this volume reflects the multiple collaborations that occurred among researchers, clinicians, service providers, and advocates during the last decade. Some contributors were members of the Working Group on Homelessness, organized by René Jahiel, M.D., that met in conjunction with the annual meeting of the American Public Health Association from 1984 through 1990, at which time the group was finally formalized as the Caucus on Homelessness of the APHA. Others participated in the Social Policy Working Group on Homelessness, organized by Milton Greenblatt at UCLA, that met from 1985 through 1987. Contributors were also recruited from a series of meetings organized by Irene S. Levine, Ph.D., for the Office of the Homeless Mentally Ill, National Institute of Mental Health, and by Barbara Lubran, M.P.H., for the National Institute on Alcohol Abuse and Alcoholism, which focused on research on homeless populations.

The book is organized into nine parts, each with a special perspective on homelessness in the United States from 1980 through the early 1990s. Part I addresses the causes of homelessness, including the social and political contexts in which homelessness has occurred with a focus on the housing crisis, welfare policy, deinstitutionalization, and criminal justice policies. Part II provides an overview of salient mental health issues, including chronic mental illness among homeless persons, problems in assessing mental illness, and special challenges to providing mental health services to this population. Part III describes the health status of homeless men, women, and children; medical problems including tuberculosis, hypertension, and HIV infection; and barriers to medical care. Part IV addresses issues related to alcohol use and treatment policies. Part V introduces special populations (e.g., the elderly and veterans) and discusses variations by gender and race. Part VI targets homeless women and explores myths about them, characteristics of homeless families, and causes of homelessness among women. Part VII focuses on homeless children and adolescents, including children in homeless families and homeless and runaway youths. Part VIII explores strategies for change, including litigation and political action. Part IX provides a thematic overview of the book, gleaning recommendations for change from earlier chapters as a foundation for strategies for general social and political change.

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The first editor also thanks several colleagues for taking the time to orient a real "outsider" many years ago, including Rabbi Margaret Holub, Gary Blasi, and Jim Preis. She is also grateful for substantial collegial support from Pamela J. Fischer, Ph.D., and Paul Koegel, Ph.D.

The second editor would like to credit a number of colleagues at the University of California at Los Angeles and at various affiliated hospitals who have given much encouragement and created an environment where this work could be done: Louis Jolyon West, M.D., Dean Sherman Mellinkoff, M.D., Albert-Jan Kettenis, M.D., Frank Parodi, M.D., Murray Brown, M.D., E. A. Serafetinides, M.D., Bruce Picken, M.D., Frank DeLeon-Jones, M.D., and Joseph Blanton, M.D.

Further, we wish to acknowledge with great admiration those people who care for and work with homeless and other disenfranchised persons in the community. Finally, we also greatly appreciate the participation and contributions of homeless men, women, and children themselves in various studies and research programs. Our hope is that in an attempt to solve the social structural problems that contribute to homelessness, our nation's responsibilities to all its residents will be more accurately defined and more vigorously pursued.

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MARJORIE J. ROBERTSON
MILTON GREENBLATT

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I

Background

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Causes of Homelessness

GARY A. MORSE

Home is the sanctuary where the healing is. . . . Nothing brings as quickly to mind the horror of natural upheaval, civil strife or war as the picture of the "homeless." The deprivation of the security of home is the worst of the mass tragedies.

—WALTER CRONKITE[1]

These causes have roots at the very core of our American life, in our industrial system, in education . . . in family relations, in the problems of racial and immigration adjustment, and in the opportunity offered or denied by society. . . .

—NELS ANDERSON[2]

The homeless are homeless, you might say, by choice.

—RONALD REAGAN[3]

INTRODUCTION

A growing body of evidence points to a disturbing fact: A substantial number of people in the United States are without homes. A national study estimated that in 31 medium-sized and large cities, an average of more than 7,000 people are homeless, including 60,000 people in New York City.[4] Current nationwide estimates are controversial; figures range from 250,000 to 3 million homeless people,[3,5–10] with 2 million the most frequently cited figure. Although these estimates are imprecise, far more people are homeless today than in the 1960s and early 1970s.

It seems reasonable to assume that few individuals in contemporary Western nations aspire to be homeless. Yet hundreds of thousands of people, perhaps mil-

GARY A. MORSE • Department of Psychology, University of Missouri–St. Louis, St. Louis, Missouri 63121.

lions, lack homes. The question arises: Why and how is homelessness allowed to continue?

The reasons have remained unclear and poorly articulated. One popular perspective has been to identify major social problems, such as unemployment, as causal forces. Other writers have focused on the personalities of homeless people, which are presumed to be defective. Blaming individuals is a narrow, grossly distorted oversimplification of the factors that lead to homelessness. On the other hand, explanations identifying only social forces are also limited. Homelessness remains a complex, multidetermined phenomenon.

CHARACTERISTICS AND NEEDS OF THE HOMELESS

Characteristics

Universal, absolute descriptions of the homeless are not possible for two reasons. First, the current homeless population seems to be heterogeneous rather than homogeneous.[7,11–15] Second, research defining specific characteristics of the homeless population is limited. Studies often lack sound methodological practices such as objective assessment, random and representative sampling, comparison samples, and longitudinal time frames.[16]

A recent review[16] concluded that the contemporary homeless population, though diverse, tends to be distinguished from the general population by extreme poverty, low job skills, high unemployment rates, high rates of personal–social adjustment problems (e.g., mental disorders, alcoholism, criminality), low levels of social support, high levels of life crises, and a great desire to obtain social and health resources that will lead to nonhomeless status.

These characteristics have changed relatively little in recent times.[16] Most notably, serious mental disorders probably have exceeded alcoholism as the single most common adjustment problem. Other characteristics have changed over time only in degree. Today's homeless are more likely to be unemployed and are substantially poorer than their counterparts from the 1950s to the 1970s. Homeless people now tend to be younger and better educated. They also include more minority members and women, both in absolute numbers and in population percentages.

Individual Problems and Needs

Being homeless, in and of itself, is the most fundamental and most critical problem of homelessness. Empirical data[12,17–19] support the notion that the great majority of homeless persons want nonhomeless status. A homeless existence is characterized by demeaning environments, a plethora of survival problems, and the most abject poverty known to a developed nation.[20–21] Homelessness, however, typically involves a constellation of other problems as well:

1. Need for temporary shelter. Each year homeless people suffer physically from the effects of exposure, occasionally including hypothermia and death.[4,8,22–24]
2. Inadequate food and nutrition.[12,25–28]
3. Shortage of clothing.[5,27]

4. Sexual victimization, especially among homeless women.[20,26,28]
5. Criminal and legal problems, including police harassment.[29–30]
6. Poverty and inadequate financial assistance.[4,15,18,31]
7. Poor physical health and inadequate medical service.[18,20,26–28,32–33]
8. Drinking problems and alcoholism.[15,18,25–26,34]
9. Mental health problems and disorders.[17–18,25,35–37]
10. Negative or low self-esteem.[38]
11. Low self-confidence.[38]
12. Social isolation and the absence of a supportive social network.[18–19,37–40]
13. Absence of day activities and programs.[41]
14. Absence of leisure and recreational opportunities.[25,42]
15. Poor work skills and the need for job training.[15,18,43]
16. Employment needs.[4,15,18–19,25,30,34,40]
17. Permanent housing need,[4,15,18–19,44] that along with jobs, ranks as the most important self-perceived need of homeless people.[15,19,25]
18. At a more abstract level, many homeless people also need a valued and personally meaningful social role.[16]

ECOLOGICAL PERSPECTIVE

The preceding review is limited to a description of individuals. An organizing assumption of this work, however, is that homelessness is a social problem existing within an ecological system. Rather than focusing on homeless people, sometimes with implied victim blaming,[45–49] we believe that the broader issues of homelessness are a more appropriate target. This analysis, adapted from previous works,[50–55] considers six levels of social organization: cultural, institutional, community, organizational, group, and individual.

CAUSAL FACTORS

Cultural Level

The disproportionate representation of minorities among the homeless suggests that racial discrimination is a significant contributing factor. As Anderson noted, racial prejudices decrease the probability of obtaining employment and therefore increase the likelihood of a minority person becoming homeless.[2,12] Racial discrimination also influences homelessness to the degree that it contributes to poorer housing, poorer education, and diminished opportunities for socioeconomic advancement. Further, cultural prejudices against persons with psychiatric and alcohol problems also decrease social opportunities and subsequently lead to homelessness. Certainly the common public attitude[2,12,16,56] that homeless persons are lazy, undesirable, hopeless, and worthless has limited homeless people's social opportunities and has damaged their self-esteem and self-confidence. Even more insidious factors, despite a recent increase in public sympathy for the homeless (best symbolized by the Hands across America event), are the apathy and the lack of involvement that characterize the dominant social position regarding the homeless. As a result, fewer social resources and services are devoted to ameliorating homelessness.

Institutional Level

Economic

Several writers have stated that at least one originating source of homelessness can be found in the existence of poverty.[15,20,40,56–60] Considerable attention has been devoted by Wood, as follows:

> The problem [of homelessness] is one which must be viewed in terms of the general social and economic structure, that is, the fact of stratification . . . inequalities in the distribution of resources and power between families, classes, and geographical regions. Some are born into poverty and continue to live in poverty, encountering experiences which are destructive of personality and life changes.[40]

"The economy" has been mentioned frequently as a historical and current cause of homelessness. Several authors have focused on the recession of the early 1980s,[3,43,61] when an additional 1.6 million Americans fell below the poverty level[62] and rates of unemployment rose. As noted elsewhere,[3] unemployment in the United States recently reached its highest level since the 1930s, affecting both skilled and unskilled workers.[4] Not surprisingly, unemployment has been posited as a cause of homelessness by contemporary[3,4,9,12–14,28,40,43,61,64] as well as noncontemporary commentators.[2,32,65–66]

Before we draw conclusions about the effects of the economy on homelessness, additional data from the past several years should be considered. By various economic indicators, the recession has now receded and unemployment has decreased. Yet the number of homeless people has increased during the same period. Although alternative explanations are possible (e.g., a "lag" period in the effects of unemployment, an increase in noneconomic causes of homelessness), it would appear that a direct, linear relationship does not necessarily exist between homelessness and the health of the national economy, including employment rates. In all probability, employment opportunities have not increased substantially for homeless people because often they have unskilled or semiskilled occupational backgrounds, limited work histories, and handicapping personal difficulties.

Housing

Baxter and Hopper,[102] Cuomo,[4] Bassuk,[3] and the National Conference of Mayors[67] have reviewed national data that support claims[12] of a major crisis in low-income housing.

The housing problem can be conceptualized most clearly as involving two dimensions: (1) a shortage of low-income housing and (2) people's decreased ability to pay for low-income housing. Diminished ability to afford housing is related both to reduced income (often the result of unemployment or of discontinued welfare or disability payments) and to rent increases.

The shortage of low-income housing has been attributed to several factors, especially the widespread redevelopment of urban areas, which often converts low-income housing into middle-class neighborhoods or commercial districts[4,5,8–9, 12,20,26,63] (see Chapter 3). Because the development of new low-cost housing has lagged behind the rate of conversion of prior units,[5] many poor people have been displaced from stable, low-income neighborhoods as well as from settings such as lodging houses, cheap hotels, and single-room occupancies (SROs), which are often

the last available form of affordable housing before shelters. Low-income rentals and houses also have been lost because of building decay and condemnation.[12]

Additional units of what was previously low-income housing have been priced out of the market by rent increases.[3–5,12,68–69] These increases appear to be attributable to (1) general inflation, (2) a decreased supply of low-income housing, and (3) increased demand for such housing, which resulted from poor persons' displacement by urban renewal.

The U.S. Conference of Mayors found that on the average, families waited 2 years for housing assistance programs.[67] In some cities, waiting periods were as long as 25 years; most U.S. cities (61%) had even stopped adding new names to the waiting lists.

From an ecological perspective, the low-income housing problem is the result of policy failures at both national and local levels.[5,28,70] For individuals, it appears that the housing problem is the major factor contributing to homelessness.

Social Assistance

Though mentioned only rarely in earlier works,[32] problems in the social assistance system have received attention in recent papers on the causes of homelessness.[3,4,9,12,28,43,63,71] The thesis is that stringent eligibility requirements and the termination of existing benefits in financial assistance programs, such as Aid to Families with Dependent Children[4,9,43] and Social Security disability programs,[3–4, 43,71] eliminated a critical source of income for many people, some of whom subsequently became homeless.

Indeed, the magnitude of recent federal social assistance budget cuts has been enormous. A congressional study reported that nearly one-half million families lost federal assistance payments in 1981; one million lost food stamps.[62] The study also found that federal budget cuts caused more than one-half million people to fall below the poverty line.

Eliminations in the Social Security Disability Income program were also extensive; more than 350,000 people lost their benefits.[4] The topic has become politically controversial; the Social Security Administration has responded by broadening eligibility and review requirements.[73]

Supportive data linking social assistance variables with homelessness are rare and usually are limited to case studies. Further empirical assessment is necessary to determine the extent and the nature of the effect, but it is reasonable to infer that budget cuts in various assistance programs have contributed to the onset of homelessness for many individuals. Further, the lack of assistance to persons who are already homeless is a major factor in maintaining the social status.

Mental Health

Mental health policies—particularly those concerned with deinstitutionalization–have been mentioned frequently as a causal factor in the development of homelessness.[3–5,11–12,36–38,61,70–72,74–76] A few writers have directed their attention and criticism solely to hospital discharge rates[26,49,63]; others have implicated more stringent hospital admission policies[4,20] and briefer hospital stays.[3] The problem, however, as most writers have noted, is not simply a matter of hospital admission and discharge policies. Rather, the most critical factor has been the failure to implement

deinstitutionalization; adequate community support services for chronically mentally ill persons are not available. The mental health system has failed to divert services, resources, and budget funds from hospital-based care to community care at the same rate as it has discharged patients to the community[61,72] (see Chapter 5).

Adequate community mental health treatment should encompass a range of services,[77–78] especially for those with chronic disturbances.[78,80] There are too few community residences,[3–4,17,81] day care and vocational rehabilitation programs, and case-management services.[37]

The problem is one of quality as well as quantity of community care.[37,79] Many former patients have been discharged into community residences that provide custodial care in settings that are more restrictive than necessary for the clients' characteristics.[82] The therapeutic environment in many of these community facilities has been called "as stultifying and disabling as mental institutions."[78]

There is evidence that deinstitutionalization does not necessarily lead to homelessness.[83] In practice, however, the shortcomings in the deinstitutionalization movement have contributed to a significant increase in homelessness. Homelessness for some people has occurred as a result of delay in providing adequate services to support stable community living. For others, homelessness has been immediate, the result of hospital discharges made without provisions for stable housing. Indeed, mental hospitals often discharge patients directly to the streets or to shelters (expediting the step to homelessness in some areas by providing taxi service from the hospital to the shelter for newly discharged patients). Homelessness also is maintained by the absence of adequate community mental health support services.

Substance Abuse

Little has been written recently about substance abuse services and homelessness. This lack of attention is curious in light of the high prevalence of substance abuse in this population (see Chapter 12). Sufficient preventive and rehabilitative services to lessen the likelihood of homelessness for those with chronic alcohol and drug abuse problems simply are not available.

Criminal Justice

Although empirical information is limited, it seems that a minority of the homeless have been previously imprisoned or jailed.[16,19] The prevalence of previous imprisonment raises questions about the adequacy of aftercare services for former inmates. Specifically, the penal system may contribute to the problem by its failure to provide adequate supports for released ex-prisoners.

The judicial system has played a lesser but still significant role in the etiology of homelessness. James's analysis and review of legal decisions implicates the courts in initiating and maintaining the situation.[58] A key variable has been judges' lack of education and experience with homelessness and associated problems. Judicial training and personal experience have focused "upon the problems of owning houses and land [rather] than upon the problems of being without either," a situation that "led predictably to unsympathetic and unrealistically narrow, if not irrelevant, decisions."[58] It is uncertain whether the recent, sympathetic trend in court decisions will be extended; this trend has been manifested in helping to improve conditions for people while they are homeless (e.g., overruling vagrancy statutes,

mandating the provision of temporary and decent shelter) (see Chapter 25 for related discussion).

Other

Several other institutional forces have been specified as contributing to the initiation and maintenance of homelessness. One significant factor is lack of coordination and cooperation between institutional systems. The mental health system, for example, has been criticized for assuming that the social welfare system will bear a major responsibility for deinstitutionalized psychiatric patients.[20] An even more important factor is the absence of any major public institution to assume primary responsibility for the service needs and problems of homeless people. No single governmental institution is responsible for providing and coordinating comprehensive services. Instead, responsibility is fragmented among a number of institutions; the consequence has been woefully inadequate services.[13,15–16,27,31,34,36,56,71,84–85]

In the absence of commitment by public institutions, private shelters and mission organizations have provided many essential services to homeless people: spiritual assistance, food, and clothing. Paradoxically, however, the shelter system may contribute to the maintenance of homelessness.[12,31,36] As Hopper and colleagues note:

> Shelter, no matter how decently offered, by its very nature maintains one on the border of ordered society, neither belonging nor quite in exile. Perpetuating a situation that maintains a population in limbo defers the social decision on whether such people are to be readmitted or not.[12]

Community Level

Relevant community activities often are influenced by institutional-level policy and funding. Local housing policy, for example, like national policy, has been criticized as a cause of homelessness[70] because of (1) the redevelopment and conversion of poor urban areas and low-income housing into middle-class neighborhoods and commercial areas, and (2) a failure to provide new low-income housing. Communities that mount successful opposition to residences for the deinstitutionalized also may increase homelessness. Sociological accounts[29–30] provide convincing evidence that skid row communities function as a subcultural alternative to the larger culture, facilitating homelessness and discouraging reintegration into a nonhomeless way of life.

Organizational Level

Common organizational policies and procedures are discussed next under three main headings: service eligibility, service delivery problems, and service withdrawal.

Service Eligibility

Three factors concern formal service eligibility requirements: address, residency, and client history requirements.

Address Requirements. Some human service agencies require prospective clients to have a fixed address in order to receive services. This requirement proves to be an

insurmountable barrier for many clients who otherwise would qualify for income assistance and food stamps.[5,75] The result is that homeless clients do not receive the needed services that would improve the quality of their lives and often would provide the additional resources necessary to obtain more permanent housing. (In Great Britain, welfare agencies typically do not provide income assistance until an applicant obtains a permanent address.[81]) Thus some psychiatric patients about to be discharged from the hospital are ensnared in a catch-22 situation—unable to pay rent until they receive financial assistance but unable to receive welfare benefits until they obtain a fixed address.

Residency Requirements. The requirement of an address different from the client's current address also may serve to initiate and maintain homelessness. Homeless or nonhomeless persons who have just relocated to a new area may be unable to obtain the welfare services needed to maintain or obtain housing.[75]

Requirements Concerning Client Characteristics. The third factor involves not residency but individual behavior and characteristics. For example, the regulations of some community placement mental health programs prohibit service to psychiatric patients with histories of violence, diagnoses of secondary substance abuse, or histories of sexual deviance. Persons with such characteristics are effectively shut out from residential assistance.

Other eligibility requirements are not matters of written policy, but they operate informally to deny service. Staff members of many organizations exercise discretionary power in determining whether a potential client may receive services. Mental health community placement workers may select a client for service if their assessment shows that client to be "stable"[75]; they may deny placement for clients who appear hostile or "antisocial."[30,86] The common denominator in the selection process is that the individual exhibits "potential," which often means that he or she will "fit in" with organizational goals and values as interpreted by personnel. Individuals who do not show such potential may be denied resources that could have prevented them from becoming homeless.[2,26,32,38,41,87–88]

Service Delivery Problems

Service problems play a causal role in three areas: service availability, accessibility, and appropriateness.

Service Availability. The most fundamental factor in availability is that services needed for income assistance, mental health residential and treatment programs, and other social service aftercare programs sometimes are not provided. Without such aftercare and follow-up support, some people become[30,75,81,88] and remain homeless. In some instances the failure to provide aftercare services results from a complete or partial lack of resources; at other times it is related to discretionary judgments or to a failure to consider the client for available services.[75]

Another problem of service shortage is that often the services or resources provided are insufficient to prevent or alter homelessness. For example, welfare and entitlement payments may not be sufficient to cover the cost of low-income housing and other basic living expenses[5,31,71]; utility assistance payments are insufficient to pay heating bills[89]; and job training and placement positions are inadequate to

promote upward mobility.[90] The futility of inadequate resources was expressed well by Bowser and his colleagues, who researched job training and placement programs for homeless men:

> These resources, while successful in providing some income, have obvious shortcomings. The individual is generally neither paid enough money nor on the job long enough to obtain any degree of social mobility . . . the person is caught in an economic trap which is viciously circular. This system provides the employer with a constant source of cheap labor which is minimally effective and at the same time gives the individual resident an accessible job market that leads nowhere.[90]

Service Accessibility. Difficulty in gaining access to services also contributes to homelessness. Applying for disability benefits and seeking financial assistance are lengthy and complicated processes characterized by a bureaucratic demand for details and documentation.[20,75,91] Some mentally disabled people who will become homeless or are already homeless are

> simply unable to amass the documents or otherwise negotiate the bewildering bureaucratic maze of appointments (frequently scheduled simultaneously in different parts of town), application forms, interviews, medical checks, and follow-ups that are required of those who receive public assistance. As many of them know from experience, one lost document, one missed appointment, one wrong answer, and their case may be closed, making the effort to comply seem futile.[91]

Service Appropriateness. For those who are able to obtain resources, the services provided may be inappropriate for their needs. Boarding homes and nursing homes often provide highly structured, controlled environments that place a premium on docile, compliant, passive, and dependent behavior. Individuals who do not meet these expectations, those who are disagreeable or disruptive, are often discharged. A number of such individuals subsequently end up on the streets or in shelters. As stated by Arce and colleagues:

> The inherent problems of our existing residential system were immediately apparent. Not only were there no suitable homes for the mentally ill whose behavior remained inappropriate or disruptive, but there were very few residences geared to individuals who were loathe [*sic*] to accept loss of personal freedom.[17]

Service Withdrawal

Agencies and businesses sometimes terminate services that are necessary to support individuals in a nonhomeless environment. The clearest example is utility companies' discontinuation of gas or electric heating. Such action often contributes to people's becoming homeless.

Summary

Collectively, the policies and practices reviewed here are the organizational components that contribute significantly to homelessness. The literature lacks detailed research that would enable us to estimate precisely the proportion of the homeless population affected by these factors. At present it appears that these organizational problems function are not "leaks"[32] or "cracks"[75] but rather gaping holes in the human service systems that force some individuals to become homeless; subsequently they function as nearly insurmountable obstacles to achieving nonhomeless status.

Group Level

A frequently implied but rarely expressed theoretical proposition is that a person's early family experiences lead to homelessness later in life.[92–94] Typically, the families of origin are believed to have been deficient in some important area, such as imparting "early training"[92] or providing a proper emotional environment.[93] The family deficiency is often considered to be the result of marital separation or parents' pathology.[93–94] An intervening variable of defective personality development is sometimes postulated.[93–94]

Empirical evidence concerning the presumed causal factors of family deficiency is lacking. The data also are inconclusive as to whether childhood family disruption is more common among the homeless than in other groups.[16] In sum, firm support for the role of the family of origin in the etiology of homelessness remains to be demonstrated.

Nevertheless, it is likely that disturbances in families of origin play a significant role in initial homelessness. Marital separation and divorce, common in the backgrounds of homeless adults, are frequent precipitants.

A related factor, current and recent family support and contact, also appears to be involved in the development and maintenance of homelessness. Research studies[12,18,35,75] consistently have found low levels of current family contact and support. The underlying reasons are unclear, but they include absence of living family members, rejection of the family by the homeless individual, or the family's rejecting or simply "burning out on" the individual. Each cause is probably valid for some people, but for many, an interaction of rejection and alienation between themselves and their families probably occurred. The absence of social supports—friends as well as families—contributes to homelessness.[36–38]

Individual Level

Three categories of causal factors are noteworthy at this level of analysis: individual characteristics, especially disabilities; personal choice; and a process of individual adaptation.

Individual Characteristics

A number of writers have sought to find an explanation for homelessness in the characteristics of homeless people. Alcoholism,[2,13,59] poor physical health,[13,27] mental disorder,[13–14,40,49,81,95] and defective personalities[2,32,94,96–99] have been identified as contributing or sole causes.

A recent literature review[16] yields the firm conclusion that many homeless people have mental and (to a lesser extent) physical health impairments or a combination of these problems. Institutional and organizational factors, as described, are significant underlying reasons why a disproportionate number of people with these impairments are found among the homeless. The characteristics themselves, however, also are implicated as causal factors for three reasons: They tend to (1) limit a person's coping abilities; (2) diminish social supports and resources; and (3) consequently make the individual more dependent on social institutions and organizations.[40,49]

Personal Choice

The element of personal choice as a causal factor in homelessness is often misunderstood. Some observers deny it completely[70]; others inappropriately consider it the chief cause of homelessness. Some people do choose shelters and the streets over mental hospitals, boarding homes, SROs, and intolerable family situations.[2,12,20,21] Similarly, some people choose to sleep on the streets rather than in shelters because of dehumanizing conditions in the shelters.[28] The choice to become homeless, however, is not an affirmation of an ideal lifestyle but a means to obtain a sense of self-control and dignity when faced with a lack of meaningful, safe, and viable living alternatives.[5,20,28] Perhaps Selma Lyons, a homeless woman, expressed this point best to photojournalist Ann Marie Rousseau:

> You see, it's practically impossible for me to get out of this situation. The only other choice I have is spending the whole year with a bunch of mental patients working for seven dollars a week. That's it. That's not a job, that's nothing. They don't give you no real education so you could get a job and hold onto it and keep it. There is nothing that you'd really like to do, that paid money, where you could buy all the things you needed, like personal items, and then have twenty-five dollars a week to put in the bank. There isn't really nothing like that, nothing for me. Just institutions.[21]

Adaptation

At some point after a person becomes homeless (perhaps after initial stages of panic, a flight of activity to get off the streets, rage, and then acceptance), a process of adaptation to homelessness begins. Gradually the person adjusts to a homeless status.

Much of the adaptive process revolves around daily activities. As Hopper and colleagues noted, the homeless life is a difficult, demanding existence where "survival is an uncertain, demeaning, full-time occupation."[12] Daily activities are geared toward meeting important basic needs for food, income, and shelter while also attempting to assure one's personal safety from physical harm and harassment. Little energy is left to negotiate for assistance or to seek permanent employment. In addition, the absence of showers and clean, fresh clothing quickly diminishes one's ability to obtain a decent job. The individual also may learn behaviors that perpetuate homelessness:

> The tactics of survival learned on the streets (be it a consciously cultivated foul odor, or techniques of vigilance and concealment) serve to further isolate and alienate. What is adaptive behavior on the streets may be ill-suited to resuming a settled mode of living.[4]

A component of the adaptation process may involve the community and group levels. Wallace[29] described homeless men as being integrated gradually into a skid row subculture, in which a significant feature was a change in the individual's self-identify to that of a skid row inhabitant. It is likely that the adaptation process involves some form of integration entailing a change in self-perception. The modified self-identity both facilitates the individual's current adjustment and contributes to the maintenance of homelessness.

CONCLUSIONS

Numerous diverse, interacting factors contribute to homelessness at each of six levels of social organization: cultural, institutional, community, organizational,

group, and individual (see Table I). For a hypothetical homeless adult male, homelessness might be regarded as the result of his mental and drinking disorders, his disdain for nursing homes, his lack of family support, a decision by the hospital staff worker not to consider him for a group home placement, the welfare office's refusal to grant financial assistance, city government's decision to replace low-income hotels with a new convention center, deinstitutionalization, lack of viable community living alternatives, recession in the construction industry, and public apathy toward the plight of the homeless. The causal relationship of these factors to homelessness typically involves a mismatch or discordance between the characteristics of the individual and the policies, practices, expectations, or characteristics of the organizations related to him or her.[54,101]

Homelessness is maintained, to a large degree, by the absence of needed human services. Homeless people keenly desire social and health services, especially permanent housing and employment.[12,16–19,103] Yet relatively few are receiving such services. These difficulties can be traced to several factors, which we have discussed, but most important, we believe, is the lack of federal leadership and commitment to serve the homeless. Without a centralized effort, the gigantic mobilization of necessary public and private resources at all levels cannot occur.

Table I. A Selective Summary of Factors Contributing to Homelessness

	Contributing causal factors	
Level of analysis	Initiates homelessness	Maintains homelessness
Cultural	Minority discrimination	Public apathy
Institutional	Unemployment Shortage of low-income housing Cuts in financial assistance programs Deinstitutionalization/failure to provide community support services	Absence of a public institution responsible for the homeless
Community	Urban redevelopment policies	
Organizational	Address requirements Residency regulations Client requirements Discretionary decisions Inaccessible services Inappropriate services Service withdrawal	
Group	Lack of social support	
Individual	Impairments/disabilities Personal choice	Adaptation process

Note. Items that are centered between columns are factors that both initiate and maintain homelessness.

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2

Homelessness and the Housing Crisis

JACQUELINE LEAVITT

INTRODUCTION

The housing crisis has generated scores of homeless households, creating a community crisis. In turn, widespread homelessness has heightened awareness of the housing crisis. Homeless people are everywhere. Some create their own turf; others wander through an entire community, no longer confining themselves or being confined to the traditional skid row or Bowery.[1] Their visibility challenges the community to respond.

In earlier periods, philanthropic societies or ward bosses in political districts helped those who could not fend for themselves. Such local interventions are still practiced today through charitable organizations and religious institutions; during the Christmas season, for example, newspapers take up the cause, soliciting secret Santas. The problem is too widespread and too costly, however, to depend on such private arrangements alone. Housing and social service bureaucracies, which in the past barely worked together or in tandem, need to become closer. Sam Galbreath makes this point:

> Local community development agencies and local housing authorities have important skills and resources that should increasingly be put to use in assisting homeless persons, *as part of a total shelter effort that includes a range of support services as well as physical shelter.* A new relationship between housing providers and service providers is evolving, centered on the needs of the homeless, and this trend should be encouraged (p 211)[2] [emphasis added].

JACQUELINE LEAVITT • Graduate School of Architecture and Urban Planning, University of California, Los Angeles, Los Angeles, California 90024.

Homelessness provides a point of departure for thinking about the housing crisis, which takes place both in the household and in the community.

In this chapter I will discuss both the household and the community crises. The household crisis reflects housing demand and consumption as affected by changing demographics, household configuration, living arrangements, and income. The community crisis concerns reduced housing supply as affected by neighborhood conditions, gentrification, abandonment, and arson, all of which lead to displacement. Beyond their direct impact on individual households, the processes of gentrification and abandonment have the potential to transform neighborhoods from one income group to another and most often from one racial group to another. The overall effect is to put more pressure on the supply of existing affordable units.

The household and community crises affect some parts of the population more than others. For example, today's homeless include more than single, older, primarily white men, often alcoholic and victims of unemployment.[1,3] Increasing numbers of poor female-headed families and younger nonwhite males are found among the homeless or those at risk of homelessness. Housing is essential to people's well-being and sense of self because without shelter, people face physiological and psychological harm.[4–5] Thus it is critical to understand why household and community crises exist for an increasing number of U.S. households, why they are more apparent now than in earlier times, and what measures can be taken to alleviate these crises.

THE HOUSEHOLD CRISIS

Arrangements of Households

Housing demand is shaped by shifts in household and living arrangements that in turn affect and reflect changes in demography. These changes are seen dramatically in statistics about household size.[6] In 1940 the average number of persons per household was 3.67; by 1985 the average had dropped to 2.69 persons. The steady decline in household size for more than 100 years has been interrupted only twice: first, during the Depression, when economic crisis led to doubling up, and second, during the recession years of 1982 and 1983, when household size remained stable at 2.73. The increase in the rate of household formation, which always has been greater than the rate of population increase, is due largely to the formation of households made up of individuals living alone, individuals living with nonrelatives, or households made up of female-headed families.[7]

Type of household is an accurate predictor for poverty. Table I shows the differences in median incomes by household types in 1984 by ethnicity of the householder. All data point to the very low income of female and nonwhite householders. For all ethnic groups, the lowest median incomes are found in female-headed nonfamily households, followed by those in male-headed nonfamily households. The lowest median income is present in black female-headed nonfamily households. Among family households, black female-headed households have the lowest median income, followed closely by female-headed households of Spanish origin.

Although incomes rise as people move through their early years to their peak earning power, female householders have the lowest median income at all ages. Table II shows that in 1983, women's overall median income, $11,789, was slightly

Table I. Median Income by Type of Household and Householder's Ethnicity, 1984

	All groups	White	Black	Spanish origin
All households	$22,415	$23,647	$13,471	$16,992
Family households (N = 26,651)	27,913	15,729	19,241	
Type of family				
Married couple	29,686	30,123	23,472	22,661
Male-headed household, wife present	24,551	26,018	16,381	20,468
Female-headed household, husband present	13,473	15,874	9,008	9,066
Nonfamily households (N = 12,987)	13,590	8,909	9,674	
Single-person households				
Total	11,512	11,953	7,723	8,263
Male	15,202	16,087	10,333	11,126
Female	9,639	9,965	6,627	6,599
Multiperson households				
Total	26,069	26,984	19,444	19,204
Male-headed	27,283	28,138	19,939	18,013
Female-headed	24,636	25,275	18,203	(0)

Reference: US Bureau of the Census.[52]

more than half of male householders' median income and slightly less than half of that for couples.

Changing poverty rates emphasize the increasing problems for households headed by females, especially nonwhite females. During the 1960s, poverty rates tended to decline; they leveled off in the 1970s, and then rose in the early 1980s. Between 1978 and 1984, the national poverty rate increased from 11.4% to 14.4%, with a peak of 15.3% in 1983. Although rates are lower today than in 1959:

> the likelihood of being poor remains much higher for persons in female-maintained households. In 1982, 36 percent of the persons living in female-maintained households were in poverty compared with 10 percent of persons in other households. In 1982, 57 percent of persons in Black households with a female householder were in poverty compared with 29 percent in White households (p 208).[7]

At the same time, incomes of nonwhite men also remain low, the result of years of discrimination[8]; thus it is extremely difficult for nonwhite families to remain intact.

Table II. Median Family Income, by Family Type and Age of Householder, 1983

			Other family	
Age of householder	Total	Married couple	Male householder	Female householder
All householders	$24,580	$27,286	$21,845	$11,789
15–24	13,841	16,660	16,036	4,910
25–34	22,776	25,970	18,868	8,109
35–44	28,944	32,591	22,790	13,633
45–54	32,592	35,872	29,107	16,167
55–64	27,407	29,171	25,078	15,953
65 and over	16,862	17,263	18,329	14,192

Reference: US Bureau of the Census.[53]

The Housing Crisis for Renters

The housing crisis disproportionately affects renters, who tend to include increasing numbers of female heads of household. This trend can be traced from 1970 through 1978, although comparable data are not readily available for 1980 and after. (In 1980 the Bureau of the Census changed the definition concerning household composition from a model based on "head of household" to one based on "householder." Although the "householder" model is now used, its definition varies slightly for various Census Bureau publications.[9])

Sternlieb and Hughes were able to construct a table of household configuration and tenure for 1970 and 1978.[10] The increase in renters among female-headed and single-person households was apparent; female-headed renters increased from 13.9% to 19%, and single-person households increased from 27.1% to 35.6%. Furthermore, Vanhorenbeck reported that by 1980, single-male and female-headed households accounted for almost two-thirds of all renters.[11]

Access to housing is related directly to income, and in the United States there has been a growing gap between renters' and owners' median incomes. The median income for owners in 1980 was $19,800, compared to $10,600 for renters. The median incomes for black and Hispanic renters were even lower: $7,600 and $9,300, respectively. Overall, renters were in worse shape than owners: in 1980 "there were more renters than owners at the very lowest income levels (below $7,000), while owners outnumbered renters by more than 10:1 in the top income brackets (above $50,000)."[12] The median income in 1983 was $24,400 for owners and $12,800 for renters. Black renters' median incomes of $8,900 lagged far behind that of renters overall, and Hispanic renters' median incomes of $11,100 also were lower than those of renters in general. Table III shows the income distribution for renters and owners by race and ethnicity, based on Annual Housing Survey data for 1980 and 1983.

Impact on the Family Budget

When incomes lag behind rising rents, greater demands are placed on the budgeting skills of households. Households may begin to trade off one necessity against another, exchanging shelter for food, or, in extreme cases, choosing 2 weeks of housing and 2 weeks on the street each month. In the 10-year period from 1973 to 1983, median gross rent rose 137% (from $133 to $315), whereas median family income rose only 79% (from $7,200 to $12,900).[13] Median gross rent as a percentage of median income rose from 22% to 29%.[13]

Renters with low median incomes pay an increasing proportion of their income for housing. The standard of a monthly rent equivalent to 25% of monthly income in the paid labor force is outdated. The Reagan administration raised the standard from 25% to 30% for government-subsidized housing. Currently, 30% is accepted widely as a rule of thumb in the private market as well, but low-income people are paying upwards of 35% of their income for rent. In 1979, 39% of renters were paying 35% or more of their income for housing.

The proportion of income paid for rent is related inversely to income.[12] For those earning between $3,000 and $6,999 a year, the percentage of income paid for rent rose from 42% in 1978 to 55% in 1983. The Annual Housing Survey reported that at the lowest incomes ($3,000 or below), renters consistently paid 60% or more. In 1980 the National Low Income Housing Coalition estimated that for these poorest households, the proportion of income paid for rent jumped to more than 72%.

Table III. Income Distribution for Owners and Renters, by Race and Ethnicity, 1980 and 1983 (Numbers of Households in Thousands)

	1980				1983			
		Renters				Renters		
Income	All owners	All	Black	Hispanic	All owners	All	Black	Hispanic
$3,000 or less	2,155	2,748	788	232	1,451	2,308	699	211
$3,000–6,999	5,750	6,479	1,483	616	4,634	6,172	1,429	605
$7,000–9,999	4,367	3,862	697	422	3,841	3,375	627	369
$10,000–14,999	7,217	5,553	841	519	6,447	5,452	875	553
$15,000–19,999	6,977	3,672	477	264	5,937	4,006	541	320
$20,000–24,999	6,707	2,263	264	156	5,678	2,746	323	195
$25,000–34,999	9,814	1,984	203	101	10,408	3,388	368	245
$35,000–49,999	6,002	699	61	29	9,007	1,699	145	89
$50,000–74,999	2,445	207	13	4	5,056	581	26	27
$75,000+	1,082	88	0	6	2,262	187	7	3
Total	52,516	27,555	4,827	2,349	54,742	29,914	5,040	2,617
Median	$19,800	$10,600	$7,600	$9,300	$24,400	$12,800	$8,900	$11,100

References: US Bureau of the Census[9,54]; Dolbeare.[23]

At the lowest incomes, a $13 increase to $29—that is, the difference between 25% of income and 30% of income for those earning between $3,000 and $7,000—may seem trivial to middle- and upper-income persons. For them, that increase is the price of an ordinary lunch in a restaurant or of the casual impulse purchase of a sweatshirt. To a single elderly woman, however, that increase determines whether she can buy more food or take a cab to the hospital to see whether she can be fitted correctly for a prosthesis.[14] For a single mother it is the cost of clothes that a baby outgrows rapidly. When the rent increases in proportion to income, very little money is left for other necessities, nor can low-income people be selective in their housing.

Housing Conditions for Poor Renters

Poor renters have not shared in the general rise in the standard of living and the improved quality of housing in the United States since the 1940s. In 1982 the *Report of the President's Commission on Housing* admitted that "the incidence of rehabilitation need was found to be highest among black households (19.1 percent), very low-income renters (18.6 percent), and rural Southern households (12.9 percent)" (p xix).[15] Burns and Grebler support the finding that there has been some or mixed improvement in housing for blacks and Hispanics, but less so for blacks.[16]

According to the 1983 Annual Housing Survey, conditions for black renter households were the worst in almost all categories. Blacks lived in urban areas and rented more frequently than the total population. Therefore they were also more likely to live in multiple-dwelling structures or in apartment buildings constructed before World War II. Black renter households also were more likely to lack some or all plumbing facilities and not to have complete kitchen facilities. A higher percentage of black renters also reported open cracks or holes, broken plaster, peeling paint, and holes in the floor.

Hispanic renter households suffered from substandard housing more severely than renters in general for all indicators except plumbing.[17] For example, the percentage of Hispanic renter households without any type of heating equipment was higher than for renter households in general (4.5% compared to 1.4%). Furthermore, compared to all renters and to black renters, a higher percentage of Hispanic renter households lived in housing built in 1959 or earlier.

Settling for What Is Available

People settle for less in housing because there are not enough existing units at prices that fit their budget. Often they create augmented households out of economic necessity by taking in boarders. Ann Petry's 1946 novel, *The Street*, depicted life in Harlem; the picture has not changed much. Her leading character, Lutie, reflects on what is meant by reasonable rent:

> Reasonable—now that could mean almost anything. On Eighth Avenue it meant tenements—ghastly places not fit for humans. On St. Nicholas Avenue it meant high rents for small apartments; and on Seventh Avenue it meant great big apartments where you had to take in roomers in order to pay the rent (p 4).[18]

Low incomes and rising rents mean that poor people consistently must lower their housing standards in order to avoid even further disaster. In *The Street*, Lutie is looking for an apartment where she can create a more wholesome atmosphere for her son, Bub. She worries about being able to find and then to keep a place.

> Night after night she'd come home from work and gone out right after supper to peer up at the signs in front of the apartment houses in the neighborhood, looking for a place just big enough for her and Bub. A place where the rent was low enough so that she wouldn't come home from work some night to find a long sheet of white paper stuck under the door: 'These premises must be vacated by _____' better known as an eviction notice. Get out in five days or be tossed out. Stand by and watch your furniture pile up on the sidewalk (p 11).[18]

The choices that poor people face in housing are circumscribed by their struggle to balance incomes with what is available. A critical determinant in this choice is the lack of affordable and decent housing. Dolbeare points out:

> Even if all other things were perfect—which we know they are not—there are more than twice as many renter households with incomes below $3,000 as there are rental units available at 25 percent of their incomes. Even using a 30 percent rent/income ratio, there is a gap of more than 1.2 million units at the very bottom of the income scale (pp 33–34).[12]

The gap in affordable rental units is all the more shocking when we consider that the 1950s and 1960s "had seen the housing shortages of the Depression and World War II largely liquidated" (p 5).[6] Although annual average housing starts in the 1960s were fewer than in the decade before, they rose again in the 1970s. By 1960 there were 56.6 million year-round units; by 1970, 67.7 million; and by 1980, 86.7 million. Two-thirds of these were single-family houses. Sternlieb and Hughes refer to the 1970s as the "Golden Housing Age," a period when the net gain of 19 million year-round housing units surpassed that of the 1950s and 1960s, although the increase was due to mobile home placements and conversions.[6] Nineteen million units may compare "favorably" to the 23 million increase in population during this period, but certainly there was a gap. This gap reflected a mismatch between units and people both in absolute numbers and in the types of housing that were constructed. Most of the new housing was aimed at people who could afford to buy single-family detached structures, or, failing this, townhouses. A shortage would have existed even if filtering had been successful, whereby poorer people move into older stock that upper-income families vacate. Filtering requires a perfect market, without segregation and other disparities, but such a market does not exist.[19] Building starts of single-family houses have been volatile. The early 1980s saw a drop from 1.3 million to 1 million units, "followed by the mini-boom of 1983–85, and then the uncertainties of mid-decade."[6] At the same time, construction of rental housing, particularly for low- and moderate-income households, was not a profitable investment, and shortages continued to mount.

Aggregate figures often mask the differences between supply and demand of rental units on the municipal level. In 1983, for example, the annual vacancy rate was 2.7% in the northeast and 4.4% in the west. In the past decade, New York City has consistently registered a vacancy rate around 2%; this figure is closer to 1% in Manhattan. Table IV shows changes over a 3-year period in the number of old rental units removed from central city stock in 60 cities; the net loss was more than 100,000 units.[20]

The Lack of Government-Assisted Housing

During the 30-year period since the 1950s, government-assisted housing failed to fill the gap between units available and units needed. The U.S. National Housing Act of 1937 enabled public housing to be provided, first for people perceived to be temporarily unemployed and then increasingly for a nonwhite, low-income, largely

Table IV. Changes over a 3-Year Period in the Rental Housing Stock of Selected Central Cities[a]

	Old units removed (number)	Median gross rent	New units built (number)	Median gross rent
All 60 cities	322,700		203,300	
Specific cities				
Boston (1974–77)	6,300	$141	2,600	$212
Chicago (1975–78)	33,700	145	4,300	253
Cleveland (1976–79)	6,900	124	500	185
Detroit (1974–77)	13,600	109	2,800	131
New York (1976–79)	92,400	160	27,800	258
Newark (1974–77)	7,200	141	1,200	213
Philadelphia (1975–78)	8,900	115	3,000	302
St. Louis (1976–79)	7,900	103	400	130
San Francisco (1975–78)	5,900	82	2,600	281
Washington, DC (1974–77)	6,100	126	1,500	294

[a]The information presented in this table comes from the Annual Housing Survey conducted by the US Census Bureau, which surveys one-third of its total sample of 60 SMAs each year, so that the complete cycle takes 3 years. Thus, the figures above represent three different 3-year periods: for some cities it was 1974–1977; for others it was 1975–1978; for still others it was 1976–1979.
References: US Bureau of the Census[55]; Adams.[20]

female population. The availability of public housing units fluctuated between 1939 and 1983.[21] The early 1940s and 1950s and the late 1960s and early 1970s were the periods of greatest production, when completion of units did not drop below 30,000; in 1971, for example, about 91,500 units were produced. The Nixon housing moratorium in 1973, however, and the Reagan cuts in housing programs, accompanied by a decision to sell off existing public housing units, decimated the supply of low-income housing. The situation would have been far worse without the preexisting inventory of public housing and without Section 8 housing, a program that took effect in 1974; it also was curtailed drastically however, by the Reagan administration.[22]

Although government-assisted units do not meet the need completely, existing units serve those who are most disadvantaged.[23] Householders 65 years or over, blacks, female-headed families, and people living in central cities are the predominant populations living in federally assisted rental housing. In 1980 the median income of all households living in subsidized rental housing was $4,978.

The number of households living in HUD-assisted and Farmers Home Administration rental housing as of September 1984 was almost 4 million.[23] By that time, Section 8, which served almost 2 million households, had provided assistance over a 10-year period for about 600,000 more rental households than the 50-year-old federal public housing program. Dolbeare, however, estimated that housing still was needed for at least 16 million more persons.

The national shortage of assisted units is apparent when records of public housing bureaucracies are reviewed. In 1983 many public housing authorities had waiting lists that exceeded their inventory; others had closed their waiting lists. New York City, for example, had a waiting list of about 200,000 for its inventory of 175,000 units. Denver's housing authority operated about 6,500 units; their waiting list was composed of 1,600 families and 251 elderly individuals. The Cincinnati Metropolitan Housing Authority managed 7,000 public housing units; as of January 1983 the local waiting list contained 1,900 names. Almost half of the people who received Section 8

rental assistance certificates returned them because they could not find decent housing. The Chicago Housing Authority operated a total of 47,115 city-owned and Section 8 units, with a waiting list just short of 75,000. In Detroit, "as soon as there is a ground breaking (for a new public housing project), there is a waiting list of a thousand people waiting to get in."[24]

In 1986, findings from the U.S. Conference of Mayors' survey of 66 cities corroborated that demand for housing exceeds availability and that existing stock is often less than desirable:

> Sixty-one percent of all cities surveyed have closed their waiting lists to households seeking assistance. The waiting period for assisted housing is about two years for eligible families in most cities, but it ranges up to a twenty-five year wait in the most hard-pressed cities. The survey demonstrated that those people on the waiting lists have a high likelihood of currently living in substandard housing, paying more than 50 percent of their income for rent, or both (p 144).[25]

The crisis for poor renters is severe and by itself can explain why the homeless population is growing. Yet even home ownership is no longer an assurance of shelter for the household. Homeowners are experiencing crises that in the most dire cases result in their households becoming homeless.

The Crisis for Homeowners

Although the proportion of homeowners in the United States has risen since the Depression—in 1979, 65% of all households owned their homes, compared to 44% in 1940—opportunities for home ownership have fluctuated in the past few years. Two-thirds of the population could afford to buy a home in 1950, but only one-quarter could do so by 1986. With a drop in interest rates and greater levels of construction, some pent-up demand has been satisfied. For example, the National Association of Realtors reported in December 1986 that typical families with incomes of about $29,000 were able or nearly able to purchase homes costing about $80,000, the median price for an existing house sold in October of that year.[26] Nonetheless, more owners have been losing their homes "than at any time since the 1930s."[27] In 1981, nationally, 5.33% of all mortgage loans were 30 days or more overdue for the third quarter. Mortgage delinquency had increased to 6.19% by the third quarter of 1985, the highest level since the Depression.

Late mortgage payments are only one indication that households have experienced financial trouble. Late utility bill payments are another. The costs of lighting, cooking, heating, and air conditioning have escalated. The prices of fuel, oil, bottled gas, and coal have risen steadily since the late 1950s. The cost of electricity also has escalated. On the Consumer Price Index, electricity rose from 106.2 in 1970 to 351.8 in 1984. Property taxes have risen as well. Any one of these increases places pressure on homeowners who have low incomes initially. Even among households with higher incomes, unemployment, marriage breakups, poor health, or other personal crises can lead to foreclosure. The ex-homeowner faces the same limited affordable housing market as do renters.

THE COMMUNITY CRISIS

The community crisis in housing is rooted in the loss of units. Units are added and removed from the housing market for a variety of reasons. Buildings are con-

verted from one use to another; for example, an industrial warehouse is made into residential units or a single-room occupancy (SRO) hotel into luxury condominiums. Demolition removes older stock. In general, the removal of units affects poor people disproportionately because the replacements command higher prices.

A community crisis occurs when reduction in low-income units extends beyond more than one building or one block. This situation was seen most clearly in the urban renewal projects typical of the 1950s. Coupled with highway building, these projects caused thousands of homes and residential buildings to be demolished and communities to be disrupted. Although substandard units were eliminated, thereby improving statistics on housing quality, the result of these programs was to reduce the choices available to poor people.[1] Scott Greer wrote, "At a cost of more than three billion dollars the Urban Renewal Agency . . . had succeeded in materially reducing the supply of low-cost housing in American cities" (p 24).[28]

One example of this reduction occurred in the Lower East Side of Manhattan. Between 1960 and 1970, 7,145 units were lost because of urban renewal and other housing projects. Although many units were rebuilt, there was a net loss of 1,400 units. "Thousands of Old Law tenements housing poor whites, Puerto Ricans, and blacks [were] replaced mainly by new moderate-income housing rented predominantly by white families" (p 55).[29]

Lewis Mumford mourned the impact of urban renewal on community life:

> In the name of slum clearance, many quarters of Greater New York that would still have been decently habitable with a modest expenditure of capital have been razed, and their inhabitants, along with the shopkeepers and tavern keepers who served them, have been booted out, to resettle in even slummier quarters (p 24).[28]

The pattern of community disruption and displacement that became visible in urban renewal projects was recognized more slowly in the redevelopment of inner-city areas in the 1970s and 1980s. As Marcuse[30] observed in the case of New York City, the twin phenomena of gentrification and abandonment have restructured the spatial configuration of center cities; this general conclusion reflects shifts in the industrial base of other cities as well.[20] Marcuse concluded that gentrification spreads to entire neighborhoods when more highly skilled workers create a demand for housing near their workplaces. As the industrial base shifts away from the central part of cities, lower-income workers previously housed in the surrounding areas are displaced. As industry moves out, abandonment takes place in other neighborhoods where there is no effective demand for improved housing. Spain also argues that gentrification is based on the shift to service and government employment within 2 to 3 miles of the central business district, a situation that makes it easy for gentrifiers to live close to their workplaces.[31]

There is no consensus about the numbers of persons displaced from their communities because figures for displacement though condominium conversion, evictions, and arson are difficult to calculate. Even so, there are two ways to analyze the problem: One can look either at the number of people displaced or at the number of units lost. After denying that any displacement had occurred, HUD reported in a 1979 study that between 1.7 and 2.4 million people had been displaced, almost double the number reported earlier.[32] HUD's figures still were less than the conservative estimate of 2.5 million displaced persons reported by LeGates and Hartman.[33] Hartman, Keating, and LeGates[34] estimated that another 500,000 low-income units had been lost through conversion, abandonment, inflation, arson, and demolition.

Other researchers also have estimated the loss of units. Greer estimates that "between 1970 and 1982 the nation lost 1,116,000 SRO units, nearly half of its supply,

first to urban renewal and highway projects, then to abandonment, gentrification, and arson" (p 19).[35] Noble[36] estimates that 1 million single-room-occupancy hotels have been converted or demolished. Over a 9-year period, San Francisco's SRO stock was reduced from 32,214 units to 26,491. Portland, Oregon, has fewer than 700 single-room housing units, down from 1,345.[37] Seattle lost about 15,000 units.

Many neighborhoods where poor renters and homeowners predominate are vulnerable to abandonment, and their neighborhood conditions are less than satisfactory. The 1983 Annual Housing Survey reported that more renters than owners found their neighborhoods to be deficient in one or more of the following conditions: too much street noise, streets in need of repair, neighborhood crime, trash and litter, boarded-up structures, and bothersome smoke, odors, or gas. Seventy percent of renters expressed a negative opinion, compared to 60% of owners; more renters than owners gave only a fair or poor rating to their neighborhood overall.

The Annual Housing Survey also questions respondents about neighborhood services such as hospitals, health clinics, police protection, and outdoor recreational facilities. Lower income is related to lower levels of satisfaction with conditions and services. Among persons earning less than $3,000 a year, 42% of renters and 39% of owners felt that neighborhood services were unsatisfactory. More renters than owners (34% versus 19%) rated their neighborhood services overall as fair or poor. About 21% of black renters and 14% of Hispanic renters reported boarded-up buildings on their street; 4.2% of homeowners in general reported boarded-up buildings on their street, as compared to 14% of black homeowners. This finding may reflect higher rates of abandonment in areas where blacks either can afford or are able to purchase homes.

Abandonment of buildings often is linked with the general onset of abandonment of a community. Abandonment in residential housing stock may be accompanied or followed by commercial abandonment, especially by convenience stores, on which residents depend for food and household staples, drugstores, shoe repair shops, and neighborhood recreation such as local movie theaters. When the neighborhood declines, political influence weakens; the result is fewer public services or poor sanitation collection, police response, street repair, and park maintenance. The sense of a community life decreases as crime increases and as people withdraw into the relative safety of their homes. Homeless people may squat in abandoned buildings, increasing the chance that fires will spread to occupied buildings. The institutions that remain, such as churches, are important resources for residents who may not choose to move out and who, because of their positive attachment to the community, want to see it rebuilt.[14]

HOMELESSNESS

The most obvious result of the unavailability of affordable units is the prevalence of homelessness throughout the country. Although the precise number is unknown, virtually all major cities have a homeless population; estimates range from 3,000 to 10,000[38] or higher for large metropolitan areas such as Los Angeles (between 30,000 and 40,000) and New York City (36,000 to 60,000). In their study of eight midwestern cities, Salerno, Hopper, and Baxter pinpointed loss of housing "as the immediate precipitating cause of . . . homelessness."[24] Although rising homelessness usually is attributed to several factors—unemployment, deinstitutionalization from psychiatric hospitals, harsher reviews of disability benefit recipients, tighter eligibility re-

quirements for government programs, and domestic abuse and violence[1,3,39,40]—lack of shelter accompanies or initiates homelessness in all cases.

Persons at risk for homelessness face many health hazards. The most startling is the new overcrowding or doubling up, which has created a group referred to as the "hidden homeless." Overcrowding is one way in which poor households solve problems of rising rents and limited incomes. In 1982 the Annual Survey of Housing recorded 1.9 million units in which two or more families shared space. This was the first "significant" increase since 1950. In 1983 the New York City Housing Authority (NYCHA) reported that about 10% of all households, or 17,000 families, were doubling up illegally; the figure at least was twice as large by spring of 1986. Other housing authorities also are reported as looking the other way rather than evicting "extra" tenants.

Doubling up is evident in private housing as well. The popular press and studies of homeless adults report routinely that a friend's or relative's apartment or house was an individual's last residence before he or she became homeless. Such doubling up was reported in a New York City Human Resources Administration study of homeless adults in city shelters.[39]

The Los Angeles City Council is considering an ordinance in response to conditions chillingly reminiscent of those found by Jacob Riis[41] at the turn of the century. More than a dozen people, sometimes as many as 20, have been found sharing two-bedroom apartments and sleeping in split shifts and on the floor, often with only one bathroom. The proposed ordinance would limit the number of tenants on the basis of the size of "'sleeping rooms' in apartments and rented houses" (p 1).[42] As with other code enforcement regulations, this ordinance may lead to increasing evictions and homelessness even while it may reduce other health and safety problems. One unidentified city official voiced this concern: "If you blow the whistle on them, you're going to take the roof off their heads and put them out on the streets" (p 5).[42]

Sexual harassment, another factor precipitating homelessness, affects women primarily. Harassment occurs when landlords and superintendents expect sexual favors in return for renting an apartment, making repairs, or tolerating late payment of rents. The first national sexual harassment case in housing took place in Toledo in 1983.[43] The landlord, Norman Lewallen, made sexual advances to a tenant. When she refused him, he evicted her and her husband. As Shanna Smith, director of Toledo's Fair Housing Center, prepared the case, she found 27 other women in Lewallen's building whom he had harassed sexually; all 27 were on welfare. Another woman who resisted Lewallen's advances was evicted with her "belongings piled on the street" (p 16).[43] The court eventually found the landlord guilty of violating the federal Fair Housing Act. Smith believes that high unemployment forces women into taking more abuse because they see few alternatives.

In a second case, a Milwaukee landlord rented to single household heads, preferably women, whom he made aware that one apartment was kept vacant for sexual encounters in-lieu-of-rent ". . . [and that he] carried a gun and walked the halls with a dog" (p 18).[43] Most of the women in the building were poor. When one woman received an extension for a rent payment and afterwards successfully avoided his sexual advances, he attempted to evict her and harassed her for a month. She filed a complaint with the Fair Housing Council in 1984, for which she received $19,000.

Another form of sexual harassment that can lead to homelessness is battering and violence against a woman and/or her children by a spouse or boyfriend.[44] The demand for shelter by battered women usually exceeds the supply. Even when

shelters exist, however, the usual policy provides only a limited stay, often 6 weeks or 90 days. As discussed in Chapter 19, the alternatives often are bleak after that stay; a woman alone or with children may end up on the street.

Although shelters take every precaution to shield battered women from their batterers, women who find themselves in hotels or homeless shelters may have little protection. In New York City, for example:

> sexual harassment from the male hotel employees is part of daily life there. . . . women get obscene phone calls all hours of the night and often worse. A security guard at the Holland [hotel] recently was arrested on charges of rape. When the women are sexually harassed, "they are often told not to tell or they'll be out on the streets" (p 19).[45]

Families also face discrimination because of the presence of children. Difficulty in finding affordable housing may lead to overcrowding or to the breakup of family; both conditions foreshadow homelessness. In New York City alone, one study found that 11,000 members of homeless families included 7,625 children.[46]

RECOMMENDATIONS

Several recommendations have been made for relieving the shelter aspect of the housing and community crisis. The National Low Income Housing Coalition recommends an annual production target of 750,000 low-income units. Salerno *et al.*[24] recommend an increase in the Coalition's figure by 250,000 to 300,000 units to accommodate the homeless more adequately. Galbreath[2] suggests taking the annual appropriations that HUD spends on housing and community development needs and using them for low- and moderate-income people and doing the same with the funds spent by Health and Human Services (HHS) on public assistance. A working group of the National Association of Housing and Redevelopment Officials recommends tying the HHS Emergency Housing Apartment Program (EHAP) to HUD funds for rehabilitation by designating units in multifamily housing temporarily as emergency housing for 1 to 3 years, thereby making available an assured cash flow to help amortize the cost of rehabilitation.[2]

At least 10 different federal agencies offer assistance for homeless persons, of which HUD and HHS are only 2.[47] Most programs on homelessness are "pieced together," except for the Emergency Food and Shelter Program of the Federal Emergency Management Agency (FEMA). At the state level, six states—California, Connecticut, Massachusetts, New Jersey, New York, and Pennsylvania—offer comprehensive assistance in each of the following categories:

- Rental or operating subsidies for homeless families;
- Capital funding for acquisition, rehabilitation, or construction of residential facilities for homeless families;
- Homelessness prevention assistance, including interim mortgage payments and emergency rent, security deposit, or utility assistance; and
- Assistance for support services to homeless persons including education, job counseling, and similar activities (p 212).[2]

A set of interrelated proposals on all aspects of homelessness has been developed by the National Coalition for the Homeless. Several recommendations apply to the homeless in the context of guaranteeing low-income housing. They include endorsing the National Low Income Housing Coalition's minimum production lev-

els of 750,000 units per year; revising the rent-to-income ratio "to reflect household size, income level, and the cost of non-shelter basics" (p 78)[13]; modernizing and maintaining the existing public housing stock; ensuring that the sale of public housing does not deplete the stock; preserving single-room-occupancy hotels; strengthening protections from eviction in public and private housing; and providing permanent relief for homeowners facing mortgage foreclosure through "procedures and subsidies . . . to allow persons facing foreclosures to assign their mortgages to a government or nonprofit agency in exchange for guaranteed continued residency at an affordable monthly cost" (p 82).[13]

Other suggestions have been made for emergency and transitional shelters; these include developing a national right to shelter and making available publicly owned property and "suitable residential alternatives for mentally ill people" (p 82).[13] New York City has a set of innovative programs for city-owned property; through direct grants and loans, the city is funding facilities for homeless families and individuals, with city-owned property made available at nominal costs.[14]

CONCLUSIONS

Because of the nature of homelessness, the variety of people who find themselves homeless, and the root causes,[1] housing alone is a necessary but not a sufficient response. The need to deliver social services and housing jointly is not a new theme among policymakers, but institutional supports have been lacking. Public housing was conceptualized originally as the development of a community that provided its residents with more than shelter (e.g., child care, work or hobby rooms, meeting rooms). Elizabeth Wood,[48] one of the public housing pioneers and a longtime administrator of the Chicago Housing Authority, commented that this vision had been lost by the 1950s. Struyk and Soldo[49] advocate analyzing housing-related services offered by the Department of Health and Human Services in order to coordinate rather than to duplicate its more social-service-oriented programs with HUD.

The implied message about homelessness encourages working-class and middle-class people as well as the poor to settle for less and to scale down their dreams. Obviously the loss of housing is most extreme for those who are homeless or nearly homeless; their needs for shelter cannot be minimized. Yet there is a difference between warehousing the homeless in barrackslike dormitories or minimum-sized rooms in SROs and providing sufficient numbers of subsidized apartments with a combination of services. Homelessness can be the catalyst for revising the idea of a unified shelter and services package in a setting where social services and community facilities are easily accessible. By integrating social services into housing policy, advocates of low-income housing and policymakers can broaden their agenda by treating housing as a service and by moving beyond the narrower demand for an increase in production of units. Community is more than the housing supply itself. The quality of community, which carries a sense of belonging, rootedness, attachment, hope, and services rendered formally and informally, needs to be reflected in housing policy. Effective thinking about the problems of homelessness requires thinking about community: Resolving homelessness includes more than simply proposing housing. Furthermore, there are prototypes for this approach.[14,50–51] When housing issues are broadened to include services and when people can maintain their social relations with neighbors and friends, households can connect with community and build it in a meaningful way. These connections need to be made on a

pragmatic day-to-day level if the larger structural issues in the society that go beyond housing are to be addressed.

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3

The Modern Pauper
The Homeless in Welfare History

JOEL F. HANDLER

INTRODUCTION

Ever since war and famine have occurred, there have been welfare policies to deal with the poor. Although these policies are complex and shift during various periods, some firm generalizations can be made. Often the immediate task of welfare policy was to help deal with disorder; throughout history, armies of the poor have posed threats to society. A second task was the relief of misery; despite the strong social control features of welfare policy, there has always been a humanitarian voice. The third task was preservation of labor markets; relief had to be given under such terms and conditions as would not encourage those who could work to seek welfare instead. This last point is known as the principle of "less eligibility"—that is, the terms of relief had to be less desirable than the conditions of the lowest-paid labor. This is the essence of the work requirement, which often conflicts with the other two principles.

The work requirement is the most important, most enduring principle of welfare policy and is most relevant for today's issues. Historically and at the present it is at the base of the distinction between the "deserving" and the "undeserving" poor. The failure to support oneself and one's family was considered to be an *individual* failure; with rare exceptions, welfare policy never looked to society as the cause of unemployment and poverty. Moreover, failure to support oneself through work was regarded as a *moral* failure. The task of welfare policy was to discourage moral degeneracy and to distinguish the worthy poor from the paupers. The term *pauper* did not have the quaint connotations it possesses today; in a prior age, paupers were

JOEL F. HANDLER • School of Law, University of California, Los Angeles, Los Angeles, California 90024.

lumped together with criminals, prostitutes, and delinquents. Finally, welfare policy included what Michael Katz calls the "hostage theory." Although those who ultimately were given relief were clearly not employable—the aged, the sick, children—the conditions of relief, and particularly the work requirements, were so onerous as to deter those who could work from seeking relief.[1]

THEORIES OF POVERTY

Historically, welfare policy has been based on theories of poverty that explain *who* the poor are and *why* they are poor. Is the person who applies for relief poor because of "unmerited misfortune" or because of "adversity produced by vice"? Although the terms have changed, we still ask the same question.

The oldest and still dominant view is the pathology theory of poverty. According to this view, poverty is caused by moral failing; the *explanation* of poverty is to be found in individual or family defects. Historically, there have been variations on this theme. In nineteenth-century America, for example, social reformers, policymakers, and administrators distinguished poverty from pauperism. Because poor persons worked and lived decent lives, being poor was not a sin. Paupers, however, those who were able to work but who failed to do so, were morally blameworthy. They were linked in the public mind with criminality and deviance because the failure to support oneself and one's family was a sign of moral degeneracy.[2]

In the twentieth century, the pathology theory was expressed in different terms. With the introduction of psychology into the social work profession, we looked for *psychological* reasons for poverty. With the popularization of Oscar Lewis's work, we began to speak of the "culture of poverty." The famous Moynihan report suggested that the persistence of poverty among blacks was due (at least in part) to the absence of the father in the home.

During the 1960s, the "culture of poverty" idea went underground. For blacks and their liberal allies, it constituted victim blaming, and it diverted attention from structural or environmental causes of poverty. More recently, however, this idea has made a comeback; attention has turned once again to the black family, and a call is made for moral reformation.[3]

Yet whatever the label and however humane or harsh the motive, the theory of poverty remains the same. People are poor because, to a greater or lesser extent, something is wrong with them: They are morally degenerate; they lack sufficient coping mechanisms; they are the prisoners of deep-seated cultural patterns; they lack a male role model; they are encouraged to have children so as to go on welfare; or they do not have sufficient incentives to work. This "pathology" theory is not the exclusive domain of conservatives, however. It flowered during the War on Poverty, when poverty programs were designed to help the poor to help themselves. Because the cause of poverty was believed to lie within the individual, it was reasoned that the remedy lay there as well.

The opposite view, the *structuralist* theory of poverty, looks to structural or situational causes including the conditions under which the poor live: poor jobs, housing, nutrition, health, and schools. The characteristics that the culturalists find to be "deviant" are perceived by structuralists as adaptations to a hostile environment. Whereas the culturalists emphasize reformation of the individual, the structuralists seek to change the conditions under which the poor live.

Another view of poverty is based on the pathology theory but looks to the nature of the individual's failings. The crucial point is *moral* fault: Is the person unable to work because of a severe mental or physical handicap or because of "immoral" behavior? A distinction is made between the "deserving poor" and the "undeserving," and only the first are given relief.

Distinctions based on moral fault often are not clear-cut, particularly when more subtle forms of physical and mental illness are involved. Moral judgments shift with changes in knowledge, values, and social conditions. For example, we view the unemployed differently in times of severe recessions.

Most of welfare policy is concerned with this conflict over the moral qualities of those who are seeking relief. Why are they poor? What should be done about their poverty?

THE NINETEENTH CENTURY AND THE SPECTER OF PAUPERISM

The major purpose of welfare policy has been the control of pauperism. Paupers, who were unwilling or unable to work, were considered moral degenerates and were outcasts from society. The goal of welfare policy was to separate the paupers from the deserving poor and to make sure that giving relief would not encourage people to cross that line. The poor were balanced precariously; the surest way to tip that balance and to start the slide into pauperism was the indiscriminate giving of aid.

As early as the fourteenth century, statutes prohibited the giving of alms to sturdy beggars, and the English continued to struggle with specter of pauperism for the next 500 years. The New Poor Law of 1834 attempted to abolish outdoor relief altogether, in part because of the difficulty of drawing distinctions between the deserving and the undeserving poor. If a person were desperate enough to seek aid, he and his family had to go the poorhouses, which were deliberately onerous and stigmatic. The instrument of relief itself became the test of necessity, and relief always had to be a worse alternative than the condition of the lowest-paid laborer; otherwise, a person might seek welfare over work. Only such harsh conditions would prevent the slide into pauperism and moral degeneracy.[2]

The poorhouses were never successful, however, in part because their goals were contradictory. They provided relief for the truly destitute, but at the same time they had to be sufficiently miserable to deter the ablebodied. Poorhouses were more expensive than outdoor relief. Thus, in most communities, a compromise was struck: Outdoor relief would be given but only under very strict conditions. In the words of a local superintendent of the poor, "Especially for strangers, nothing would certify worthiness as well as the willingness to break stone."[1]

During this formative period, several features are worth noting. First is the central moral importance of work; this point distinguishes the deserving from the undeserving poor. The former, *as a category,* are excused morally from work. Second, the work requirement has two aspects. One is the *administered* work requirement, which is one of the conditions of relief: breaking stones yesterday, workfare today. Yet those who are excluded from relief—the ablebodied—are, in effect, subject to the *market* work requirement; they work or starve. Because most of the poor receive no cash assistance at all, the market requirement is much more important than the administered requirement.[4] Third, during this period the great mass of the poor was

the responsibility of local jurisdictions under very broad mandates. It was the business of local administrators to decide who was poor, who was worthy, and what to do about it.[5]

The English pattern was transplanted to America, where the poor were cared for at the local level—by the towns, the cities, and the counties. Work relief and the poorhouse were available for the ablebodied; in rural areas the poor were auctioned off, and the children were apprenticed. As in England, relief was intentionally stigmatic. One noted welfare reformer said, "When a person comes to me for relief for the first time I sit down and talk with him kindly. I say to him: 'Do you know that you are throwing your family onto the county, and it will be a disgrace to you as long as you live? Now go home and see if you can't get along.' "[6] Deterrence was considered reformation. A common defense of the woodyard or the stonepile ran as follows: "We wish to help, not pauperize, as a constant bestowing is apt to do—and to relieve the feeling of helplessness and dependence which often makes a man degenerate into a beggar or a tramp. To help others to help themselves is true charity."[6]

The "Deserving" and the "Undeserving" Poor

The local community decided who was worthy or unworthy. Yet when it became clear that moral fault was no longer an issue, the states began to distinguish the "deserving" poor from the undifferentiated masses. The first group included the blind, the deaf mute, and the "curable insane." These unfortunates were incapable of work, and separate state institutions were built for them. It was quite clear that persons in this category were to be treated differently. In Wisconsin, for example, a means test was rejected on the grounds that it would require otherwise eligible persons to obtain "certificates of pauperism."

The next group to receive favored treatment were Civil War orphans. In the nineteenth century, orphans were lumped together with all the other poor. Civil War orphans were different, however, and separate state institutions were formed for them.

A third major category consisted of indigent Civil War veterans and their families. In this case the institutional solution would not work. Instead the states created administrative units to deal specifically with these deserving poor people. In the words of a state board of charities, needy soldiers are not a "class of professional paupers, but are poor from misfortune."[6] In time the Civil War veterans' pensions grew into a massive income-maintenance program; eligibility requirements included being a veteran (any veteran) or his dependents *and* being unable to perform manual labor.[1]

The Child-Saving Movement

Another major development in the nineteenth century that would have important effects on welfare policy was the child-saving movement.[7] The child savers were particularly concerned about predelinquent children. They believed that children growing up in poverty and ignorance and living amidst crime and vice in the city slums were certain to become criminals and deviants. The distinction between delinquent and predelinquent was false, they argued; the state had a duty to extricate such unfortunate children from an unfavorable social environment to prevent a career in crime. The child-saving movement produced a number of significant reforms by the turn of the century, including establishment of the juvenile court,

which had jurisdiction over delinquent, dependent, and neglected children, and reformatories and state schools, which served as substitutes for an undesirable home environment. Interventions were justified on the grounds that they prevented crime and pauperism.

Two broad themes emerge from this influential century during which much of welfare policy was directed at preventing deviant behavior and was justified on those grounds. First, poverty policy was designed as social control; its effects were measured in terms of the impact on pauperism. Second, modern categories of relief developed from local efforts to distinguish varying levels of blameworthiness among potential relief recipients. Once certain categories of poor people were declared blameless, they received the benefit of separate programs and institutions.

THE RISE OF THE MODERN CATEGORIES

State Programs

Early in the twentieth century, two of the major categorical programs in the United States were enacted: Aid to the Blind and Aid to Dependent Children (now called Aid to Families with Dependent Children). Although they originated at the same time, the two programs were very different; together they illustrate the legacy of pauperism.

Aid to the Blind

Aid to the blind was included in state statutes dealing with other provisions for the blind, such as education. Blindness was objective and was determined by a physician, although other eligibility criteria included age, residence, and need. Administration of the program was routine; the stipend was uniform and often was referred to as a pension. Although in this early period there were many programs designed to encourage the blind to become self-sufficient, participation was a condition of relief in only one state. The only reference to moral character was that the applicant not be soliciting alms in public.[8–9]

Aid to Dependent Children

The Aid to Dependent Children (ADC) program arose from entirely different circumstances. As a result it had a very different structure. The child savers had envisioned reformatories and state schools as rehabilitative substitute homes, but the realities were otherwise. Institutions were overcrowded and lacked adequate staff and other facilities; they were filled with large numbers of delinquents and unruly slum children. The facts were brutally inconsistent with the idyllic notion of country cottages, and the reformers began to search for other noninstitutional alternatives.

Illinois, which was home to the first juvenile court, also instituted the first Aid to Dependent Children statute, the Fund to Parents Act in 1911. This act was an amendment to the Juvenile Court Act; it was *not* part of the welfare code, a fact of utmost importance. The Juvenile Court Act already had established jurisdiction in the juvenile court over "delinquent," "dependent," and "neglected" children. If the

court found that a child fit one of those categories, it could send the child to a reformatory, to a state school, to a guardian family, or home on probation.

The Funds to Parents Act stipulated that if the home was otherwise proper and if lack of money was the only factor preventing the parent from caring for the child, the court could award an amount to the family to maintain proper care. In other words, the Fund to Parents Act was not a welfare measure, as we usually consider welfare, but an alternative remedy for the juvenile court and an agency of social control. The proponents of the Fund to Parents Act stressed its crime-prevention goals: The poor children ("dependents") of an otherwise proper home would be prevented from sliding into pauperism. Opponents of the act, including the Charitable Organization Society, thought that it would be too difficult to make the distinction between proper and improper homes and that the consequent indiscriminate giving of aid would increase deviant behavior.[5]

The Fund to Parents Act applied to households headed by single females. Contrary to popular impression, however, it was not restricted *statutorily* to white widows. The statute covered the entire class of single females—widowed, divorced, deserted, and never married. It also included a work test. Judges decided, however, which members of the class were worthy, and in those days the "worthy" were primarily white widows.

The important point is the contrast between the two contemporaneous programs. For the blind—the clearly deserving poor—the enactment is a welfare statute administered by welfare officials. Eligibility was objective; administration was routine. In contrast, children and their single mothers were less clearly deserving. Before the early ADC statutes were passed, poor mothers *and* their children were included in the general mass of the poor, and they worked.[10]

The Illinois Fund to Parents Act and the early ADC statutes did not disturb this basic classification. Poor mothers and their children, as a category, were not transformed into the "deserving" category. Rather, the local judge (in about half of the states) or the local administrators decided which persons in the category were worthy of help and which persons would be excluded. Additional questions were considered, such as why the mothers were single and poor and what effect aid would have on the children's moral character. The local judge made fine-tuned distinctions, and both eligibility and benefits were discretionary. In fact, the great majority of poor mothers were excluded. The state programs were restricted basically to white widows; even most of them still had to work because the grants were so small.[11]

Old Age Assistance

The next major category, old age assistance, appeared during the 1920s. In many respects the states viewed old age assistance in the same suspicious manner as Aid to Dependent Children. They worried about intergenerational responsibilities and about whether a relief program would discourage work and saving and would encourage voluntary pauperism. Most Americans believed that if one worked hard and saved one's money, one would not be destitute in old age, and that such a program would encourage the shiftless and the lazy. The early statutes bristled with conditions designed to weed out the morally unfit. There were long residency requirements. The applicants had to have high moral standards; eligibility would be denied if the applicant had been imprisoned for a felony within a specified number of years, had failed "without just cause" to support one's family, or had been "a

habitual tramp or beggar." There were provisions concerning fraud, particularly divesting property in order to qualify for aid. The old-age statutes, more than any of the others, sought to exclude the "morally unfit." Administration of the program was given to the county court judges, who also could commit people to the poorhouse. In the 1920s, the aged were clearly not in the same category as the blind.[8]

Federal Programs

The Social Security Act of 1935 did not disturb the basic framework of these three state categorical programs. Although the Roosevelt administration focused on unemployment and on general social security, welfare was still essentially a state matter. Nevertheless the state programs lacked funds, and the Social Security Act did establish grants-in-aid for the states' categorical programs. States submitted proposals; if these proposals fit federal requirements, the federal treasury paid roughly half the costs of state programs. The basic conditions of eligibility and the amount of the grant were still matters of state policy, and federal requirements were minimal.

Social Security

The major accomplishment of the Social Security Act was the creation of the Old Age and Survivors Program, popularly known as Social Security. The contrast between the Social Security system and the categorical aids is instructive. Social Security is a completely federally administered program that is relatively condition-free and routinely operated. If a person reaches retirement age (usually age 65) and has worked in a "covered" job for at least 40 quarters, he or she is entitled to a pension calculated by a formula. There is no means test; both rich and poor retirees receive Social Security benefits. The program is insurance-based—that is, financed by payroll taxes on the employer and the employee. Although the insurance concept has been attenuated because of the liberalization of the program, the myth of Social Security as insurance is still very powerful.

Curiously, in contrast to the old state-level age-categorical programs, the Social Security System was not concerned with its clients' moral character. How can this difference be explained? By 1935 our perceptions and attitudes toward the aged poor had changed. As a result of the Great Depression, it no longer seemed reasonable to require the average working person to weather the vicissitudes of the market. The depression produced large numbers of aged poor persons, who had worked hard all of their lives. The submerged middle class could not be considered deviant. Thus work was not an issue. Furthermore, Social Security benefits encouraged the aged to retire to make room in the job market for unemployed younger people. In addition, and by no means an inconsequential point, the aged were white, they were (and are) politically active, and they voted. They were clearly the deserving poor.

Supplemental Security Income Program

The states' old age assistance programs, which had become welfare for the aged who were not covered by Social Security, also were transformed. Gradually the great bulk of the aged, including the aged poor, came under the Social Security system, and the treatment of insured persons began to reflect back on those who were not

covered and still were on old-age relief. As these state programs evolved through the Depression, they took on the characteristics of the Social Security System. Although they remained grant-in-aid programs operated by state welfare departments, the conditions dropped away, the programs became routine, and old age assistance increasingly resembled Social Security in the treatment of its recipients.

The most recent change in state programs came in 1972. By that time there were four state-level categorical programs—Aid to the Totally and Permanently Disabled had been added to the original three. There was considerable political agitation to federalize the four programs and to relieve the states of their welfare burdens. Consequently three of the four—aid to the blind, old age assistance, and aid for the disabled—were merged into the Supplemental Security Income program, which is completely federal both in financing and in administration. The "adult" programs, as these are called, had passed the test. Because willingness to work was not an issue for any of these categories of poor people, all were considered to be among the deserving poor.

AFDC, the "children's" program, was not adopted as a federal program, however. It has continued to be a state and local grant-in-aid program because the female-headed household is still viewed with suspicion. We are concerned about work incentives, moral behavior, and child rearing. The recipients were and are disproportionately black; clearly they are not the deserving poor. The conservative opponents of the federalization of AFDC argued that the control of deviant behavior traditionally had been a state and local matter. The AFDC program, as distinguished from the adult programs, included laws, regulations, and administrative discretion designed to check eligibility, financial need, and work effort; in short, to change moral behavior. Unlike the adult programs, the AFDC program still is regarded with hostility and distrust.

The Food Stamp Program

The Food Stamp program has had a different history. Its origins lie in the Surplus Commodities Corporation of the Depression, when surplus farm products were distributed to the needy. The original program remained small and was terminated in 1943.

Interest revived with the rise of farm surpluses in the 1960s. President Kennedy, who was struck with the extent of poverty in the United States during his campaign for the West Virginia primary election, stated pilot programs. The Food Stamp Act of 1964 eventually established the program nationwide. In this act, the United States Department of Agriculture established the purchase requirements (i.e., the cost of the stamps to the recipients), but the states set the eligibility standards. The Food Stamp program languished until the Nixon administration nationalized it fully in terms of eligibility and benefits and made availability mandatory in all counties. The program was liberalized in subsequent years and expanded very rapidly.[12–13]

The Food Stamp program was noncategorical; it applied to all poor persons—old, young, single, or female-headed households. The poor were not differentiated as deserving or undeserving; even the working poor were eligible. Moreover, the program was completely federal and uniform in eligibility and benefits, although administered locally.

The implementation of the Food Stamp program is anomalous in welfare history. In the traditional pattern it was assumed that when the recipients of a particular program were considered to be deserving poor, the program was financed and

administered at the federal level with uniform standards and was relatively condition-free. In contrast, programs for the undeserving poor were administered at the state and local level with numerous conditions.

This anomaly has not gone unnoticed. The Food Stamp program has undergone repeated attacks because it fails to distinguish the deserving from the undeserving poor. Gradually more social control requirements have been added to the program, including a work test. In other words, the program is taking on more "undeserving poor" characteristics.[5] At the beginning of the Reagan administration, there was a spirited attempt, led by Senator Jesse Helms, to return the program to the states. This attempt was stopped by Senator Dole and his colleagues from the farm bloc. Currently it continues as a program under the Department of Agriculture.

Medicare and Medicaid

Medicare and Medicaid were enacted in 1965 as new titles to the Social Security Act. Medicare was designed basically to cover acute care hospitalization and, if recipients elected to pay a premium, physicians' bills. All recipients of Social Security are eligible; thus there is no means test. It is a fully funded federal program.

Medicaid, in contrast, is a grant-in-aid program. In order to participate, the states must agree to provide certain basic services to people who are on AFDC or Supplemental Security Income. As an option, states can agree to provide more services and also can include the "medically indigent"—those who fit the eligibility categories but whose incomes are somewhat above the welfare limits. Some states have exercised the option; others have not. Moreover, states have broad discretion in deciding both the level and the kinds of care to be provided. Medicaid, however, does not require coverage of the noncategorical poor. Those individuals are entitled only to whatever health care they can obtain from public and charity hospitals or from county and local programs.

GENERAL RELIEF—THE PROGRAM FOR MODERN PAUPERS

Who is left? We have described a two-century process of creating categories of the deserving poor to distinguish them from the general mass. The deserving poor have progressed all the way to completely federal programs. AFDC is a halfway house, partially federally funded and carrying some federal requirements, but basically it is a state and local program, full of conditions. Who is left at the local level, in the original relief programs inherited from England? Those who do not fit the categories: nonaged, nondisabled single adults, and childless couples. What happens to these people if they are poor? General relief is the answer.

In the past and today, this residual category has been viewed with the most suspicion. The stereotype is the single male, the drifter, the sturdy beggar, or the tramp. Why should these people be excused from work? They are not old, they are not disabled, and they do not have to take care of children. Work is always available for those who are willing to work. Do they prefer a life of idleness and vice? If so, society has no obligation to support them. These people, the *noncategorical and undeserving poor,* are part of the historic mass of the poor who are dealt with at the local level. They are the twentieth-century paupers.

General relief stands in sharp contrast to Social Security and now to Supplemental Security Income programs. General relief programs vary widely among the states.

In approximately half of the states, existing programs are completely local, financed by local property taxes and administered by the counties, cities, or townships. In some jurisdictions, particularly in large urban areas, these programs are quite extensive. Nevertheless the programs at the local level are the most miserly of all welfare programs, impose the most conditions, are the most discretionary, and include the most severe work test. Some programs employ what is called the "60-day penalty" rule. For a whole range of infractions, ranging from failure to meet an appointment to violating the work test, recipients automatically are terminated for a 60-day period, during which they are prohibited from reapplying for relief. The object of general relief is to deter; there is no pretense at rehabilitation.[5,13] Many jurisdictions, however, offer no public program at all, and private charity is the only resource for the noncategorical poor.

To obtain any public aid, many homeless adults today must go to general relief. To be sure, if they are over 65, are female heads of household with minor children (some states allow intact families with children if the parents are unemployed), or are permanently and totally disabled, they may qualify for the other programs. Certification of disability is often difficult to achieve, however. Although exceptions exist, if the applicant can handle any kind of gainful employment—for example, a sedentary watchman's job—that person may be denied eligibility even though no such job may be available or even though nobody would hire such a disabled person.

Barriers to General Relief

It is hard to become a general relief recipient. Physical barriers include large, noisy central offices that are crowded with a variety of people from the street, long lines, and untrained, harassed workers. The forms are lengthy and complicated. As costs have increased, so, too, have the regulations designed to screen out the unworthy. In Los Angeles County, for example, the initial application package contains at least 18 pages of complex instructions and questions. Moreover, it is estimated that the forms require a twelfth-grade reading level. Many requirements are hard to fulfill—for example, providing specific addresses dating back a number of years or giving evidence that the applicant was not fired for cause from the last place of work.[14] Supplying a permanent address is a particularly difficult requirement for the homeless.

General relief always has imposed work requirements. In Milwaukee County, for example, the stonepile has been replaced by extracting copper wire from discarded engine blocks. In Los Angeles County, work relief includes trash collection, custodial work (cleaning public buildings), gardening, and assisting at the public crematorium. Work-search requirements also exist: Each month a recipient is required to show written evidence that he or she has applied for a certain number of jobs. If a recipient violates the work rules (for example, is late to an appointment or fails to complete the required number of job searches), he or she may be suspended or eventually terminated. Moreover, many general relief programs cover only fixed, short terms. Some are considered only as emergency, one-time support.[13]

The barriers to general relief are often deliberate. A local official in Los Angeles stated, "Right now, even a competent homeless person has a rough time getting through a welfare application process that was designed to be rough. It is designed, quite frankly, to be exclusionary."[14] In Milwaukee as well as in Los Angeles, the instrument of relief has become the test of need, as it was in the nineteenth-century English poorhouse.

Who are the homeless who must negotiate these barriers? Other chapters in this volume will describe their characteristics in greater detail, but in general, the group includes many single adults who have lost their jobs or their housing. There is a growing class of women who have been separated or divorced, or whose children have aged out of the AFDC program. These groups often have weak labor market connections. Now one also finds intact working families, thrown on the street because of the extreme shortage of affordable housing for the lower-skilled working populations. The homeless also include those with physical and mental disabilities.

For those who have mental disabilities, the barriers are especially cruel. It is difficult to keep appointments, to cope with congested, noisy waiting rooms, to remember former places of residence when one has moved so many times, to retain required documents when one lives on the street, and to look for jobs when one does not have bus fare. Particularly onerous for the homeless, the disabled, and the mentally ill are the required documents and verifications—such as identity cards, physical examination forms, and forms to be filled out at other offices—that require appointments, travel to different and often distant locations on public transportation, waiting lines, and more forms.

Under the best of circumstances, welfare workers are overworked and undertrained; they must follow strict bureaucratic requirements for getting the work out. Applicants with problems become problems for the workers to get rid of. Workers lack the training, the time, and the patience to communicate with mentally disabled applicants who are easily confused and frightened, or who may not understand or be able to comply with required tasks. Often language barriers exist.

CONCLUSION

The administration of general relief fits the historical pattern of welfare; it is local relief for the undifferentiated mass of the poor. The barriers and requirements trace their roots to the days of the English poorhouse and before.

Signs of change may be present, however. Researchers and advocates for the homeless have been exposing the myth of the single male malingerer, and there has been a great deal of publicity about the homeless. We are beginning to make distinctions among the mentally ill, the physically disabled, the working poor who have lost their housing, and other subgroups among the growing homeless population in the United States. Perhaps some of these groups will begin to take on the status of the deserving poor, and separate programs will be developed for them. This appears to be happening now with mentally disabled homeless persons. Such has been the historic pattern, but still there will be those who are left behind.

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4

Deinstitutionalization and Reinstitutionalization of the Mentally Ill

MILTON GREENBLATT

INTRODUCTION

In modern history, three great shifts in concepts and practice in the treatment of the mentally ill are recognized. The first "revolution" followed the political and intellectual liberation of humans arising from the struggles of the French Revolution. Its counterpart in the mental hospitals of the day was moral treatment, a philosophy expounded by Philippe Pinel,[1] which emphasized kindness, forbearance, and a personalized approach to patients. Pinel claimed that the mentally ill generally did not demonstrate recognizable lesions of the brain and would respond to enlightened tolerance and understanding without the necessity of chains, straitjackets, or other punitive measures. His philosophy spread throughout Europe and then to America, where the early hospitals, founded on principles of moral treatment, boasted gratifying therapeutic results even in seriously ill patients. Indeed, Parke's[2] remarkable follow-up of patients admitted to the Worcester (Massachusetts) State Hospital, the first of its kind in the nation, showed that the majority of persons admitted with less than a year's evidence of mental illness eventually could be discharged as recovered.

History also records that after 1855, with the introduction of the Industrial Revolution in American society, moral treatment declined and faded away. It gave

MILTON GREENBLATT • Department of Psychiatry and Biobehavioral Sciences, and San Fernando Valley Program in Psychiatry, University of California, Los Angeles, Los Angeles, California 90024, and Department of Psychiatry, Olive View Medical Center, Sylmar, California 91342-1495.

place to increasingly custodial management of the mentally ill, with consequent long hospitalization, poor prognosis, and sometimes lifelong stigmatization.[3–7]

During the first half of the twentieth century, a second revolution, often characterized as the Freudian enlightenment, swept through the Western world. It moved from the private consulting room, where mostly neurotic patients were treated, to the mental hospitals, where primarily psychotic patients were in custody. Whereas Pinel emphasized removal of punitive physical restraints, Freud emphasized release from the unconscious mental barriers that shackled the minds of men and women. Exploration of the individual's most intimate thinking and feeling became central in understanding the psychodynamics of the individual's behaviors and in "working through" the patient's unwholesome defenses.

In the 1930s and 1940s, the Freudian approach competed with somatic therapies—shock, insulin, and psychosurgery; in the 1950s, Freud's psychoanalytic approach had to contend with the new discoveries in psychopharmacology, especially as applied to the treatment of psychotic individuals.

The third revolution,[8–9] ushered in after World War II and still in force, appears to be a mixture of social and community insights into the etiology and treatment of emotionally impaired persons, together with a massive development of research and clinical innovations constituting a new behavioral science. It not only views the individual as shackled by social injustice and distress—unemployment, urban crowding, family dismemberment, poverty, discrimination against minorities, and socially deviant lifestyles; it also addresses systems of delivery of care and treatment. Even more, it attempts to confront the larger public health challenge of providing adequate and appropriate services to all the individuals in need within defined geographic boundaries. In the context of this third revolution, the deinstitutionalization movement was born.

THE DEINSTITUTIONALIZATION MOVEMENT

For many years, the abuses of patients and the inadequacies of treatment in the nation's large and remote mental hospitals had weighed heavily on the consciences of enlightened citizens. In his 1948 book, aptly titled *The Shame of the States,* and again in 1949, Albert Deutsch[10–11] proclaimed the U.S. mental health system to be a national disaster. World War II taught the nation that a large percentage of its young adults were unfit to serve in the armed forces because of mental illness; even those who were accepted for service often were incapacitated emotionally by the strains of combat.[12–13]

In 1955, the Joint Commission on Mental Illness and Health was organized, under the aegis of the American Psychiatric Association, to recommend a national policy of reform.[14] In its final volume, published in 1961, the Commission stated that treatment of the mentally ill in the United States was a national disgrace. It recommended a doubling and tripling of funds for the mentally ill; training in many more professions, especially in the core disciplines of psychiatry, psychology, nursing, and social work; and phasing down the populations of the large mental hospitals. The Commission called for a massive increase in basic research and clinical innovation.

Perhaps the most important recommendation by the Joint Commission was that the nation be divided into circumscribed population areas of 75,000 to 200,000 persons, with a single authority assuming responsibility for the mental health of a person's given area. That authority would plan and implement services for all the

people in the area without discrimination of any sort. The Commission recommended the establishment of small, comprehensive community-oriented mental health centers to serve these areas, situated in or near concentrations of population. These centers, with their community outreach programs, were designed to assist the phasing down of the large state hospitals by shifting treatment of a great many patients to extramural facilities. A public health-oriented service system, with integration of resources from federal, state, and local areas, would attempt to deliver treatment to all patients in need. Thus the populations of the state hospitals would be reduced (some would be phased out altogether), and community-based treatment would become the accepted standard of the day.[15–16] The whole program was aided providentially, by the introduction of psychoactive drugs, which made patients more tranquil and less feared by caregivers, by families, and eventually by the community itself.[17–18]

At the same time, a renewed interest in the civil rights of hospitalized patients accelerated and further shaped the movement toward extramural care and treatment. Perhaps the most famous case is *Wyatt v. Stickney,* in which the Federal District Court of Alabama, under Judge Johnson, decided in 1971 that confinement against the patient's will without adequate treatment was unconstitutional.[19–21] Johnson ordered the State of Alabama to meet a series of standards set by his court; he would not accept lack of funds as an excuse for violation of patients' rights. Thereafter, throughout the nation much greater attention was directed to due process leading to confinement, justification for continued detention, and treatment under the least restrictive conditions. Patients' rights were expanded greatly as the conditions for involuntary hospitalization came to be defined more stringently. In most cases mental illness had to be defined as constituting a danger to oneself or to others, or as such a grave disability that the individual was unable to provide for his or her food, clothing, and shelter.

The result of all these measures was a nationwide reduction of federal, state, and county hospital populations from 559,000 in 1955 to 133,550 in 1980.[22] Concomitant with this population phasedown was an enormous increase in ambulatory care, construction of more than 750 comprehensive community mental health centers, and multiplication of transitional facilities such as day centers, halfway houses, board and care homes, sheltered workshops, and cooperative apartments.[23–24] In addition, the number of mutual self-help programs increased greatly.[25] Many inspired citizens carried the work even further by filling gaps in service with highly innovative community support structures—not to mention their participation as volunteers in direct assistance to the mentally impaired.[26]

Indeed, the burden of care shifted dramatically from the mental hospitals to the community. It also was transferred to a considerable extent to nursing homes and to law enforcement; when no care was provided, the mentally ill were relegated to the streets. The financial burden, as a result of Supplementary Security Income and Medicaid, shifted in part from the states to the federal government.

Unfortunately, all did not go well for the deinstitutionalization movement.[27] The phaseup of community facilities did not keep pace with the flow of discharged patients into the community. During the Nixon administration, federal funds dried up, and the states were unable to accept the burden. As national priorities shifted, billions of dollars in federal money were withdrawn from nutrition, welfare, and health. Affordable housing became scarce. Criminalization and victimization of the mentally ill became commonplace.[28] Ex-mental-hospital patients congregated by the thousands in soup kitchens, missions, social service depots, temporary shelters,

parks, beaches, alleys, and culverts.[29–30] As the homeless interfered with business or blighted the dignity of well-ordered communities, the citizens rose up in protest.[31,33]

WAS DEINSTITUTIONALIZATION A SUCCESS OR A FAILURE?

In 1984 the American Psychiatric Association Task Force on the Homeless estimated that approximately 25% of the homeless were affected by serious chronic mental illness.[34–36] Koegel's study of the Los Angeles skid row area reported that schizophrenia was 38 times more prevalent there than in a random community sample, manic episodes were 25 times more common, and panic disorders and antisocial personality disorders were 13 times more common. Approximately 62% of the skid row population suffered either from major mental illness or from chronic substance abuse.[37–38]

Robertson's review of the major epidemiologic studies in the nation revealed that between 15% and 42% of the homeless reported a history of previous hospitalization (the majority clustered between 20% and 35%).[39] Therefore it is apparent that a major factor in homelessness is deinstitutionalization. It is also obvious that the goal of deinstitutionalization—to provide treatment for all the patients in a given community—has gone awry.[40–42] Community alternatives simply did not develop in sufficient numbers to take care of the flood of patients discharged from the mental hospitals, especially as federal funds were withdrawn from the deinstitutionalization movement and the states seemed unable to take up the slack. Forces beyond the reach of mental health professionals conspired to make homelessness a national crisis. These forces included a change in national priorities, a "trickle-down" economic philosophy, housing shortages, industrial instability, unemployment, family dismemberment, and many other trends.[43–44] Thus some observers have declared the deinstitutionalization movement a failure.

On the other hand, the deinstitutionalization movement produced a number of positive changes whose effects may be felt for generations. For the first time in history, the disastrous system of care and treatment of the mentally ill evoked national leadership in planning and implementing a new approach. Training of new professionals and research into causes and treatment were stimulated greatly. Citizen's participation was enhanced. Legislative and judicial actions outlined a whole new set of rights for patients. The total number of patients treated increased vastly, especially in ambulatory care.

Nevertheless, it is a national tragedy that as the hospitals have improved and as research, both basic and empirical, has flourished, the number of neglected mentally ill persons has multiplied shamefully. These people are neither in hospitals nor in community facilities. In a short time, a sizable subculture has grown up in the midst of prosperity in the cities of a great nation.[45]

IS REINSTITUTIONALIZATION THE ANSWER?

Two forms of "reinstitutionalization" may be considered. The first is placement of the homeless mentally ill in temporary shelters, single rooms in hotels, halfway houses, foster homes, or apartment complexes that mainly provide shelter, but where the elements of adequate and appropriate treatment are totally neglected or

are offered only to a few. The second is return of the homeless mentally ill to the formally established treatment facilities—the mental hospitals and associated clinics—from which they came.

The shelter movement has received great impetus in recent years, although it is still far from adequate. On any given night in downtown Los Angeles, shelters may be available for about 2,000 people, but another 6,000 to 7,000 places are needed. Those without a roof over their heads survive on the streets or in alleys, doorways, parks, culverts, or beaches—or on heated grates. The emblem of homeless persons in downtown Los Angeles is the cardboard box, which is flimsy protection against the elements or against predators.

Some homeless persons do not sleep at night for fear of attack; in the morning they rush to the nearest bench, cot, chair, or mattress available under some blessed roof. A fearful night in the cold, followed by cramped dozing in a chair by day, does not enhance the peripheral circulation. Lowered resistance, chronic stress, and subsequent physical illness abound among the homeless.[46]

As discussed in Chapter 3, hundreds of thousands of single-room hotels have been phased out in our large cities during the last two decades. In New York alone, there were 171,000 single-room dwellings in 1971; in 1984, only 14,000. Nationwide, 715,000 units renting for $300 per month or less have been phased out. In many places where the homeless depend on general welfare assistance, the allotments are not sufficient to rent a room throughout the month. In some cities, legislation requires that all homeless people sleeping on the streets on cold nights must be provided with shelter.*[47] Yet even where shelters may be available, persons with serious mental illness often are excluded. Fear of victimization, a preference for open spaces, or simply inability to fill out applications may prevent them from entering shelters.**

Shelter alone is not enough. Without state-of-the-art medicine—mental and physical examinations, accurate diagnosis, sophisticated treatment planning, pharmacotherapy, psychotherapy, work therapy, social and recreational therapy, family and community supports, adequate placement, and intensive follow-up—we do no more than guarantee chronicity and deterioration even in a sheltered environment. This is a hard reality for the powers that be; a true rescue operation will require billions of dollars. New professionals, a legion of case managers, and individualized programs using hospitals, clinics, and community facilities in an integrated manner will be necessary. Thus a return to the hospitals and clinics of the established mental health systems becomes a serious consideration.

James[48] surveyed the mental health commissioners of all the states and reported

*In one study (New York City),[61] only .9% of homeless women and 2% of homeless men reported current receipt of veterans' benefits, although 28% were veterans. Reasons were poor reputation of Veterans Administration services, inaccessibility of services, and inadequate outreach.[62]

**In *Callahan vs. Carey* (New York 1979), an action was initiated against Governor Carey, Mayor Koch, and others, demanding that the defendants supply adequate shelter to the homeless persons who apply for it. Few shelters were available at that time, and those few were only for men. Hundreds slept on floors or in chairs in a big room; many more slept in doorways, subways, vacant buildings, steam tunnels, or parks. In December 1979, Justice Tyler stated that it was the responsibility of public officials to find lodging for the needy and that shelter should include clean bedding, adequate security and supervision, and wholesome board. In 1982 the Coalition for the Homeless filed a class action suit in the state Supreme Court, claiming that the *Callahan* standards had not been met for women. Unfortunately, difficulties and delays have arisen in enforcement of the court's orders; meanwhile the costs of adequate housing and care for homeless persons in New York have been staggering.

that 46% have not reduced their budgets for aftercare; only 10 have increased inpatient beds in the last few years; several have increased spending for the chronically mentally ill; and 22 are under court orders to improve their mental health systems. He concludes that no major movement toward reinstitutionalization has yet taken place.

Elpers[49] calls attention to recently enacted laws in California that suggest that the swing to deinstitutionalization has reached its limits. These bills propose (1) to extend the length of incarceration of persons whose violent crimes were caused or aggravated by mental illness; (2) to mandate that mentally ill persons apprehended by the police be transferred rapidly to the mental health system; (3) to make difficult the discharge of severely ill patients into the community; (4) to alter the interpretation of "gravely disabled" to allow a larger number of the chronically disabled homeless to return to the hospital; and (5) to facilitate conservatorships for the protection of the seriously ill. Elpers also notes that the concept of the "least restrictive" alternative is gradually being replaced by the concept of the "optimal therapeutic environment."

A lawsuit mounted against the County of Los Angeles by the City of Santa Monica charges that the county has a mandatory duty to provide shelter for the homeless and that county relief is inadequate; often it sends the homeless to below-standard hotels, where rape, muggings, and disease are rampant and where showers and toilets are inadequate for even minimum privacy.[50–51] The legal brief calls attention to the lack of beds in county hospitals; it states that the "gravely disabled" concept means that the mentally disabled not only must have available food, clothing, and shelter but also must be willing and able to use assistance if and when offered. Accordingly, many more persons fit the definition of "gravely disabled" than under the present definition and should be hospitalized. Further, a shortage of beds or alleged financial deficiencies on the part of the county cannot justify denial of citizen's rights. We await the outcome of this court battle.

As another possible step toward alleviating the problem of mentally ill homeless persons, involuntary or mandatory outpatient treatment has been recommended for those who meet the following criteria: high use of inpatient services, failure of status as a voluntary patient, acute need for treatment, available treatment modalities with a high likelihood of effectiveness, and expectation of further deterioration without treatment. These criteria would be added to the usual requirements of dangerousness and grave disability, but presumably these would be less intense than would be required for direct, involuntary commitment to a mental hospital. All plans assume that if the patient is uncooperative or violates the rules of the treatment program, he or she would be referred to the mental hospital without further due process. Statutory provisions for involuntary outpatient treatment now exist in about 20 states, although this approach is used infrequently.[52–57]

In Massachusetts and North Carolina a "*likelihood* of serious harm" is allowed by the law; the individual need not lack the capacity to understand the enforced nature of his or her treatment or the ability to make competent judgments. Involuntary outpatient treatment is easier to implement in these states than in those that insist on stronger current evidence of dangerousness. The whole experiment is an attempt to prevent recurrences of illness as a result of past noncompliance, which result in the "revolving door" phenomenon; it also tries to correct the past failures of our inadequate follow-up systems. In addition, this program treats the patient in a less restrictive setting than the hospital and preserves the elements of a community-based philosophy.

Mulvey *et al.*[58] have marshaled the arguments for and against involuntary outpatient commitment. Arguments against mandatory outpatient treatment include infringement of civil liberties, professionals' reluctance to apply coercion, lowering of state standards for intervention, possibility of arbitrary use of power, and merging of *parens patriae* and police power in the same individual.

In favor of mandatory outpatient treatment, the authors argue that the problem of the homeless mentally ill has reached crisis proportions; these people cannot be ignored. They live in misery and constitute a health hazard to the community (e.g., the prevalence of tuberculosis is rising rapidly among the homeless,[59] as discussed in Chapter 13). They alienate the larger community and threaten the liberty and safety of others. What good are liberty and autonomy to a patient enslaved by psychosis?

After decades of struggle to gain greater liberty and rights for the mentally ill and to establish a community program that is known, under the right conditions, to be better than hospitalization for a great many patients, it is a hard decision to return to a more coercive practice. Several options are presented and must be understood[56,60]: (1) outpatient commitment practiced under a district court, without authority under mental health law; (2) statutory outpatient commitment under the same criteria as inpatient commitment, with or without provision of intervention against noncompliers; or (3) outpatient commitment under a less strict standard than inpatient commitment. Revision of laws may require "probable" rather than "present" dangerousness and a broader definition of "gravely disabled." For years professional responsibility has been eroded in favor of patients' rights. Is the public now willing to return to greater trust in the wisdom and judgment of mental health professionals?

SUMMARY AND CONCLUSIONS

Since the days of Pinel's moral treatment, psychiatry has experienced the Freudian enlightenment, advances in psychopharmacology and in basic brain research, and (since World War II) a revolution in organization and conceptualization of treatment of mental illness along social and community lines. The deinstitutionalization movement has been the greatest coordination of efforts in modern times, involving federal, state, and local resources. This movement has included a shift of treatment from intramural to extramural sites; reduction of state hospital populations and the total phasing out of some hospitals; delineation of population areas as a basis for planning and implementing treatment for all citizens in need; strong governmental support for training of professionals and for research and clinical innovation; and legislative and judicial actions that have greatly extended the rights of patients.

Adequate treatment of patients in the community, however, has been undermined by a rapid and largely unanticipated rise in the number of mentally ill adults who are homeless. Many of these individuals are former mental hospital patients; others have never received inpatient treatment. They have been rendered homeless by shifts in national priorities, negative economic trends, lack of affordable housing, family disruption, and reluctance of government to attack a complex problem of staggering proportions.

In this context a movement toward reinstitutionalization is taking shape. It takes two forms: (1) shelter in temporary situations, which without the full panoply of modern treatments is nothing more than a stopgap measure, and (2) the return of

the seriously mentally ill to the hospitals and clinics from which they came. This process will require the very costly expansion of the physical and professional resources of hospitals and clinics; in addition, it will call for a far more satisfactory development of aftercare services, in which most of the systems of care generally have been deficient in the past.

Recently there has been great interest in mandatory commitment to outpatient treatment for those with serious psychosis, with high and unsuccessful past utilization of treatment resources, and with poor prognosis in the absence of interventions. Many important legal, ethical, and practical issues arise in this connection. The pros and cons are being argued vigorously. Still needed are rigorous empirical research programs and careful analytical follow-up of experience with this highly controversial modality.

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5

The Criminalization of Homelessness

PAMELA J. FISCHER

INTRODUCTION

Homeless persons have been described as exhibiting impressive rates of psychosocial pathology.[1–5] A resurgence of interest in the relationship of mental illness to criminal behavior has been fueled by the substantial and possibly increasing proportions of jail and prison inmates with histories of mental illness and/or homelessness as well as by high rates of arrest and incarceration in homeless populations.[6–14] Investigations are being conducted to determine whether mental illness has been "criminalized" as a consequence of deinstitutionalization and the reforms in involuntary commitment laws.[11–12,15–18] This chapter examines the relationship among illegal behavior, mental illness, and homelessness through the study of arrests of homeless persons in Baltimore and interprets this relationship in light of historic and contemporary literature.

THE BALTIMORE ARREST STUDY

Methods

The primary goal of the study was to describe the pattern of arrests of homeless persons relative to the total arrests occurring in the city of Baltimore in 1983.[19] A second goal was to use arrest data to infer information concerning the behavior,

PAMELA J. FISCHER • Department of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine, Baltimore, Maryland 21205.

movements, and attributes of the homeless population from which arrested individuals were drawn.

Data on all arrests of adults occurring during calendar year 1983 (N=50,524) were analyzed using data from the Baltimore Police Department's computerized crime reporting system. Among the suspects, homeless (N=634) were defined as those who reported either no address or an address determined to be that of a mission, shelter, soup kitchen, or other facility likely to be used as a mail drop by the homeless.

In addition, a random sample of 50 offense reports for homeless suspects was drawn from the roster of arrests for Part I offenses. I consulted these reports, which contain the arresting officer's narrative description of the incident and its disposition, to collect contextual information on the arrests as well as to judge whether the seriousness of the charge was a valid representation of the suspect's actions.

Findings

The homeless arrested population consisted of 275 individuals with a total of 634 arrests, the majority of whom were nonwhite (69%). The mean age of arrested individuals was 38.4 years. The number of arrests ranged from 1 to 18 per person; 145 (53%) had multiple arrests within the year, with an average of 3.48 arrests each. Because only aggregate data were available for all Baltimore arrests, individuation was not possible.

Significant differences were found between the two arrest groups in terms of demographic attributes and the pattern of criminal activity. Men and nonwhites predominated in both arrest groups, but the homeless group included fewer females (4% vs. 15%) and fewer nonwhites. Perhaps the most striking difference found between the two groups was the suspect's age. As illustrated in Table I, homeless suspects were older; only 9% were under age 25, compared to 41% for all arrests. In addition, there was evidence suggesting that among arrests of the homeless, whites were older than nonwhites and were found to have higher numbers of arrests.

Age–race profiles constructed from census data[20] and information from an earlier study of Baltimore mission users[3] were selected as indicators of the demographic composition of the domiciled and homeless populations of the city. The age structure of the homeless persons' subgroup differed significantly from the Baltimore city residents but was similar to that of the mission sample. Within each population, nonwhites were characterized by higher proportions of younger members than were whites; this pattern was most apparent in the homeless arrested population.

Table I. Distribution of Arrests of Homeless Persons, All Individuals, by Age of Suspect, Baltimore City, 1983

Age group	Arrests of homeless[a]	All arrests
18–24	9.3%	41.1%
25–44	57.4%	49.7%
45–64	28.5%	8.4%
	4.7%	0.8%
N	634	50,524

[a] $p < .05$, χ^2.

As shown in Table II, the pattern of criminal activity as reflected by arrests was different among the homeless from that in the general population. Fewer of the arrests of the homeless were made for serious or violent crimes, as defined in the Crime Index by the Federal Bureau of Investigation (Table II).[21] In both arrest groups, charges of serious offenses declined with age. Also, among the Index crimes, crimes against property were most common. Arrests of the homeless for crimes against the person, however, were more likely to occur among nonwhites, whereas arrests for these crimes among all Baltimore arrests were more likely to occur among whites.

Review of the arresting officer's narrative for a sample of 50 arrest reports revealed that serious offenses often accrue from relatively inoffensive actions on the part of homeless persons; for example, burglary charges resulted when the homeless were discovered sleeping in vacant buildings. In 28% of these reports, there was clear indication that the suspect was mentally disturbed or intoxicated.

Arrest data were used to infer information about the attributes, behavior, and movements of the homeless population from which arrested individuals are drawn. For example, the frequency of offenses related to intoxication (e.g., liquor law violations, public consumption, and disorderly conduct) establishes the importance of alcohol abuse in the homeless. Four-fifths of arrests of the homeless, but fewer than half of all Baltimore city arrests occurred within commercial and low-income residential areas of the central city, which also contain most of the missions, shelters, and soup kitchens that serve the population. Three-fifths of the arrests of homeless persons took place during the spring and summer, compared to about half of all city arrests; almost half of homeless persons' arrests occurred during the day, compared to one-third of the arrests in the general population. This finding suggests either that homeless people are more visible and thus more vulnerable to arrest in hot weather, when they are not "holed up" against the elements or that the arrested population reflects seasonal fluctuations in the size of the total homeless population. The numbers of homeless persons may increase in the warm season, when there may be less reluctance to turn family members, friends, or tenants out on the street. Similarly,

Table II. Distribution of Arrests of Homeless Persons, All Baltimore City Arrests, by UCR Offense Category and Race, 1983

	Arrests of homeless			All arrests		
Offense	White (%)	Nonwhite (%)	Total (%)	White (%)	Nonwhite (%)	Total (%)
Part I[a,b]	21.8	27.3	25.4	27.4	38.3	35.2
Crimes against the person[c]	27.7	44.7	39.8	48.8	36.0	38.8
Crimes against property	72.3	55.3	60.2	51.2	64.0	61.2
Part II[d]	78.2	72.7	74.6	72.8	61.7	64.8
N	216	418	634	14,224	36,300	50,524

[a]Part I offenses constitute the FBI's Uniform Crime Reporting Program (UCR) Crime Index because of both seriousness and frequency of occurrence; they include homicide, rape, and assault (crimes against the person); and robbery, burglary, larceny, motor vehicle theft, and arson (crimes against property).

[b]Significant differences were found between arrests of whites and of nonwhites in each arrest group and by comparing within races between the two arrest groups.

[c]Significant differences were found between arrests of whites and of nonwhites in each arrest gorup and by comparing within races between the two arrest groups ($p < .05$).

[d]Part II offenses consist of all crimes not classified as Index crimes, including offenses against public order.

the homeless appear to place themselves at risk of arrest during the day. Paradoxically, whereas darkness is sought to cloak criminal activity in the general population, the night appears to reduce opportunities for arrest among the homeless, who may be indoors in nocturnally operating missions or on the streets but relatively invisible.

DISCUSSION

The results of this and other recent studies make it apparent that criminal activity remains a prominent characteristic of the contemporary homeless population.[2,4–5,7–14,19,22–26] Little has been reported to date, however, concerning the nature of homeless people's criminal behavior and its function in the etiology and maintenance of the homeless lifestyle. A framework for understanding how criminal behavior, mental illness, and homelessness interact can be constructed from the literature.

Excess Criminal Activity among the Homeless

Criminal activity among the homeless exceeds that of the general population. This fact has been well established by recent reports documenting rates of arrest and/or incarceration. These rates range from one-fifth to two-thirds of the homeless,[7] compared to an estimated 22% of men and 6% of women in the general population.[27] Rates of participation in criminal activities vary across subgroups; men,[4,23,28–29] substance abusers,[1,22,25,30–31] shelter users,[5] and the mentally ill are more likely to be arrested.[1,10,25] Age, race, and ethnicity also are likely to affect risk of arrest.

The Nature of Criminal Offenses among the Homeless

Although it is unclear whether arrest precedes or follows the plummet into homelessness, some studies suggest that criminal activity is of recent date. For example, more than three-quarters of previously arrested homeless persons in Los Angeles reported being arrested within the past 6 months,[2] and more than one-fifth of homeless persons surveyed in St. Louis had been arrested since becoming homeless.[23] Moreover, recidivism is high.[3–4,26] In an earlier Baltimore study, it was found that four times as many of the homeless as of a comparison sample of domiciled men had experienced multiple arrests.[3]

Although the data from the Baltimore city arrests cannot be used to estimate rates of arrests among the homeless, they serve to establish a different pattern of criminal activity. The Baltimore homeless arrests appear to result mainly from relatively trivial and often victimless crimes, such as disorderly conduct and violation of park and liquor laws. This pattern echoes the predominance of misdemeanor offenses described in the literature since the turn of the century.[7] Nevertheless, there is evidence that the criminal activity of the homeless costs an estimated $3 to $4 million annually.[31]

Although felony offenses may account for as many as one-third of convictions,[19] evidence from the sample of 50 offense reports suggests that even these serious offenses may stem more from the homeless condition than from genuine criminal intent. Larceny often was shoplifting of food and clothing, burglary charges resulted

from seeking refuge in vacant buildings, and arson was charged when fires were built to provide warmth through a winter night. Thus although some homeless persons may commit crimes for profit or malice, it appears likely that most offenses result from the need to survive, in which petty thievery and opportunistic sheltering play functional roles.

The Role of Criminal Behavior

The role of criminal activity in the behavioral repertoire of homeless people can be interpreted in at least four different ways: deviance, subsistence, adaptation, and diminished capacity.

Deviance. The first possibility is that criminal behavior is one expression of a larger class of chronic deviant behavior, in which homelessness itself is another indicator of deviance. This type of habitual criminal behavior may be undertaken deliberately as part of a career in illegal enterprise. In reviewing prison records of a Detroit homeless sample, for example, Solarz[26] found documentation of long-term engagement in systematic criminal behavior for some individuals; about 10% revealed that their main source of income was derived from illegal activities.

Drug addiction and its associated patterns of crime also may be classified as chronic deviant behavior. Although it is generally accepted that alcohol is a drug of choice (probably from economic necessity as well as from habit or preference), substantial use of street drugs also is reported.[2,14,23,25–28,32] For example, more than one-fifth of the homeless surveyed in Chicago reported current drug use[14]; in St. Louis two-fifths of the drug users reported more than one episode per week.[23] Schutt and Garrett[25] found that 30% of the homeless adults surveyed in a Boston shelter took hard drugs and were almost three times more likely than persons with neither drug nor mental health problems to have current legal problems. In addition, epidemiologic studies of homeless populations suggest an elevated prevalence of character disorders, including antisocial personality, which may be associated with criminal behavior.[2–3] Although habitual criminals surely constitute the minority among the homeless population at large, they also contribute to their ranks when they go underground either to evade arrest or to survive a period of waning fortune. Thus homelessness may be a natural part of the life cycle of these few individuals whose livelihood derives principally from illegal enterprise.

Subsistence. A second interpretation is that criminal activity is one of few available means of augmenting meager resources in a population where the majority of individuals have been unemployed for a long time.[1–2,4–5,23–24,32–34] The homeless find it difficult to obtain gainful employment for a variety of reasons such as inability to obtain appropriate clothing or access to transportation, lack of education and training, and incapacitation. In general the contemporary homeless still occupy the niche in the working world filled traditionally by transients and skid row residents: they have part-time or temporary jobs, including casual labor, but also may sell blood or participate in paid research.[7,33–34] Despite their need, recent research suggests that substantial proportions of the homeless do not benefit from public support programs.[2,5,7] Consequently some may resort to illegal acts on a modest scale, including panhandling, petty pilfering, shoplifting, small-scale drug dealing, nonpayment of cab fares and restaurant tabs, and prostitution to supplement income and/or resources.[2,14,26] Criminal activity of this type grows out of necessity more than intent and might be reduced substantially by increasing social services.

Adaptation. A third interpretation is that criminal behavior constitutes an important functional adaptation in the ecological niche occupied by the homeless. Skills that greatly enhance the survival prospects of the homeless person on the streets are often illegal or readily criminalized despite their lack of criminal intent. For example, homeless people frequently use unorthodox places as shelter; they may need to employ illegal means of entry (e.g., breaking into an abandoned building or a parked vehicle) that can be interpreted as constituting criminal intent (e.g., trespass or violation of park laws, which prohibit sleeping on benches). Moreover, some homeless people appear to use arrest itself as a survival strategy, having learned how to manipulate police into providing temporary asylum in jails.[35–37] This strategy may be reinforced by behavior of the police, many of whom believe that "they are saving the men's lives when they send them to jail to get 'built up.' "[38] This type of criminal behavior suggests opportunism rather than premeditated illegal activities. These individuals are described more accurately as criminally homeless than as homeless criminals.[39]

Diminished Capacity. Finally, arrests may indicate diminished capacity in offenders who exhibit ill-judged or bizarre behavior that lands them in a correctional institution rather than in a more appropriate system of care. Such arrests may increase the criminal experience of substantial proportions of the mentally ill, including the alcoholics, among the homeless population. Residents of skid rows, many of whom are alcoholic, historically have experienced high rates of arrest.[6–7,33,38,40–44] Evidence from recent studies in Baltimore[29] and Los Angeles[30] suggests that alcoholics continue to have disproportionately high rates of arrests. In particular, "young chronics" among the mentally ill homeless are a subgroup with high rates of criminal activity.[45] Studies of homeless persons, which have attempted to correlate arrests with psychiatric measures, have found evidence of increased criminal activity among the mentally ill, particularly among those with a dual diagnosis of substance abuse.[1–2,10,25]

Mounting evidence shows that changes in involuntary commitment laws have an unanticipated effect: They prevent the mental health system from functioning as a means of control for the severely mentally ill. Consequently, socially aberrant behavior, even where it is symptomatic of mental illness, has tended to become criminalized.[11–12,15–18] Psychotic behavior (sometimes violent), disheveled appearance, or the disorientation associated with intoxication, mental illness, and mental retardation may bring the police into play; thus the homeless become "police patients."[46] The police in general are poorly trained to recognize mentally ill individuals and to handle them appropriately. Although they are subject to a great deal of public pressure to remove unsightly or "crazy" persons from streets, they have limited options for disposition of such troublesome cases.[47] These conditions are reasons to believe that homelessness, perhaps even more than mental illness, has been criminalized.

JAILS AS SERVICE SITES

The movement of substantial proportions of homeless persons through the criminal justice system represents a significant public health problem. Recent studies of the U.S. homeless population underscore the importance of law enforcement personnel as providers of an array of services—particularly general health and men-

tal health care—and point to jails as service sites for large numbers of the homeless.[2–3,7,19,26,29,34] Indeed, the jail may be "our most enduring asylum."[45]

It is painfully apparent, however, that for the homeless in general and particularly for those who are most disabled by severe mental illness, alcoholism, drug addiction, and physical deterioration, arrest and incarceration represent failures of the appropriate human services systems to meet their needs. In fact, it is clear that for this group of people desperately in need of care, police and corrections personnel have supplanted the health and social services systems in providing services. For a substantial part of the homeless population, interaction with the criminal justice system provides a gateway to other service systems. Thus they are assured of receiving some services, however minimal and fragmented.

Because deinstitutionalization is the guiding principle of the mental health services system, the criminal justice system, through a hydraulic process whereby individuals are shifted from mental institutions to correctional institutions, is burdened with providing care that is not within its proper bailiwick. A major pitfall of this "reinstitutionalization" process is the implication that certain individuals are more advisably kept behind institutional walls than left free to join with the populace. This implication raises critical questions related to the costs and benefits of such a diversion, which must be resolved not only in economic but also in humanitarian terms.

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II

Mental Health

6

Homelessness and the Chronically Mentally Ill

MILES F. SHORE AND MARTIN D. COHEN

INTRODUCTION

In some respects, homelessness is the basic human service problem. Before there was an organized public response to mental illness, mental retardation, family disruption, or even physical illness, provision was made for the care of the homeless.

With the breakup of feudal society in the early Middle Ages, homelessness became a social problem. Serfs and others displaced from the responsibility of feudal lords had to find their own shelter and means of support. Those who were unable to care for themselves because of a variety of tragic disabilities and circumstances began to wander the countryside. The first organized response to the problem of homelessness came in the form of *xenodichia*, or inns for strangers, which were set up by religious orders to shelter these early wanderers.

It was only later that separate institutions were established to house the physically ill, the mentally retarded, and the mentally ill, as the difficulty of offering generic services to people with very specific and different needs (still all too familiar) became overwhelming. These were the harbingers, if not the direct ancestors, of our current specialized institutions.[1]

It is hardly surprising that homelessness today continues to be the result of a

MILES F. SHORE • Department of Psychiatry, Harvard Medical School, Boston, Massachusetts 02115, and Massachusetts Mental Health Center, Boston, Massachusetts 02115. MARTIN D. COHEN • The Robert Wood Johnson Foundation Program on Mental Illness, Boston, Massachusetts 02115, and Massachusetts Mental Health Center, Boston, Massachusetts 02115.

wide variety of economic, physical, mental, and social problems. Although shelter is a fundamental human need and the provision of shelter is one of the defining characteristics of society, it is not necessarily a simple matter. Particularly in complex Western societies, having a home requires both sufficient money and the "executive capacity" to turn money into a place to live: negotiating with real estate or rental agents; satisfying landlords in regard to cleanliness, personal responsibility, and the ability to keep paying the rent; or, more formidable, acquiring a mortgage with its myriad complications. It is little wonder that in many societies, particularly our own, persons with major economic and social disadvantages become homeless.

What we now regard as human service problems in the United States were not recognized as such until the middle of the eighteenth century. The first secular poorhouse was opened in Boston in 1664, almost half a century after the Pilgrims landed. Yet pauperism, which was really a measure of social dependency, did not become a significant concern of American society for another hundred years. Not until the mid-eighteenth century, when population centers grew to number more than 25,000 persons, was a more organized effort made to address a host of social problems. That effort grew into a major movement in the first quarter of the nineteenth century, when institutions were created to deal with social dependency. The nineteenth-century mental hospital, as a total institution, reflected a widespread organized social response to individuals' incapacity to provide for themselves. The hospital had the legal authority to act on behalf of its patients. It provided a setting, staff, and programs to compensate for the personal and social impairments of chronic mental illness.

In more recent decades, total institutions for the mentally ill have been altered drastically or abolished, and their contemporary equivalents are varied. In some places, nursing homes provide important services for chronically ill patients. Many state programs depend on comprehensive community mental health centers to serve this population through integrated systems of care and case management. The ideal is that community services will provide, in as normal a setting as possible, the precisely tailored supports that each patient needs, but no more—lest the patient become institutionally dependent.

Homelessness among the mentally ill in modern society reflects a failure of both the executive capacity of the disabled individual and the institutional substitutes for that capacity. Recently the focus has been on the failings of the system; legal advocates are more concerned with preserving patients' freedom and rights than with asserting the state's responsibility to provide for persons who cannot provide for themselves. Problems abound in many states. Funding is often inadequate, the funds that are available come through a bewildering variety of mechanisms, and systems of care are organized inefficiently. Moreover, persons with serious mental illness are not always welcomed either by community agencies accustomed to treating less serious disorders or by the communities themselves. Thus it is hardly surprising that most studies of urban homeless adults find that a significant minority suffer from serious, diagnosable mental illnesses.

This chapter reviews the characteristics of chronic mental illnesses that contribute to homelessness, with a special focus on schizophrenia. We discuss the great difficulty that current mental health systems encounter in assisting persons who are both chronically mentally ill and homeless. Finally, we describe a program launched in 1985 by the Robert Wood Johnson Foundation to develop integrated systems of care to meet all the needs of individuals with chronic mental illness, including the need for a home.

THE CHARACTERISTICS OF CHRONIC MENTAL ILLNESS

Schizophrenia

Persons with chronic mental illness, particularly schizophrenia, suffer from a multitude of social disabilities that make it difficult for them to provide homes for themselves. One diagnostic feature that assists clinicians in identifying schizophrenia is withdrawal from involvement with the external world. Schizophrenic persons, preoccupied by delusions and hallucinations, often are unable to maintain productive social relationships. They have difficulty establishing eye contact, being assertive, and expressing warm emotional responses in everyday dealings with others. They may laugh inappropriately or may read sinister meanings into things people say. They are socially awkward and, because of intense shame and suspiciousness, have trouble making friends or even conducting routine social interchanges.

A key feature of schizophrenia is thought disorder, an intrusion of bizarre, often frightening ideas into the individual's thinking. A schizophrenic person may hear voices or may have delusions of persecution or harassment. Because even the average person sometimes feels persecuted or harassed when dealing with the problems of finding a home, it is hardly surprising that those with serious mental disorders, especially schizophrenia, have more than the usual difficulty in this respect.

Schizophrenic persons are very concrete in their thinking; they attend to the details of things without thinking of their broader significance. Thus they may have great difficulty comprehending the more abstract aspects of finding and maintaining a home. Leases, mortgages, interest rates, and the welter of housing regulations may be more than they can handle. Even comprehending that a check is equivalent to money is difficult for some normally intelligent but seriously impaired persons with schizophrenia.

Equally significant are the vocational difficulties that interfere with earning money. The onset of schizophrenia typically occurs between 18 and 24 years of age—the years during which most persons establish work skills and begin to climb the vocational ladder.

Acute schizophrenia is marked by episodes of psychosis, which require skilled treatment in a hospital. These episodes, lasting from a few weeks to a few months, may be heralded by very disturbed and disturbing behavior, including violence and suicide attempts. Acute psychotic episodes and the consequent hospitalization required to treat them entail major disruptions of living arrangements. Neighbors and landlords often are alarmed; the rent or mortgage goes unpaid; and the individual may find it difficult, upon discharge, to pick up the threads of normal life in the community.

By the time schizophrenia has subsided, typically in the middle to late 30s, the afflicted person has lost 10 to 15 years of vocational training and experience. This deficiency, added to social withdrawal, isolation, and thought disorder, makes it extremely difficult for schizophrenic persons to compete for jobs. Unemployment, in turn, often results in homelessness.

Other Major Disorders

The other major clinical conditions that lead to chronic mental illness and homelessness are disorders of mood and affect, such as chronic depression or mania, and

profoundly disturbing character problems. Serious depression brings lethargy, sadness, and suicidal thoughts, which make it very difficult to work or to negotiate with the world. Manic hyperactivity, which sometimes alternates with depression, impairs judgment. A manic attack may be associated with profligate spending, alcoholism, or work instability, all of which can lead to homelessness.

Profound character disorders cause a variety of problems, including turbulent social relationships, poorly controlled sexual behavior, use of drugs and alcohol, unstable employment, and hair-trigger emotional control. Poor judgment about self-care and repetitive self-destructive behavior are regular concomitants of many of these problems.

Thus chronic mental illness, in all its forms, is marked by poor adaptation to the world. To the extent that having a home requires vocational and social skills, it is clear that serious mental illness conduces to homelessness.

An additional feature of mental illness, particularly in its chronic forms, is disruption of family ties. The high cost of housing has forced many young adults to remain somewhat dependent on their parents, either by living at home or by receiving help with mortgages or rent payments. Many of the mentally ill, however, have lost all connections with their families. Some resist contact, harboring deep resentment against their parents for real or imagined hurts. Those who have tendencies toward violence may have acted out against their families. Many of the families, in turn, feeling frustrated, disappointed, and angry, have given up trying to be helpful. Whatever the particular circumstances, it is not unusual for those with mental disorders to be unwilling or unable to rely on family help. Thus poverty, which is a characteristic feature of chronic mental illness, is compounded by lack of family contact and support.

Driven by unsatisfactory relationships and by social and vocational disabilities, some mentally ill persons move from one part of the country to another, seeking both anonymity and the hope of a better situation. This pattern of wandering makes it difficult for them to obtain social services, because both government and private agencies typically require identifying information and some element of stability for enrollment in social assistance programs. Moreover, suspiciousness and the need for anonymity often make seriously mentally ill persons resistant to the services of social agencies.

Thus chronic mental illness encompasses a host of primary disabilities (thought disorder, hallucinations and delusions, withdrawal from social relationships, and so forth), as well as secondary problems caused by difficulties in dealing with the world (unemployment, poverty, and alienation from family and social agencies). It is these secondary problems that result in homelessness.[2–3]

MENTAL HEALTH SYSTEMS AND HOMELESS PERSONS

Few large cities in the United States are able to provide the comprehensive array of mental health and social services required to assist persons who are homeless and who suffer from chronic mental illness. As discussed in Chapter 3, population growth, condominium conversions, urban development, and arson have reduced the supply of low-cost housing. In addition, large cities attract a disproportionate share of mentally ill persons, many of whom are young, have never received continuous care, and are resistant to treatment.

Fragmentation of Services

Another problem of large urban areas has been the fragmentation of services required to treat the chronically mentally ill. The organization and financing of such services typically prevent the type of coordination needed to develop alternatives to institutionalization or homelessness. Services are often the responsibility of different departments of local, county, or state government, with little or no coordination among them. A striking example is the development of supervised housing, which requires collaboration between the public housing authority (a local or county government unit) and the community mental health center (a state or county unit). The relationship between the two agencies is usually informal, without established procedures for the mental health agency to call on the resources of the housing authority in acquiring or managing supervised housing for the mentally ill.

Catchment Areas

The fragmentation of government units is compounded by the structural disorganization created in the late 1960s by the establishment of catchment areas for community mental health services. Most large cities have more than one community mental health center, each serving a catchment area of 75,000 to 250,000 people. In most cases the catchment area borders do not follow traditional neighborhood lines, police districts, or other preexisting boundaries. As a result, systems of care developed within a catchment area often lack formal ties to one another, to the state hospital, and to other public mental health systems. Moreover, the economic and social supports (e.g., welfare and vocational rehabilitation) that the chronically ill require are usually citywide systems that must interact with many mental health centers. These services are not linked adequately; the result is confusion for both staff and clients. The problem is compounded in the case of persons who must be hospitalized periodically for acute episodes of illness. Such persons often lose their housing, medical, and financial entitlements, and their lives are disrupted severely as a result.

The catchment area concept weakens the influence of mental health advocates and providers in garnering resources not under their direct control but necessary to create a continuum of services for the chronically ill. For example, advocating along catchment area lines for financial assistance in acquiring housing may be the least effective way for mental health providers to approach city government. Political leaders and housing development staff usually divide a city budget into categories that they believe will maximize the return on public dollars—for example, urban redevelopment, neighborhood revitalization, and economic development. These categories are fundamentally unrelated to mental health needs and services. As a the result, mental health advocates are pitted against advocates for other needy groups in the competition for financial assistance.

The fragmentation and disorganization of mental health services result in weak links in patient care. Community mental health systems often fail to provide chronically ill patients with the continuity of care that they need to find and maintain a home. Support services, financial entitlements, inpatient and outpatient care, and case management may be available to the patient but may be delivered by multiple providers. Without formal links among these services, the patient suffers confusion and loss of entitlements, especially a patient who requires periodic hospitalization for acute episodes of illness.

A CENTRAL AUTHORITY

A potential solution to these problems is the reorganization of urban mental health systems under a central authority with administrative, fiscal, and clinical responsibility for all services to the chronically ill within the urban area. This type of reorganization is being demonstrated by the Robert Wood Johnson Foundation Program on Mental Illness.[4]

The Robert Wood Johnson Foundation Program for the Chronically Mentally Ill

As a joint initiative of the Robert Wood Johnson Foundation and the U.S. Department of Housing and Urban Development, the Program for the Chronically Mentally Ill is providing approximately $28 million in grants and low-interest loans and 1,000 Section 8 rent subsidies to 9 of the nation's largest urban centers (chosen from 60 with populations over 250,000). The grantees were selected competitively in 1986 to receive support for 5 years.

The goal of the program is to help people with chronic mental illness to live as independently as possible, avoiding both unnecessary institutionalization and homelessness. Toward this end, the program is funding a variety of citywide projects designed to consolidate and expand services, including health care, mental health care, social supports, and housing. All the projects emphasize three features that the program sponsors believe are essential in serving the needs of the chronically ill: a central authority, a full range of services, and continuity of care.

Centralization

Public authorities are common in the operation of state and local governments and have proved effective in managing cross-jurisdictional services such as ports, roads, and housing. In most cases the public authority has legal powers that are separate and distinct from its sponsoring government, and it may issue bonds as a source of revenue.

Like other public authorities, those being developed under the auspices of the Robert Wood Johnson Foundation seek to retain public accountability while achieving the operational flexibility characteristic of private-sector initiatives. The specific form of the authority will vary from one site to another. It may be a government entity, a private nonprofit corporation, or a coalition of providers and interest groups. At all nine sites, however, the goal is for the mental health authority to have full responsibility for providing services to the chronically mentally ill and to receive all funds associated with the provision of those services, including federal Medicaid funds; state, county, and local government allocations; and any third-party revenues.

For example, the Mecklenburg County commissioners (Charlotte, North Carolina) have concluded an agreement with the local hospital authority to operate the mental health center serving the entire community. County government, however, will retain responsibility for monitoring the quality of care.

Ideally, both hospital- and community-based services for persons with chronic mental illness are to fall under the jurisdiction of the mental health authority. (In some cities the authority also will have responsibility for the acutely mentally ill, because it would be inconvenient, duplicative, or illegal to set up a separate system for persons with chronic mental illness.) The authority will have administrative

responsibility for delivering services throughout the city. Although individual mental health centers and agencies will continue to exist, their funding and service delivery systems will be directed by the central authority. Essentially the authority will control and allocate resources to meet the needs of the population it serves.

Centralization brings increased flexibility and accountability to the management of public mental health services. Both are necessary to support changing patterns of service delivery and to foster innovation. The current difficulty in operating public mental health services is nowhere more apparent than in the detailed procedures for appropriation and expenditure of funds, creation of line positions, and recruitment. In many systems, it is virtually impossible to provide incentives, such as differential pay, bonuses, or increased benefits, to those who work with difficult patients. Under the central authority model, systems have fewer bureaucratic requirements, much like a turnpike authority, which collects and spends its own revenue and conducts its operations with relative freedom from civil service or state contracting requirements. Another analogy is a state university, which receives its finances from the legislature but has the freedom to make tenure commitments and to engage in many other enterprises with the same flexibility as schools in the private sector.[5]

Full Range of Services

The success of the central authority depends largely on the array of services available to patients. At a minimum, there must be access to inpatient care for acute episodes of illness, housing with differentiated levels of supervision, socialization programs such as social clubs and drop-in centers, outpatient treatment, medical care, and vocational rehabilitation.

In an ideal situation, these services would be operated directly by the central authority rather than by autonomous agencies outside the authority. Although contracts or affiliation agreements may be viewed as more cost-effective or more efficient, they create additional problems if the central authority cannot command resources by means of such agreements. The authority must be able to provide services according to the needs of individual patients rather than the needs of the agency. There must be a fit between the patient's requirements and the array of services available. Thus, for example, a system of residential care must offer differentiated levels of support and supervision to meet the housing needs of persons with varying levels of disability.[6]

Continuity of Care

In addition to a full range of services, continuity of care is an important organizing principle for a centralized mental health system. Each patient must have a primary caregiver who assumes overall clinical responsibility for that patient within the mental heath authority. The caregiver works with the patient to ensure that all of his or her needs are met and that the authority and its various components are providing the required care.

A clinical record that follows the patient throughout the mental health system helps to ensure continuity of care. The record provides a single reference point for all aspects of care. It also serves as a tracking mechanism so that the patient can be located when he or she moves from one part of the system to another. This feature is critical in cases where the patient is homeless or when care is not provided at regular locations.

Continuity of care can be promoted further by establishing explicit clinical links among services. To make referral, admission, and discharge procedures work for rather than against patients, the authority must be established in such a way that resources can move with the patient. Large mental health systems often provide no financial incentive for a facility or a program to accept a patient; in fact, there may be disincentives, because each new patient dilutes the care available to patients already in the system. Ideally the patient's needs should be determined at the outset by the treatment team, and a payment rate should be established on the basis of these needs. As the patient moves from one service to another, the payment rate remains the same. This arrangement creates a financial incentive to serve all patients, including those with complex needs.

Housing

To operate effectively, a centralized mental health system must control a broad range of services and settings, including housing. A fundamental problem with the provision of urban housing for patients with chronic mental illness is that mental health agencies tend to view themselves as users rather than as producers or owners of housing. As users they avoid the responsibility of ownership, but they also relinquish control over the types, quantity, and quality of available housing. Mental health agencies tend to be pessimistic about developing new housing; they cite such obstacles as zoning, building codes, financing, community and political opposition, and lack of experience. As a result, most agencies are forced to rent or otherwise acquire existing housing in undesirable urban areas where community opposition is likely to be minimal.

Mental health authorities must adopt an entrepreneurial perspective if they are to satisfy their patients' housing needs. They must become housing producers, enlisting the aid of private developers. To the fullest possible extent, housing for the chronically mentally ill should be integrated within plans for community development and neighborhood improvement. Financial incentives must be sought to promote private development, such as rental certificates, low-interest development loans, and tax credits. Another enticement for private developers is the use of surplus state hospital grounds. For example, excess land could be developed as a residential community in which 10% of the units would be earmarked for the chronically ill. Such initiatives have worked successfully in the development of low-income housing and can be expanded to provide housing for persons with chronic mental illness.[7]

SUMMARY

Having a home requires funds, the skills to manage those funds, and an ability to handle the responsibilities inherent in home ownership or rental. Many people with chronic mental illness lack these resources and require the support of an institutional system. The state hospital traditionally provided that support, including housing. As deinstitutionalization has taken place, the fundamental needs of the chronically ill have not changed, but the institutional capacity to meet their needs has diminished. As a result, many patients have been left homeless.

One possible solution to the current fragmentation of services is to centralize mental health care for the chronically ill in urban areas. A central authority with

administrative, fiscal, and clinical responsibility for the chronically ill throughout the city can provide a full range of services and can ensure continuity of care. Housing should be viewed as a primary service component, with differentiated levels of supervision and support available, depending on each patient's disability. The mental health authority must become a producer of housing, using whatever financial incentives are available to attract private developers.

The central authority model may well provide the financial and administrative structure necessary to develop effective service systems for patients with chronic mental illness. In the absence of such a model, services will remain fragmented and inadequate, and the city streets will continue to be the home of many of the chronically mentally ill.

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7

Problems in the Assessment of Mental Illness among the Homeless

An Empirical Approach

PAUL KOEGEL AND M. AUDREY BURNAM

INTRODUCTION

Throughout most of the twentieth century, one image was sufficient to depict with reasonable accuracy the population of individuals with no fixed, stable abode at any given point in time. First there was the hobo, an itinerant worker who rode the rails while following the dictates of a lifestyle coherent and established enough to earn its own name—hobohemia—and to have its own newspaper—the *Hobo News*.[1–3] Next came the victims of the Great Depression—residents of squatter towns dubbed Hoovervilles, and migrants, both single men and families, who traveled in the hope that elsewhere they might find the means to earn a living.[4] Following the era of prosperity ushered in by World War II came the skid row alcoholic, an older white male whose ties to family and to the institutions of mainstream society had been overwhelmingly strained, if not completely severed.[5–8]

More recently, however, changes in the composition of the homeless population have made it impossible to reduce homeless individuals easily or accurately to a single type. Although elderly white denizens of the Bowery and skid rows are still present, they have been relegated to minority status by an influx of younger, largely nonwhite individuals.[4,9–10] Alcoholics have been joined by individuals suffering

PAUL KOEGEL AND M. AUDREY BURNAM • Social Policy Department, the RAND Corporation, Santa Monica, California 90407-2138.

from chronic mental illness as well as by individuals with no apparent disability whatever; all of these persons now can be found not only in the inner-city areas in which they traditionally resided but also in the city at large, the suburbs, and even rural areas.[11] What was previously a predominantly male population now includes increasing numbers of women—not only single women but battered wives and women with children.[12–16] Runaways, throwaways, intact families who have lost their sources of livelihood, undocumented workers from Latin America—all contribute to a level of pluralism in the contemporary homeless population that was previously unimaginable.[4]

Even so, one group more than any other—the homeless mentally ill—has captured the attention and interest of the public to such an extent that in spite of the marked diversity characteristic of today's homeless population, a single image—that of the floridly psychotic street person—has eclipsed all others and mistakenly has come to represent the population as a whole. There are many reasons for this conceptualization. The high visibility of the homeless mentally ill is certainly one contributing factor. We are far more likely to notice and remember the disheveled bag lady, dressed in rags, clutching a potpourri of possessions, and muttering to persons unseen, than the indistinguishable individual with no psychiatric impairment who leaves a shelter in the morning and disappears into the general population during the day. Media attention generated by such dramatic incidents as the death of Rebecca Smith in her cardboard box on the streets of New York City during the winter of 1982 also has kept the plight of the homeless mentally ill uppermost in the minds of the public. The widely heralded failure of deinstitutionalization[17–19] likewise has played a prominent role; it provides a simplistic and easily understood, though misleading, explanation of why homelessness is so much on the rise. Deinstitutionalization confirms what people readily assume and seem to want to believe: that a person whose support network is so severely attenuated that it cannot protect him or her from ending up on the street must be seriously disturbed.

As one consequence of this heightened focus on the homeless mentally ill, most of the research on contemporary homelessness has concentrated on, or at least has included, the empirical effort to determine the actual prevalence of mental illness among the homeless. A vast array of studies has provided estimates of the proportion of homeless individuals who might be characterized as mentally ill. As a group, these studies display as much diversity as the homeless population whose characteristics they aim to describe; each has addressed the task of measuring mental illness and has faced the enormous challenge of drawing representative samples of the homeless population in widely different ways and with varying degrees of success. Estimates of mental illness among the homeless have been based on a variety of measures: self-reports of general psychiatric problems and/or history of psychiatric treatment[20–23]; symptom scales, including those that simply identify likely cases of serious psychiatric illness as well as those that specify dimensions of disorder such as psychoticism, anxiety, and depression[11,24–25]; general clinical impressions of severe disorder[26]; clinical examinations resulting in diagnoses based on DSM-III criteria[9,27]; and structured instruments with known validity and reliability that yield diagnoses based on established diagnostic criteria.[28–30] Such measures have been applied to homeless samples drawn exclusively from shelters[9,10,20,24,30]; to nonprobability samples of individuals in either nonshelter settings (soup kitchen lines, congregating areas, the streets) or in a combination of shelter and nonshelter settings[11,21,26]; and to probability samples of both sheltered and unsheltered homeless individuals in entire cities or in particular sections of a city.[25,29]

This methodological diversity and confusion complicates the task of estimating the proportion of homeless individuals nationwide who are mentally ill. From the more recent efforts cited, we know that the proportion of the homeless population suffering from *severe* mental illness (as opposed to any diagnosable disorder) lies somewhere between 20% and 50%. Although hardly a precise estimate, this reported range has increasingly influenced the media and the service community to state that approximately one-third of the individuals who constitute today's homeless population are chronically mentally ill; this figure suggests an extremely serious problem without implying that *all* homeless people are chronically mentally ill. Even so, the rudimentary state of psychiatric epidemiology among homeless individuals is evidenced by the discrepancies between the high and low figures and by the difficulty of determining the combination of factors that might account for these differences: regional variation, the choice of criteria by which to define mental illness, the way in which mental illness is measured, the way in which homelessness is defined, the sector of the homeless population that is sampled, and the manner in which the sample is drawn.

The challenge that faces those who attempt to determine the extent of mental illness among homeless individuals extends even beyond sampling issues and measurement choices. Innovative sampling designs that include shelter and nonshelter populations already have been devised[25,31]; such innovation shows that a greater degree of methodological rigor is possible than has been employed customarily in surveys of homeless populations. Strategies reflecting careful attention to measurement issues have been reported as well.[28] With time and funding, we can hope for a greater number of studies that incorporate high standards in each of these areas. Even then, however, nagging doubts will remain regarding whether we are measuring mental illness accurately among homeless individuals. Such doubts stem from a measurement problem that extends beyond the issue of whether the observer is using a standardized diagnostic instrument with acceptable levels of validity and reliability. These doubts reflect the difficulty of answering the following question: How do we know that the symptoms we observe in an apparently mentally ill homeless individual are caused by mental illness rather than by some combination of factors tied to the individual's homeless condition? In other words, how can we be sure that the behavior we observe in a homeless person suspected of being mentally ill does not reflect environmental or even adaptive factors rather than psychopathological factors that exist independent of the person's homeless condition?

There are several reasons to suspect that diagnostic assessment of homeless individuals may be complicated by factors related to their homelessness. To start, homeless individuals constantly find themselves in conditions known to produce symptoms that mimic mental illness. Chronic malnutrition, sleep deprivation, hypothermia, and many other consequences of extreme privation are known to induce delirium, memory impairment, apathy, dementia, personality disorganization, and even paranoid psychosis.[32–33] Unrelenting stress and demoralization are also known to affect an individual's ability to remain psychologically intact.[25,34–35] In addition, dramatic evidence exists to suggest that being relegated to a nonentity role, one in which people act as if one is not really alive, can affect physical and mental health to the point of being life-threatening.[36–37] When we consider that homeless individuals constantly experience exposure to the elements, interrupted sleep cycles, inadequate diets, chronic uncertainty over whether they will meet their most basic needs, ever-present threats to their personal safety, and the nagging sense that their

misery goes unnoticed by those who pass them,[38] it is hardly surprising that many decompensate.

The paradigmatic example of this situation may be Anne, one of many homeless people whose experience was captured in Baxter and Hopper's ethnographic research on homeless individuals in New York City:

> I met Anne in the bus terminal in the spring of 1980, days after she had begun residing there. She was friendly and articulate, clean, well-groomed and wore a dress, stockings and a green coat, over which she expressed concern over having lost a button. I barely recognized her a few months later. Lice covered her eyebrows and the scratching made her manner appear frantic: her now-whispered voice was barely audible. She was dressed in multiple layers of dark, men's clothing with a hood pulled tightly over her head. She repeated elements of her story which I recalled from our earlier conversations, but this time in a broken and illogical fashion. I remembered how distastefully she had spoken of others who resorted to sleeping directly in view of the public, as she was motioned away from the entrance way by a tenant of the apartment building where she had sat down to rest (p 401).[39]

Had Baxter and Hopper not met Anne in the spring, before homelessness had taken its toll on her, they probably would have concluded, on the basis of her self-presentation, that she suffered from chronic mental illness. Instead it was clear that behavior that appeared to be symptomatic of chronic mental illness might in fact be a reaction to a stressful environment. This distinction may be obscured by many measures of mental illness.[40]

Homelessness, then, inflicts environmental stress on individuals that may *produce* symptoms of mental illness[41]—symptoms that might well disappear if individuals were fed, clothed, sheltered, cared for, and assured that they could count on a more stable future.[42] In addition, homelessness may complicate the psychiatric assessment of homeless individuals in another way. It may be that because we lack an understanding of homeless individuals and the exigencies of their life, we are more liable to misinterpret their behavior and to brand as psychotic or as signs of mental illness behavior that would make complete sense if viewed in the context of their current existence—that, indeed, may be quite adaptive. To cite a popular example, the unsavory appearance and the bizarre behavior of some chronically homeless women may be due less to schizophrenia and to a concomitant obliviousness to hygienic care than to the recognition that offensive body odor and a reputation for being crazy may be one's best protection against the predatory attempts of others, particularly men.[43] Martin,[44] for instance, was told by one of the women she interviewed that she wore layer upon layer of clothing in a way that many might judge as inappropriate because most rapists, in her experience, simply could not tolerate the frustration of fighting their way through so many articles of apparel. In a slightly different vein, Schiller,[45] on the basis of ethnographic research with clients in an outreach program for the homeless mentally ill, noted that behaviors that social workers regarded as bizarre and inappropriate were actually time-worn adaptations to poverty that mirrored practices commonly found among the marginal and working-class poor. Another ethnographic study, conducted on the streets of Austin, also concluded that behaviors that might be interpreted as symptoms of psychiatric disturbance took on very different meanings when viewed in context and over time.[23]

These findings suggest that to assess the psychiatric status of homeless individuals, one must give credence to the possibility that observable symptoms are in fact temporary responses to the various stresses to which homeless individuals are exposed or perhaps even adaptations to aspects of a homeless existence. Unfortu-

nately, this view is rarely adopted. To our knowledge, only one study has built a sensitivity to context into its instrumentation; even there, the correction pertained to level of functioning (i.e., whether a person's poor hygiene was attributed most accurately to psychiatric disorder or to lack of access to appropriate facilities) rather than to actual diagnosis.[28] Instead, most recent research has relied on symptom scales to estimate the prevalence of mental illness—the very measures most likely to obscure the influence of environment and subculture.

Measures that yield diagnoses based on established criteria may be less sensitive to these confounding factors than are symptom scales in that they rely not only on the presence of symptoms but on a particular patterning of those symptoms. In instruments such as the Diagnostic Interview Schedule (DIS)[46] or the Schedule for Affective Disorders and Schizophrenia–Lifetime Version (SADS–L),[47] for instance, the presence of hallucinations or delusions in itself is not sufficient to produce a diagnosis of schizophrenia. Such a diagnosis is not made until it is ascertained that those symptoms resulted from neither alcohol, drugs, nor a physical condition, and that they were accompanied by the other criteria that define schizophrenia (deterioration from a previous level of functioning, duration of at least 6 months, presence of prodromal or residual symptoms). In this sense, diagnostic instruments provide a more refined picture of psychiatric impairment, in contrast to the more undifferentiated view afforded by scales that count symptoms regardless of their etiology and patterning. Even so, diagnostic instruments, like symptom scales, tend to be developed with reference to inpatient populations rather than to people who have experienced a level of privation that clinicians could hardly imagine. Even when diagnostic instruments are employed, environmental influences still may increase the likelihood that a diagnosis will be given and that mental disorder will be overdiagnosed as a result.

Although this issue is periodically raised in the literature on homelessness and mental illness and although the literature now contains descriptive accounts that demonstrate further that attention to context is imperative, little has been done to determine empirically how conditions of homelessness affect psychiatric diagnosis. This situation exists largely because the longitudinal, contextual, multimethod research required to elucidate this kind of problem has not yet taken place. In the absence of these kinds of data, we turn to a cross-sectional database in order to explore the effect of being homeless on the determination of mental illness. We begin by describing a psychiatric epidemiologic survey conducted in the skid row area of Los Angeles, which obtained psychiatric diagnoses of homeless individuals through the DIS. After briefly reviewing some of the relevant results of this survey, we will focus on two disorders—antisocial personality and depression—to determine whether symptoms that, according to DSM-III criteria, should count toward the determination of a particular psychiatric diagnosis might be explained more accurately by homelessness. We also consider whether rates of mental disorder change when diagnostic criteria are revised to be sensitive to this possibility.

A SURVEY OF THE INNER-CITY HOMELESS OF LOS ANGELES

Between July 1984 and March 1985, the Los Angeles County Department of Mental Health, with funding from the National Institute on Mental Health (NIMH), fielded a survey in the skid row area of Los Angeles. This survey was designed and carried out with three goals in mind: (1) to arrive at an empirically based understand-

ing of the characteristics of the inner-city homeless population; (2) to determine the proportion of homeless individuals in this area suffering from specific psychiatric disorders; and (3) to compare homeless individuals suffering from severe and chronic mental illness to the nonmentally ill homeless on a host of demographic, social support, and quality of life measures. During these 9 months, face-to-face interviews lasting from 1½ to 3 hours were conducted with a probability sample of homeless adults. Fully 379 individuals of the 445 who were approached agreed to participate in the survey, yielding an acceptance rate of 85%. Respondents were paid $5 each for their time.

In contrast to previous studies, this project succeeded in (1) drawing a probability sample that represented as nearly as possible the entire inner-city homeless population and (2) assessing the mental health status of those sampled by using a standardized diagnostic instrument with known properties of reliability and validity. Because the worth of a study's findings is directly proportional to the methodological care taken in its design, we review in some detail the sampling design and the measures used in this survey before summarizing the primary demographic and mental health findings that emerged.

Sampling

The objective that guided the development of our sampling plan was to recruit for the survey a sample of approximately 300 homeless persons who could be considered representative of the entire homeless population inhabiting the downtown skid row area. For purposes of sampling, Skid Row was conceived of as consisting of four overlapping sectors of homeless people: (1) people who avail themselves of temporary beds, whether in missions, through Department of Public Social Service vouchers for skid row hotel rooms, or through other programs; (2) people who use free meal services offered by missions and other organizations; (3) people who pass through indoor congregating areas such as day centers, drop-in centers, and chapels, either simply to hang out or to receive basic services; and (4) people who congregate on the streets or in well-known outdoor congregating areas. As we moved from the first of these sectors to the last, it proved increasingly difficult to create a sampling frame—that is, to enumerate the defined population in some way so that each person would have a known probability of being selected into the sample. As a result, our sampling strategy involved first sampling those in beds, then moving on to the meals sector, where we sampled only those who did not have a probability of being caught in our bed net (that is, those who used meals but not beds), and finally proceeding to the congregating areas, where we sampled only those who did not have a probability of being sampled as they used beds or meal services. In this way we extended the representativeness of our sample, ensuring that it would include proportional numbers of those who did not use beds and/or meals. At the same time we allocated the maximum possible number of interviews to the beds sector, where there was the greatest possibility of methodological rigor (that is, catching people who used beds while they were in beds rather than in either of the other sectors).

The number of interviews allocated to each of the sectors was based on the results of a sampling survey designed to reveal the relative proportions of people in each of these sectors—(1) the proportion of people found in congregating areas who use neither meal nor bed services and (2) the proportion of people who use meal services but do not avail themselves of beds. Likewise we allocated interviews to

facilities and locations *within* each sector on the basis of results from similar surveys designed to reveal (1) the number of different people who use each facility within a 30-day period and (2) the overlap between facilities—in other words, the extent to which people use more than one facility. The number of interviews allocated to each facility, then, was proportional to the number of *different* people it served in the total homeless population in Skid Row.

We did not allocate interviews to the outdoor sector because it was extremely difficult to create a sampling frame in areas characterized by no real boundaries and by an inordinate amount of population movement. Instead we conducted a short survey with approximately 350 individuals in a wide range of outdoor areas, asking them questions that allowed us to determine whether they were homeless and whether they would or would not have a probability of being included in the sampling frame generated by bed–meal–indoor congregating areas. Fully 86% of those surveyed revealed that they had passed through our sampling frame in a 30-day period; this figure was large enough to support our confidence in the representativeness of our sample.

In the end, the sample was drawn from the universe of Skid Row bed, meal, and congregating facilities (with the exception of three that declined to cooperate): We drew from a total of 7 different locations in which people find beds, 11 different meal settings at 5 facilities where people are served meals, and 7 different indoor congregating areas. Selection of respondents at each of the locations was random; we used a random numbers table wherever possible and employed systematic sampling in all other places.[31]

Measures

We obtained diagnoses through the use of the DIS.[46] This highly structured instrument allows trained lay interviewers to collect data that, when analyzed with a computerized scoring algorithm, produce current and lifetime diagnoses based on the diagnostic criteria of the American Psychiatric Association (DSM-III). Also included was the Center for Epidemiologic Studies Depression Scale (CES-D).[48] This 20-item measure of current depression-related symptoms has been used successfully as a measure of generalized psychological distress or demoralization.[49–50] Additional nondiagnostic questions assessed demographic characteristics, subsistence patterns, health, use of medical services, use of mental health services, employment, public support, social network, homelessness history, victimization, and wandering and mobility. A subset of these questions was adapted from instrumentation designed for the Los Angeles Epidemiologic Catchment Area (LAECA) study,[51] one of five NIMH-funded research sites in which the prevalence of mental disorder in U.S. communities was determined through the DIS. Most of the nondiagnostic questions, however, were developed specifically for this study.

Demographic and Mental Health Results

Individuals in this sample were overwhelmingly male, somewhat younger than the county population as a whole, and disproportionately nonwhite. Only 4% of this sample consisted of women, though women may have been underrepresented because we had been denied access to the only Skid Row facility serving women exclusively. Mean age in this sample was 38; median age was 35. Moreover, approximately two-thirds of these homeless individuals (65.5%) were below the age of 40.

Almost three-quarters were minority group members: 38.6% were black; 24.9% were Hispanic; 5.1% were American Indians. Only 27.1% were white. The majority had never been married (59.1%); in virtually all cases those who had been married were either separated or divorced at the time of the interview. As a group, they were less well educated than the general county population, though more than one-half had at least a high-school education.[52]

As for the prevalence of mental illness, rates of mental disorder among this inner-city homeless sample, whether based on lifetime or on current definitions (i.e., present within the last 6 months), were quite high, though not as high as in previously published reports based on clinical interviews.[9,27] Indeed, when this sample was compared to a community sample in Los Angeles for whom DIS diagnoses were available,[53] prevalence of disorder was substantially higher in the homeless sample with regard to each of the disorders measured. This finding was true particularly with regard to the disorders most likely to produce chronic and severe mental illness—schizophrenia and bipolar disorder. For instance, lifetime prevalence of schizophrenic disorders in the homeless sample was 13.7 per 100 persons, almost 28 times higher than the comparable figure for the LAECA sample. (The LAECA prevalence rates were adjusted to the age, sex, and race distribution of the homeless sample.) The lifetime prevalence of bipolar disorder was 10.6 per 100 persons in the homeless sample, almost 18 times higher than the prevalence of bipolar disorder in the household sample. Lifetime prevalence of antisocial personality and substance use disorders were quite high in the homeless sample; these disorders tended to be relatively high in the household sample as well. Lifetime prevalence of substance use disorder, for instance, was 69.2 per 100 persons in the homeless sample but 30.9 in the household sample; thus a homeless individual was twice as likely as a household respondent to be a substance abuser.

Current prevalence, defined as present within the last 6 months, was much lower for all diagnoses except schizophrenia. For the most part, however, the relationships between the homeless and the nonhomeless samples remained the same: Again, prevalence rates in the homeless sample were most disproportionately high in the area of major mental illness. An individual in the homeless sample, for instance, was 38 times more likely to have experienced a manic episode within the last 6 months and almost five times as likely to have experienced a major depressive episode.

Because each prevalence rate is based on the number of people who met criteria for a disorder, whether or not they met criteria for any other disorder, the prevalence rates produced by the DIS are not additive. In other words, one cannot simply add together the prevalence rates of certain categories in order to arrive at summary statistics, such as the percentage of those with severe and chronic mental illness. To estimate this percentage, we developed an operational definition of chronic mental illness based on the DIS data.[53] On the basis of this definition, 28% of the homeless sample met criteria for severe and chronic mental illness. This figure rises by 5% if one adds to this group individuals whose behavior and answers to non-DIS questions (such as past hospitalization, receipt of SSI, past neuroleptic medication, a diagnosis of schizophrenia by a psychiatrist at some time in the past) indicated probable chronic mental illness, even though they had not received a DIS diagnosis of major mental illness. However, it may be diminished by an unknown number of false positives.

In keeping with these findings on specific disorders, the great majority of our homeless respondents currently were experiencing depressive symptoms indicative of psychological distress, as measured by the CES-D. Approximately 71% of these

homeless individuals (as compared to 9.4% of the LAECA males) scored 16 or above on the CES-D, the cutoff commonly employed to establish significant psychiatric impairment. Thus psychological distress and demoralization among this sample were high. Moreover, the elevated level of distress among the homeless individuals was not simply a function of elevated rates of current psychiatric disorders. Almost one-third (32.9%) of the individuals meeting criteria for current psychological distress had no current DIS/DSM-III diagnosis. (For additional information on the results of this study, see prior reports.[29,52–56])

HOMELESSNESS AND THE ASSESSMENT OF ANTISOCIAL PERSONALITY DISORDER

In the review of prevalence findings from the Los Angeles Skid Row study, we emphasized the major mental illnesses, not only because prevalence rates were most disproportionately high in that area but also because these psychiatric disorders are most closely associated with chronic mental illness; as a result, they have received most of the attention directed at homelessness and mental illness. Several studies, however, also focus on many other disorders, including personality disorders, either in the interest of obtaining an estimate of the extent of *any* diagnosable DSM-III disorder in the homeless population or because of a recognition that these disorders can also be functionally disabling, inhibiting many individuals' ability to form relationships and hold jobs.[9,30,57–58]

Of the many personality and characterological disorders described in DSM-III, the DIS provides a measure of only one: antisocial personality. The absence of other personality disorder measures in the DIS reflects the exceptional difficulty involved in constructing objective measures of personality disorder. Unlike disorders such as schizophrenia and major depression, which are characterized by discrete and relatively easily recognized symptoms clustering in distinctive ways, personality disorders reflect the presence of personality traits—traits that many people possess at least to some degree—that have become "inflexible" and "maladaptive" and that "cause either significant impairment in social or occupational functioning or subjective distress" (p 305).[59] Although some individuals certainly are extremely disabled by maladaptive personality characteristics, it is difficult to identify an individual's personality traits and to determine when they have become sufficiently maladaptive to warrant being termed *pathological.* Not surprisingly, the decision-making process that leads to a diagnosis of personality disorder is not, in most cases, easily broken down into objective components; more often it is based on clinical acumen. Accordingly, personality disorders do not lend themselves readily to being measured through research instruments, which must be characterized by an acceptable level of reliability.

Antisocial personality, however, is one personality disorder in which the symptoms *are* objective behaviors that lend themselves readily to measurement. Individuals diagnosed as having this disorder are characterized by a history of antisocial behavior that begins in childhood and extends through adulthood. The essence of this behavior is the persistent disregard for the rights of others. Its consequences and/or manifestations include problems in vocational functioning, difficulties in adequately fulfilling the role of spouse or parent, aggressiveness, and unlawfulness.

In spite of the seemingly objective nature of the symptoms that constitute antisocial personality disorder, there is much to suggest that the definition of anti-

social personality betrays an insensitivity to cultural and subcultural factors. It is not our intention here to enter the debate over whether the behaviors constituting antisocial personality disorder belong rightfully in the realm of psychiatry. Yet even if one accepts the validity if antisocial personality as a psychiatric construct, it is still clear that the diagnosis of antisocial personality imputes a pathological quality to many inescapable consequences of a homeless existence.

Consider, for example, the question of vocational functioning. Many individuals become homeless when they lose a job, are unable to find a new job, and ultimately lose their residence. Finding themselves homeless, they by necessity focus their energies on survival—on finding a place to sleep and obtaining enough to eat. These tasks often become full-time endeavors in and of themselves, leaving homeless individuals little time to do anything else. Showing up for a job interview on time, for instance, may mean foregoing the opportunity of securing a bed for the night. Moreover, as time goes by, homeless persons may find themselves increasingly less well equipped to present themselves in a marketable light. They may no longer have clothes that are suitable for an interview; they may not have the opportunity to shower before applying for a job; they face the necessity of accounting for a longer and longer period of unemployment. Day labor jobs soon may become the only work they are able to secure. Thus it becomes clear how homelessness, even aside from its possible effects on an individual's self-esteem, can become a trap, preventing individuals who are anxious to work from obtaining stable employment.

The question goes beyond vocational functioning, however. Although living in Skid Row affords homeless individuals the best chances of meeting their subsistence needs (in view of the concentration of missions and other facilities that provide such services), it also exacts a price: the willingness to confront constant danger. Danger lies in many directions, including the authorities. The police, for instance, may arrest homeless individuals for as minor an infraction as jaywalking. Such an arrest may culminate in a short jail term if the individual cannot afford to pay the requisite fine. Far more life-threatening, however, is the danger from those who would victimize homeless persons for whatever little they have or from the random violence that periodically erupts in Skid Row. To protect themselves, homeless individuals may take to carrying weapons. In light of these dangers, as well as the lack of both stable employment and stable residence, it is hardly surprising that many homeless individuals move on, searching for better opportunities and better living conditions in other locales.

All of these realities of homelessness—lacking a regular place to live, being unemployed for protracted periods, having many jobs in a short period, moving around without making arrangements in advance, having a history of frequent arrests, carrying a weapon—are symptoms that count toward a diagnosis of antisocial personality based on DSM-III criteria (though a history of antisocial behavior throughout one's childhood must also be present for such a diagnosis to be made). Thus it seems possible that homeless individuals risk being labeled antisocial precisely because they are homeless.

Although this conjectural argument provides persuasive justification for removing these symptoms from those indicative of antisocial personality disorder among homeless individuals, an even more compelling approach would be to determine *empirically* whether these symptoms are, in fact, explained more accurately by homelessness than by antisocial personality disorder. If this is the case, the next step would be to determine how removing them from the diagnostic criteria changes the prevalence of antisocial personality disorder in this sample.

Because two of these symptoms were not actually used in the DIS scoring algorithm that generated DIS/DSM-III diagnoses of antisocial personality among the homeless respondents in our sample, we performed analyses with reference to only four of the six symptoms. One of the symptom questions—moving around without having made arrangements—had already been deleted from the version of the DIS used by the LAECA study in recognition of its pervasiveness in the community at large, especially among college students and young adults. Thus it was not included in the homeless instrument either. Another question—carrying a weapon—was included in both the homeless and the LAECA instruments. Yet careful review of the DIS scoring algorithm used to generate DIS/DSM-III diagnoses in the LAECA and the homeless samples showed that this symptom was not included in the symptom counts that led to a diagnosis of antisocial personality.

In addressing the question of whether these symptoms are valid indicators of antisocial personality among the homeless, we first examined the percentage of positive replies to each of the adult antisocial personality symptoms. These percentages, which are presented in Table I, show that the four symptoms in question are precisely the four symptoms with the highest frequency. More than half of these homeless inner-city adults had been arrested more than once. Almost two-thirds had experience a 5-year period during which they had held three or more different jobs. More than four-fifths had been without work for 6 months or more; a comparable number reported having no regular place to live for a month or longer. Clearly, then, these four symptoms represent behaviors that are highly prevalent in a homeless sample—certainly higher that the other behaviors that contribute to a diagnosis of antisocial personality disorder.

The fact that these symptoms were so highly prevalent in the homeless sample is suggestive, but not conclusive, evidence that they are viewed most accurately as consequences of homelessness rather than of antisocial personality disorder. To further determine whether these symptoms were best explained by homelessness, we performed analyses to learn whether any of these items were correlated with the

Table I. Percentage of Positive Replies among Homeless Persons to Adult Antisocial Personality Symptoms (N = 322)

Left children under the age of 6 home alone	2.7
Accused by professional of child neglect	3.8
Spanked child hard enough to leave bruises or require medical attention	4.3
Neighbor had to care for child due to neglect	5.5
Ran out of money for food for family because spent the money on him/herself	15.8
Hit or threw things at spouse or partner more than once	16.0
Used an alias or assumed name	20.6
Lied often as an adult	22.8
At least four traffic tickets for moving violations	25.6
Convicted of a felony	30.7
Got into trouble driving while drinking	32.2
Quit a job three or more times without having another lined up	34.7
Walked out on either spouse or partner	34.9
In more than one physical fight since age 18	48.9
Late or absent on job average of 3 days/month or more	52.2
Arrested more than once	53.4
Three or more different jobs in 5-year period since age 18	65.7
Six months or more without work not caused by physical illness, school, or housewife role	81.7
No regular place to live for a month or more	82.2

presence of childhood conduct disorder. According to DSM-III criteria, this disorder is a necessary prelude to true adult antisocial personality. Our assumption was that those items that were better explained by homelessness than by antisocial personality would *not* be correlated with childhood conduct disorder. On the other hand, those that were best seen as reflecting antisocial personality disorder *would* be associated with childhood conduct disorder.

As Table II reveals, two of the identified symptoms—having spent 6 or more months without work within the last 5 years and not having a regular place to live for a month or more—showed no relationship at all with childhood conduct disorder. Of the remaining symptoms for which no significant correlation was found, five were symptoms of child abuse or neglect. The fact that we found no significant correlation between these symptoms and childhood conduct disorder is a result of the very small numbers of individuals who reported such symptoms, as shown in Table I. The remaining two symptoms that were not significantly related to childhood conduct disorder were symptoms pertaining to driving infractions. In the case of getting into trouble for driving while drinking, the lack of significant correlation is probably a function of high lifetime prevalence of alcohol abuse or dependence in this sample.[55–56] It is difficult to explain why having received at least four traffic tickets for moving violations did not correlate with childhood conduct disorder, but there is no reason to suspect that this symptom is related to homelessness. It may well be that it does not correlate with childhood conduct disorder in the nonhomeless population either, in view of the common occurrence of such infractions. This finding would suggest that this symptom should be considered a poor indicator of antisocial personality in general.

A third symptom—having three or more jobs in the last 5 years—showed only a weak relationship with childhood conduct disorder. Indeed, of all the adult antisocial symptoms that correlated significantly with childhood conduct disorder, this symptom showed the weakest correlation. We concluded that these three symptoms (not having a regular place to live, not working for 6 months or more, having three or more jobs in the last 5 years) are to be regarded more accurately as manifestations of homelessness than of antisocial personality disorder. The fourth item—being arrested more than once for infractions other than traffic violations—*was* significantly related to childhood conduct disorder (Pearson correlation coefficient = .24, p = .0001). On the basis of the logic of this analysis, we concluded that this symptom should count toward the determination of antisocial personality diagnosis.

What happens when the three symptoms identified as highly problematic to the diagnosis of antisocial personality among homeless adults are removed from the scoring algorithm that produces the DIS/DSM-III diagnosis of antisocial personality disorder? Table III presents lifetime and current (defined as present within the last 6 months) prevalence rates for antisocial personality disorder in this sample of homeless individuals, based first on the scoring algorithm that includes the three problematic symptoms and then on the scoring algorithm that deletes these three symptoms. As Table III shows, the lifetime prevalence of antisocial personality drops by almost 10 percentage points when criteria for the diagnosis are modified to be sensitive to the distinctive situations in which homeless individuals find themselves. Likewise, the current prevalence of antisocial personality drops by almost 8 percentage points, from 25% to 17%. Here, then, is clear evidence showing how sensitivity to the way in which homelessness affects behavior can lead to a deflation in the estimated prevalence of a particular disorder.

Table II. Correlation of Adult Antisocial Personality Symptoms with Childhood Conduct Disorder

Absence of significant correlation	Significant correlation[a]	Correlation coefficient[b]
Got into trouble driving while drinking	Three or more jobs in 5-year period	.17
At least four traffic tickets for moving violations	Quit at least three jobs without next job lined up	.18
Hit child hard enough to leave bruise or require medical attention	Hit or threw things at spouse or partner	.20
	Late or absent on job average of 3 days/month	.20
Left children under age 6 at home alone	Walked out on spouse or partner	.22
Accused by professional of child neglect	Arrested more than once	.24
Neighbor had to care for child due to neglect	Used alias or assumed name	.26
Squandered family's food money on self	Lied often as adult	.30
Six months or more without work	More than one physical fight since age 18	.30
No regular place to live for month or more	Convicted of felony	.33

[a]All correlations significant at $p < .001$.
[b]Pearson product-moment correlation.

Table III. Prevalence of Antisocial Personality Disorder in a Sample of Homeless Adults (N = 322)

	Without modification	With modification
Lifetime prevalence	31.4	20.8
Present in last 6 months	25.2	17.4

HOMELESSNESS AND THE ASSESSMENT OF MAJOR DEPRESSIVE EPISODES

After substance use disorders and antisocial personality, the single most prevalent disorder found in this sample of homeless adults was major depressive episode. The essential feature of major depressive episode is "either a dysphoric mood, usually depression, or loss of interest or pleasure in all or almost all usual activities," accompanied by other symptoms such as "appetite disturbance, change in weight, sleep disturbance, psychomotor agitation or retardation, decreased energy, feelings of worthlessness or guilt, difficulty concentrating or thinking, and thoughts of death or suicide or suicidal attempts" (p 210).[59] Major depressive episodes are characteristic of individuals with two of the major affective disorders: (1) bipolar disorder, a disorder that includes individuals who have experienced a manic episode; and (2) major depression, a disorder in which individuals experience major depressive episodes without experiencing manic episodes. According to DSM-III, a diagnosis of depressive episode can be made only if an individual has experienced a prominent and relatively persistent dysphoric mood *and* symptoms that have been present nearly every day for at least 2 weeks in at least four of the eight symptoms groups mentioned above.

As with antisocial personality disorder, several of the symptoms that count toward a diagnosis of major depressive episode would appear to be inextricably tied to the homeless condition. Losing weight without trying to do so, for instance—as much as 2 pounds a week for several weeks, or as much as 10 pounds altogether—is one of the symptoms constituting the appetite group in the DIS. The presence of such a symptom implies that a sufficient amount of food is readily available to an individual. This assumption is not justified in the case of homeless individuals, who often face the difficult challenge of feeding themselves on very limited resources. No stretch of the imagination is needed to imagine that a homeless person, especially upon becoming homeless, might lose weight persistently without attempting to do so. Although the DIS excludes positive symptoms that can be attributed to physical causes, it is also easy to imagine that homeless individuals who have lost weight because of their inability to obtain enough food might not respond positively when asked the relevant DIS probing question: "Was your loss of weight ever a result of physical illness or injury?"

Having trouble falling asleep or staying asleep, or waking up too early, a symptom that appears in the sleep disturbance group, is another of the depressive symptoms that might be problematic in the case of homeless individuals. Because of the settings in which they sleep, an uninterrupted night's repose is a rarity for homeless people. In shelters, dormitory sleeping arrangements leave one vulnerable to the nighttime sounds of scores of other people, many of whom are in poor physical and mental health and thus are prone to noisy outbursts. Moreover, the ever-present threat of danger and theft in many such settings—so acute that many individuals in

the New York City shelters place the legs of their beds into their shoes in order to ensure that they will not wake to find the shoes gone—affords an adaptive advantage to those who sleep lightly. For those on the streets or in public waiting areas, the possibility of a quiet night's sleep is reduced and the likelihood of having trouble falling or remaining asleep is increased by demands by the police to move on, by the rain and cold, and by vulnerability to victimization. Thus it makes sense that homeless individuals might disproportionately report yet a third depressive symptom—feeling tired out. The fact that food is problematic and that one might spend most of one's day on one's feet, lugging one's possessions, only makes this possibility more likely.

Two final depressive symptoms may be consequences of homelessness more often than of depression. Exacerbated difficulty in concentrating for 2 weeks or more can be readily hypothesized as a function of the frenetic public environments in which homeless people typically find themselves and of their diminished access to the kinds of settings—settings characterized by quiet and privacy—that are conducive to clear thinking. Similarly, a diminished interest in sex might have less to do with depression than with the power of the stronger, more basic needs that homeless individuals typically face, namely food and shelter.

Although there is *a priori* evidence for removing these five symptoms from the pool of symptoms that count toward a diagnosis of major depressive episodes, empirically derived evidence, as in the case of antisocial personality disorder, would provide a sounder rationale for doing so. In the case of major depressive episode, there is unfortunately no touchstone (similar to childhood conduct disorder for antisocial personality disorder symptoms) by which to measure the psychiatric relevance of the identified symptoms. A comparable database exists, however, for nonhomeless adults in the general community—the LAECA database. We turned to this database to evaluate whether the five symptoms noted were seen more accurately as consequences of the homeless condition than of major depression, and, by extension, whether they should be removed from the DIS scoring algorithm.*

To pursue these questions, we merged data on the LAECA males with the dataset on the homeless. (We used only males because the homeless sample was overwhelmingly male and because the presence of depressive symptoms varies significantly by gender.) We performed a two-way analysis of variance with depressive symptoms as the dependent variable and with sample (homeless or household) and depression (present or absent) as the independent variables. As in the DIS scoring algorithm, we scored depressive symptoms as present only if they were coded as psychiatrically relevant; thus we eliminated all instances in which symptoms did not meet DIS severity criteria or in which the presence of the symptom could be explained by physical illness or injury or by alcohol, drugs, or medication. The statistical significance of differences between group means was determined

*The Epidemiologic Catchment Area (ECA) is a series of five epidemiologic research studies performed by independent research teams in collaboration with staff of the Division of Biometry and Epidemiology (DBE) of the National Institute of Mental Health (NIMH). The NIMH principal collaborators are Darrel A. Regier, Ben Z. Locke, and Jack D. Burke, Jr.; the NIMH project officer is William J. Huber. The principal investigators and co-investigators from the five sites are Yale University, U01 MH 34224—Jerome K. Myers, Myrna M. Weissman, and Gary L. Tischler; The Johns Hopkins University, U01 MH 33870—Morton Kramer and Sam Shapiro; Washington University, St. Louis, U01 MH 33883—Lee N. Robins and John E. Helzer; Duke University, U01 MH 35386—Dan Blazer and Linda George; University of California, Los Angeles, U01 MH 35865—Marvin Karno, Richard L. Hough, Javier I. Escobar, M. Audrey Burnam, and Dianne M. Timbers.

through the Duncan multiple range test; significance level was set at .05. Results of this analysis are presented in Table IV.

The data in Table IV allow us to approach the issue of homelessness and depressive symptoms in two ways. First, it is possible to compare the extent to which depressive symptoms are disproportionately present among homeless nondepressives as compared to household nondepressives. If individuals are more likely to experience the five symptoms enumerated as a result of being homeless, we would expect these symptoms to be disproportionately present among nondepressed homeless respondents in contrast to nondepressed household respondents.

As the "nondepressed" column in Table IV reveals, nondepressed homeless individuals were significantly more likely than household individuals to have reported *each* of the 18 symptoms that contribute to a diagnosis of major depressive episode, a general indication that a higher degree of psychiatric disorder and distress is present in this population. The issue, then, becomes not whether differences exist between individuals from the two samples for the five identified symptoms as opposed to the remaining symptoms but whether the magnitude of the differences is greatest in the case of the five symptoms identified as potentially problematic. In order to rank the magnitude of these differences, we calculated a risk ratio for each of the symptoms by dividing the proportion of nondepressed homeless individuals who experienced a given symptom by the proportion of nondepressed household respondents who experienced this symptom. The ratio simply shows the degree to which nondepressed homeless individuals were more likely than nondepressed household individuals to have reported the symptom.

Table V presents risk ratios for each of the 18 symptoms, listed in order from

Table IV. Proportion of Positive Replies to Depressive Symptom Questions in Homeless Adults and Household Males, by Depression

	Nondepressed		Depressed	
Symptom	Homeless	Household	Homeless	Household
Dysphoric	.51	.24[d]	.96	.93
Dysthymic	.23	.03[d]	.37	.48
Lost appetite	.13	.04[d]	.52	.35
Lost weight[e,f]	.15	.04[d]	.48	.36
Gained weight[f]	.17	.09[c]	.33	.28
Trouble sleeping[e]	.21	.13[b]	.64	.70
Excess sleeping	.17	.07[d]	.44	.44
Tired out[e]	.17	.07[d]	.68	.65
Talked slowly	.10	.02[d]	.46	.28[a]
Excess movement[f]	.18	.02[d]	.55	.36[a]
Less interest in sex[e,f]	.08	.03[b]	.43	.37
Feelings of worthlessness	.34	.08[d]	.89	.78
Trouble concentrating[e]	.20	.07[d]	.69	.68
Thinking slower	.17	.03[d]	.49	.51
Thoughts of death[f]	.35	.18[d]	.76	.63
Wanted to die	.17	.04[d]	.65	.43[a]
Suicidal thoughts[f]	.29	.09[d]	.76	.58[a]
Suicide attempt	.17	.02[d]	.37	.17[b]

[a] $p < .05$.
[b] $p < .01$.
[c] $p < .001$.
[d] $p < .0001$.
[e] Hypothesized as problematic.
[f] No significant interaction effect.

Table V. The Added Risk of Experiencing Depressive Symptoms among Homeless Nondepressed Individuals (N = 328) as Compared to Household Nondepressed Individuals (N = 1,466)

Symptom	Risk ratio
Trouble falling asleep, staying asleep, or waking up too early[a]	1.6
Eating increased, leading to weight gain of 2 pounds per week for several weeks	1.9
Thought a lot about death, either own, others', or in general	1.9
Two weeks or more during which felt depressed, sad, blue, or lost interest and pleasure in things (dysphoric)	2.1
Felt tired out all the time for 2 weeks[a]	2.4
Slept too much for at least 2 weeks	2.4
Interest in sex a lot less than usual for several weeks[a]	2.7
Trouble concentrating for at least 2 weeks[a]	2.9
Thought of committing suicide	3.2
Lost appetite for at least 2 weeks	3.3
Lost weight (2 pounds a week for several weeks) without trying[a]	3.8
Felt worthless, sinful, or guilty for 2 weeks	4.3
Wanted to die	4.3
Walked or moved more slowly than normal for at least 2 weeks	5.0
Thoughts came slower or seemed mixed up for at least 2 weeks	5.7
Two years or more during which felt depressed or sad almost all the time (dysthymic)	7.7
Attempted suicide	8.5
Had to be moving all the time for at least 2 weeks	9.0

[a]Hypothesized as problematic.

lowest to highest. Contrary to what we had hypothesized, the five symptoms identified as problematic were not clustered at the upper end. Indeed, if anything, the opposite was true. Four of the five symptoms (trouble with sleeping, feeling tired out, diminished interest in sex, and trouble concentrating) clustered at the lower end of the range, ranking first, fifth, seventh, and eighth. The last of the five symptoms—losing weight without trying—ranked eleventh. Thus in spite of a general tendency for all depressive symptoms to be elevated among homeless respondents, it was not the case that the symptoms identified as potentially problematic were most disproportionately high, as we would have expected if homelessness were exerting an especially strong effect on those symptoms.

Even more important than the risk ratios are the actual results of the analysis of variance. As shown in Table IV, the main effects of both homelessness and depression were highly significant in the case of each symptom, a sign that homeless individuals were more likely to experience *each* of the depressive symptoms than household respondents and that depressed individuals were more likely to experience each of the symptoms than nondepressed individuals. For all but 6 of the 18 symptoms, however, there was a significant interaction effect. Among these 12 symptoms, the data reveal that although nondepressed homeless individuals were more likely to experience a given symptom than nondepressed household respondents, these differences disappear when depressed homeless individuals are compared to depressed household residents.

In the case of each of these symptoms, then, which include three of the five symptoms with which we are concerned (trouble sleeping, feeling tired out, and having trouble concentrating), the depressed homeless respondents were no more likely than household respondents to have experienced the symptom. This finding suggests that at least for these 12 symptoms, the DIS is performing its task ade-

quately: It distinguishes between homeless individuals who may be experiencing these symptoms for any number of reasons from those who are experiencing symptoms as part of a pattern that warrants a diagnosis of depression. In other words, it does not overdiagnose depression on the basis of symptoms that were hypothesized to be part of the homeless condition.

Significant differences between depressed homeless respondents and depressed household respondents *were* apparent in the case of three symptoms for which significant interaction effects were found: talking or moving more slowly than usual, wanting to die, and attempting suicide. None of these symptoms was identified on conceptual grounds as symptoms that would be explained more accurately by homelessness than by depression. These differences probably reflect the fact that depression is more serious in depressed homeless individuals than in depressed nonhomeless individuals, rather than showing the advisability of removing these symptoms from the DIS scoring algorithm for homeless individuals.

The presence of six symptoms for which there were no significant interaction effects but in which there was a significant main effect for homelessness suggests that for these symptoms, homelessness may play a confounding role in the diagnosis of depression. In four out of these six symptoms, however (lost weight, gained weight, less interest in sex, and thoughts of death), differences in the proportion of depressed homeless individuals and of depressed household respondents who experienced the symptom were not statistically significant. Both of the remaining identified symptoms (lost weight and less interest in sex) fell within this group. Significant differences were found only for excessive movement (i.e., having to move around all the time) and for thoughts of suicide; again, these differences may stem from a higher degree of severity among homeless depressives and/or from a higher degree of comorbidity of depression and other disorders in the homeless sample.

In the case of depressive episodes, then, we found no evidence to warrant deleting the five symptoms identified as potentially problematic from the DIS scoring algorithm for depression. Although depressive symptomatology was generally more elevated among homeless individuals than among household respondents, the differences were not disproportionately greater for the five identified symptoms in relation to other depressive symptoms; we would have expected such a finding if these symptom questions had been answered with the consequences of the homeless experience in mind. Nor was there evidence to suggest that depressed homeless individuals were more likely than depressed household residents to experience these symptoms; again, we would have expected such a result if confounding aspects of homelessness had been implicated in the high proportion of individuals who met criteria for a diagnosis of major depressive episode. In this instance the DIS appears to be measuring what it was designed to measure.

On the basis of these analyses, we suggest that the DIS assessment of major depressive disorder did not result in inflated prevalence estimates due to the misinterpretation of behavior that is part of the homeless condition. This is not to say, however, that homelessness is not implicated in the very large number of individuals who, by DSM-III criteria, had experienced an episode of major depression. Indeed, there is evidence to suggest that homelessness may well play a role in catalyzing episodes of major depression. Table VI presents data on the sequence of the reported ages of onset for the first episode of major depression and first episode of homelessness. These data allow us to address the question of which occurred first and, by extension, which may have exerted a causal influence on the other. Although in most

Table VI. Sequence of First Depressive Episode and First Episode of Homelessness among Homeless Individuals with a Diagnosis of Major Depression (N = 58)

Percentage depression preceded homelessness	70.7
Percentage depression preceded homelessness by at least 5 years	40.0

cases (70.7%), depression preceded homelessness, in a significant minority of cases (29.3%) homeless individuals did not experience an episode of major depression until *after* they first became homeless. Moreover, if we heed evidence that homelessness may be preceded by a rather lengthy downward spiral[25] and if we note the percentage of individuals whose depression preceded homelessness by at least 5 years, it becomes clear that fully 60% of the homeless adults in this sample who had experienced a major depressive episode at some point in their life had done so either after they first became homeless or within the 5 years preceding their first episode of homelessness. Homelessness may not be implicated in the diagnosis of depression in the sense that our misinterpretation of homeless adults' behavior leads us to overdiagnose depression. Yet it is probably the case that the stress and the demoralization associated with homelessness precipitate some of the episodes of major depression experienced by the homeless individuals in this study.

CONCLUSION

Among those who lead secure lives in which the guarantee of adequate shelter and sufficient food has never been threatened, it taxes the imagination to understand how the moorings that tie individuals to the conventionalities of life—job, shelter, backup resources—can fray to such an extent that certain persons have no choice but to drift on the streets. Homelessness is so far from most people's experience that they can explain it only by the notion that homeless people must be terribly different from ordinary people—indeed, that they must be mentally ill. The fact that psychotic people are so highly visible on our urban streets does nothing to dispel this notion. Nor does a literature that has been dominated by those who primarily subscribe to a medical/psychiatric perspective.[23] A growing body of empirical evidence, however, suggests that the chronically mentally ill are only one of many subpopulations that constitute the homeless population as a whole and that they are almost certainly a minority subpopulation among the homeless. We say "almost certainly" because there is also increasing evidence, including the data presented in this chapter, that suggests that we have much to learn about the psychiatric assessment of homeless adults before we can speak with any kind of precision about the degree of mental illness in this population.

Our findings support the view that in the case of certain diagnoses, mental disorder may be overdiagnosed because methods of ascertainment are insensitive to the fact that symptoms associated with pathology in general populations may also be inadvertent consequences of the homeless condition. The prevalence of antisocial personality disorder among homeless residents of Los Angeles's Skid Row, for instance, dropped by 10 percentage points when diagnostic procedures were modified to incorporate this recognition. These data make it clear that the behavior of homeless individuals cannot be evaluated outside the context in which it takes place. Even

the most stereotypically schizophrenic behavior may take on new light if viewed from the perspective that incorporates the realities of a homeless existence. For instance, notions that appear to be delusions about being followed, watched, or plotted against may be accurate perceptions of reality in some of the neighborhoods in which homeless individuals congregate. Indeed, more than 25% of the individuals *without* a diagnosis of schizophrenia in the Skid Row study volunteered a belief that they were being watched that was not counted as psychiatrically relevant because it was deemed plausible by the interviewer. In almost as many cases, the belief that the person was being followed or plotted against was dismissed for the same reason.

Studies that rely on gross measures of psychotic symptoms as evidence of chronic mental illness may not distinguish such cases from those that truly reflect psychosis. Further, neither diagnostic instruments nor symptom scales allow the evaluation of the numerous alternative explanations, whether biomedical or cultural, that potentially produce hallucinations and delusions. Until there is evidence to the contrary, the possibility remains that mental illness is being overdiagnosed among homeless individuals because context and a host of competing etiological explanations are not receiving the attention they deserve.

This issue is even more difficult because we may be led astray by intuitively reasonable modifications of diagnostic criteria, rather than empirically derived modifications, to increase the utility of such criteria in a homeless population. In spite of much careful reasoning that led us to earmark certain depression symptoms as problematic, analyses revealed that the high level of depression found in this sample of homeless adults could not be explained by the presence of those symptoms. This finding suggests the importance of carefully attending to these issues diagnosis by diagnosis and of resolving these problems empirically rather than simply on the basis of what might seem to be. More research on these issues is needed, especially research that follows individuals over time and yields data capable of evaluating the subcultural influences on behavior, the cumulative impact of conditions (such as malnutrition and sleep deprivation) of which individual respondents themselves may not be aware, and the way in which symptoms change over time.

Although the data on depression may not have produced evidence for the distorting influence of conditions of homelessness on the assessment of this psychiatric disorder, it did produce evidence to suggest that the social selection perspective that dominates the literature on homelessness and mental illness[41]—that is, the notion that mental illness causes homelessness—may not always be warranted. In a significant number of cases, individuals did not experience depression until after they became homeless; in most cases they did not experience depression 5 years before first becoming homeless. In other words, the demoralizing and stressful experience that a homeless existence involves may manifest itself in high rates of reactive depression. These data, then, highlight the fact that homelessness may not always be the result of increased vulnerability due to a preexisting psychiatric problem. Rather, homelessness itself can catalyze and/or exacerbate mental illness, producing disorder where previously it did not exist.[55]

In spite of all it can tell us, research on homelessness that relies exclusively on a psychiatric perspective can be limiting if it blinds us to alternative explanations as to why people are where they are and why they behave as they do. Far more work—work that incorporates many contrasting perspectives—must be done before we can distinguish the manifestations and effects of disorder from those of environment and

culture among homeless individuals. Such work is critical, however, if we are to understand and appropriately respond to homeless individuals.

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8

Mental Health Services for Homeless People

WILLIAM R. BREAKEY

INTRODUCTION

By definition, the homeless are a severely disadvantaged population. One of their disadvantages is a high prevalence of psychiatric disorder.[1–4] Studies of the mental health of the homeless conclude that the prevalence of serious mental disorder is considerably higher than in the general population; about one-third of homeless adults have had a psychiatric hospital admission at some time.[2,4] The need of this population for mental health services is great, but providing such services is made difficult by their extreme poverty, their lack of insight into their psychiatric problems, their distaste for psychiatric treatment, and the complexity of their service needs. These needs, therefore, are often poorly met.[5] This chapter considers how clinical work with homeless people is affected by the special characteristics of the target population and how these characteristics affect the development of effective service systems.

THE HOMELESS POPULATION

The homeless population is not homogeneous, and its needs are not uniform. Homeless persons vary in educational levels, personal strengths and vulnerabilities, and the helping resources available to them; thus they present an infinite variety of life histories and problems.

WILLIAM R. BREAKEY • Department of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine, Baltimore, Maryland 21205.

Despite their heterogeneity, however, common characteristics of homeless people have a bearing on the provision of treatment and the planning of services.

Disaffiliation

The concept of disaffiliation, which indicates a relative lack of social support networks, is helpful in understanding the origins of homelessness for some persons[7] and is important in planning treatment. Homeless people are rarely in an active marriage; links to family, friends, neighbors, a church or club, or other occupational or social group are often lacking or fragmentary. In many cases, homeless persons report no friend or confidant to whom they can turn in time of need.[8–9] What is more, many of the personal qualities that create distance from other people also have adverse effects in treatment. This situation militates against cooperation and compliance and may explain the "lack of motivation" that is often a problem in the treatment of homeless patients.

Distrust

Distrust of authority and disenchantment with mental health service providers also contribute to lack of motivation. Some homeless persons have had bad experiences with hospitals, doctors, or other professionals and are wary of further involvement. Patients who have experienced unpleasant medication side effects may choose to stay away from psychiatrists to avoid treatment.

Multiplicity of Needs

Homeless persons are rarely "simple" or uncomplicated cases; usually they present an array of problems. Generally their physical health is poor. In particular they suffer from problems that are common to their lifestyle, such as peripheral vascular disease, infectious and parasitic diseases, respiratory diseases, skin and joint problems, trauma, and the complications of substance abuse.[11]

Substance abuse disorders and alcoholism have been salient features among homeless people over the past century. Homeless alcoholics seldom present simple treatment problems because alcoholism frequently occurs in combination with other psychiatric disorders.[13] In any treatment program for the homeless adult, it should be expected that 20% to 45% of the patients will suffer from substance abuse or dependence.[3]

Social service needs of homeless people are myriad. The homeless need assistance in access to entitled benefit programs, to transitional or permanent shelter, and to food and clothing.

The Homeless Lifestyle

The homeless lifestyle often complicates the treatment plan. For example, it may be difficult for a homeless person to keep a safe supply of medication. Some patients complain that neuroleptic medications make them drowsy, whereas on the street it is important to be fully alert. For an alcoholic trying to stay sober, life on the street may present many opportunities for indulgence.

The homeless are not as mobile as many people suppose. Despite the publicity given to "Greyhound therapy" and the accounts of migrations of homeless people

from one area of the country to others, most homeless people originated in the cities where they are now living.[8,14] Within cities, however, homeless people may have to move frequently from place to place in search of a bed or other services, and these movements may be unpredictable. Because the patient may not turn up when and where expected, planning services or offering continuity of care becomes very difficult.

PRINCIPLES FOR CLINICAL PRACTICE

The special characteristics of the homeless population have practical implications, and mental health professionals who work with this population take on a particularly demanding role.

Overcoming Stigma and Bias

It is nearly impossible for a therapist to avoid bringing a set of preconceptions into the therapeutic encounter. One set of biases is that which our society holds generally in regard to the poor. There is a very prevalent notion that poverty is attributable either to a character flaw in the individual or to some moral or spiritual failing. This conscious or unconscious idea has an adverse effect on the ability to empathize with an impoverished client. Prejudice also exists specifically against the homeless. They are not generally considered "good patients," and many psychiatric professionals believe that treatment is unlikely to succeed.

Another set of preconceptions that may have an adverse effect concerns the causes of homelessness. Some professionals, in their zeal to avoid "blaming the victim," tend to underestimate the role of personal factors and to emphasize the role of social, economic, or environmental forces leading to homelessness. In focusing exclusively on these factors, they may fail to encourage individuals to deal with intrapersonal issues or to seek treatment for a crucial psychiatric or addiction problem. At the other end of the continuum are those who focus strongly on intrapersonal factors, underestimating the external difficulties encountered by homeless people. Thus they may provide less empathic and practical support than is needed.

A common and unhelpful notion is that the homeless "choose to live this way." Although a small proportion may opt deliberately and rationally for the transient life, they are very much in the minority. The great majority live as they do because of a combination of intrapersonal and environmental factors that conspire to exclude them from the mainstream of society.

Skill and Innovation

Homeless clients are generally among the most difficult a clinician is likely to encounter. Their psychopathology is diverse and their motivation for treatment difficult to sustain. Clinicians therefore need a wide range of therapeutic skills if they are to be successful. This is not a field for the inexperienced or faint-hearted or for a therapist with a narrow view of what he or she is expected to do. Versatility and creativity are essential. Some programs have made extensive use of nonprofessional workers; many others emphasize outreach into the streets or places where the homeless congregate. For example, Farr took his clinical program into a shelter in Los Angeles's skid row. Baltimore's mental health program for the homeless reaches into

several homeless shelters. Susser and his colleagues developed a program in a single-room occupancy (SRO) hotel in New York City.[16] Imaginative approaches may overcome a variety of barriers and resistances.

Patience

Reluctance to develop trust in a service provider may be based on bad experiences, distrust of authority figures, or delusional fears. Often extraordinary patience is needed to establish trust. Simply offering a friendly word or some food or clothing may be all that is possible at first. Over time, as trust develops, more active interventions may become possible. For example, Susser needed many months to gain the confidence of both staff and residents of the SRO. He assumed the role of organizer of the weekly bingo game; this role then permitted him to move into the hotel. Once Susser gained the residents' and staff members' confidence, he moved into deeper levels of inter-personal and therapeutic relationships.

Another example is Project Outreach at the Goddard Riverside Community Center in New York. Each day social workers made trips into their community. They distributed sandwiches, exchanged greetings, and engaged in brief conversations with men and women they encountered. Contact with the more timid street people required months.

Realism

As noted, homeless patients are "treatment-resistant" and have minimal material and social resources. Some may be reluctant to contemplate change in their lifestyle or may not believe that a better way of life is feasible. For some the street offers a haven of anonymity. They have achieved a level of competence in coping with a dangerous environment; to leave that environment may not be an attractive prospect. For these reasons, homeless people may reject help when it is offered along conventional lines.[17] It is hoped that this rejection will be less a cause of despair than a challenge to develop creative and effective approaches. The striking success that can be achieved with some patients provides motivation to persist against what often appear to be overwhelming odds.

Attending to the Hierarchy of Needs

Homeless people themselves are clear about the existence of a hierarchy of needs.[18–19] Mental health or substance abuse treatment is far down on their lists of priorities. First priority generally goes to housing, food, clothing, and money. It is unrealistic to expect homeless people to participate fully in treatment programs until these basic needs have been met. Treatment providers must work closely in concert with providers of basic subsistence needs.[20–21]

Developing Support Systems

The lack of support networks for many homeless people may be a significant hindrance to successful treatment and rehabilitation. Strategies are needed to cultivate whatever natural support networks the homeless person may have and to encourage additional opportunities for social interaction. Rap groups, joint activity programs, and group therapies may be effective. Buddy systems, foster families,

apartment sharing, and other social arrangements also may help the individual to increase social skills and to develop skills useful in supporting rehabilitation.

ELEMENTS OF A SERVICE SYSTEM

Providing for the treatment of psychiatric disorders in the homeless requires a comprehensive and flexible array of services, as is the case for domiciled persons.[22] Because they are likely to be more symptomatic and more disabled than domiciled patients, homeless patients require more active intervention on the part of the treatment team. The range of services in a mental health program should include outreach, case management, direct clinical services, supervised housing, and consultation with shelter providers. All services offered must be easily accessible to the clients.

Outreach

Some homeless persons, particularly those in the street people or chronic alcoholic subgroups, have developed lifestyles difficult to change. Many report that apathy, resignation, and a loss of hope ensue after a period of homelessness. Outreach services attempt to overcome these barriers.[23] An outreach worker's job, therefore, is to persuade potential clients of their need for help, to assure them that services will be provided in a manner acceptable to them, and to try to overcome fatalistic notions that nothing will do any good.[24–25] One agency in Philadelphia sends caregivers to the railroad station, where homeless people congregate. Others employ homeless persons as outreach workers to inform other homeless individuals about the services available and to reassure them that it is safe to accept help from the program. A team in Baltimore conducts a blood-pressure screening program at a soup kitchen. The program is useful in itself as a preventive health measure; it also serves to establish contact and to stimulate motivation to seek more complete health care.[24–25]

Case Management

Case management has become a central function in the community care of people with severe mental illnesses.[26–27] A case manager generally does not provide direct services, but he or she should have a full understanding of the complex social service network, as well as of the wide range of services needed by the mentally ill person.[28] Integrating patients into existing community mental health services systems is a special skill of the case manager.

Direct Clinical Services

Direct clinical services must be nonintimidating and must be provided at sites where the homeless congregate.

The first priority is to establish trust and rapport. The prudent therapist will be slow in urging a patient into accepting medication, or he or she may administer lower doses in order to avoid side effects that might endanger a fragile collaboration. To be sure, obtaining medicines and supplying them to a patient may present problems. The patient may not have third-party benefits or may be reluctant to go through the arduous application process for Medicaid or Medicare. Special funds for

medicines thus are essential. Prescribing practice also must be tailored to the particular circumstances of the homeless lifestyle. Many of these patients are poorly organized in their daily habits and will have considerable difficulty adhering to a complex regimen of divided doses. Issuing small quantities of tablets may be advisable; intramuscular injections of depot medication also have obvious advantages.

Psychotherapy in the homeless context is generally directive, pragmatic, and focused on solving immediate problems. For individuals with major mental illnesses, support is needed to accept the fact of illness and the need for treatment, to develop a sense of empowerment, and to understand the importance of a stable environment. For other patients, particularly the situationally homeless, whose specific habits or traits of character may contribute to their homelessness, more introspective approaches extending over a longer time will be necessary.

Housing

Housing is the fundamental need of any homeless person, and a range of shelter and housing options is the basis of any satisfactory program.[25] In the wake of deinstitutionalization, various supervised housing arrangements have been developed for the mentally ill. Because of these individuals' marked lack of socialization and their deteriorated living skills, such arrangements are particularly essential. For some it may be possible to obtain access to housing provided by local community mental health agencies. For the "hard-core" homeless, however, special housing programs oriented to their needs and peculiarities must be developed. Experiments with alcohol-free living centers and residential buildings for recovering alcoholics are promising.[29]

Rehabilitation

Rehabilitation services are essential for recovery from mental illness. Structured psychosocial training programs in a clubhouse setting are effective in enabling and empowering mentally ill persons to function to their maximum capacity in the community. In many cases, however, the very structure of such programs may be a deterrent; rehabilitation then must be brought to the shelters or residences where they feel at home. Assistance in developing basic prevocational skills will be needed.

Until comprehensive service systems for the homeless are developed, clinicians must take advantage of community mental service systems that are already in place. Links with other treatment or rehabilitation programs in the area should be established wherever feasible. No state has yet provided adequate community services for deinstitutionalized psychiatric patients or for the long-term treatment of chronic alcoholics or drug abusers. Clinicians must join forces with advocates, political activists, rehabilitation experts, and others to influence policymakers to develop service systems adequate for the needs of the nation's most disadvantaged people.

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9

Mental Health and Homelessness

The Clinician's View

J. Thomas Ungerleider, Therese Andrysiak, Naomi Siegel, Derrell Tidwell, and Toni Flynn

INTRODUCTION

This chapter presents the clinician's view of homelessness and related mental health issues based on the experiences of a mental health outreach team (the "team"), which operates in the shelters, the meal programs, and the jail of a high-density homeless area in a coastal suburb of Los Angeles County. The beach cities of Santa Monica and Venice differ from downtown Los Angeles's skid row, New York's Harlem, and Boston's "combat zone" in that they are largely residential areas, are easily accessible by bus from downtown, border on the Pacific Ocean, and contain many public parks.[1] Violence is less than in downtown skid row, but there are fewer shelters and social service facilities.

The residential areas include a mix of retirees and senior citizens, affluent young professionals, and families with children. Business professionals and single-store merchants abound. There are several distinct business districts; some are located on

J. Thomas Ungerleider • Neuropsychiatric Institute, University of California, Los Angeles, Los Angeles, California 90024. Therese Andrysiak • St. John's Hospital, Santa Monica, California 90404. Naomi Siegel • Private Practice, Santa Monica, California 90025. Derrell Tidwell • Outreach Team to the Homeless Mentally Ill, St. John's Hospital, Santa Monica, California 90404. Toni Flynn • Salvation Army, San Luis Obispo, California 93401.

the main street at or near the beach, whereas others are located at outdoor or indoor shopping malls.

The outreach team provides on-site mental health services to a homeless population (an estimated 5,000 to 15,000 adults) that underutilizes existing traditional mental health services. In addition to psychosocial assessment, referral, case management, and tracking, team members assist staff at the outreach sites to develop and implement interventions on behalf of the clients.

Community education about the special situation of homelessness is also an important function of the team. This work is carried out via both formal lectures and informal presentations to various community groups. The team is multidisciplinary; yet all members function as evaluators and mental health service advocates. Special skills of team members are used when indicated, however.

The team, a project of St. John's Hospital in Santa Monica, is an interdisciplinary staff including a psychiatrist, a psychiatric social worker, a psychiatric nurse, and a psychiatric technician. The team operates at eight community sites within a 5-square-mile area, visiting each site once or twice weekly. Office space and telephones are provided at each site.

The team makes contact with homeless individuals at the following sites:

- A city park where each weekday morning 100 to 200 homeless persons are served breakfast by the Salvation Army.
- A weekday lunch program at a drop-in center with clothing, showers, and social service referrals (Clare Foundation).
- An advocacy center that provides case management, clothing, groceries, and social service advocacy and referral to 30 to 50 homeless persons daily (Ocean Park Community Center).
- An outpatient medical facility that conducts a "homeless clinic" each weekday afternoon, attended by 10 to 30 persons (Venice Family Clinic).
- A social service agency and day center that offers clothing, showers, laundry services, telephone, mail delivery, and advocacy services. In addition, a special program expedites applications for persons with psychiatric disability. Staff members function as payees to ensure clients' prudent expenditure of awarded funds (St. Joseph's Center).
- A day center socialization program that serves homeless as well as nonhomeless persons with chronic mental illness (Step Up to Second Street). The outreach team conducts a weekly "homeless issues" group for 10 to 20 persons. Primary topics for group discussion include how to prevent and how to cope with homelessness.
- A resource center providing groceries, clothing, and social service advocacy to the homeless (People Assisting the Homeless).
- The Santa Monica City Jail, the only public facility that the clinical team visits, where voluntary homeless clients are interviewed for psychosocial assessment and referral immediately before release.

The *client population* during the first year of the outreach team's operation included more than 350 individuals. Two-thirds were males; three-fourths were between the ages 20 and 40. Seventy percent were Caucasian, and 20% were black. Over two-thirds were both unemployed and receiving no form of public assistance.

Fifty-seven percent reported a history of previous psychiatric contact. Approximately one-fifth of the clients were diagnosed with schizophrenia, one-fifth with

primary affective disorder, and one-fifth with dual diagnoses, that is alcohol or other drug abuse plus major psychiatric problems.

Contacts with clients were one of three types: client-initiated, agency referral, or outreach-team-initiated. These contacts were either "casual" or in-depth assessments. Casual contacts were usually brief interviews with clients that often progressed naturally into deeper assessment after a series of interviews and the development of trust. In-depth assessments included detailed evaluation of presenting problems and psychopathology as well as medical, psychosocial, and substance abuse histories sufficient to establish an initial diagnosis and a relevant treatment plan. Follow-up visits were scheduled to ensure compliance with the treatment plan and identification of additional needs.

Treatment plans included strategies to meet basic needs such as food, shelter, personal hygiene, medical care, and income (e.g., SSI and general relief), as well as psychological services (e.g., outpatient treatment, residential placement, psychotropic medication, or hospitalization).[2]

We have found the case management approach essential in working with homeless adults with serious mental illness, who are often noncompliant with treatment plans.[3] In particular, aggressive tracking through multiple community sites is often required.

PROBLEMS ENCOUNTERED

System-Related Problems

During the period of deinstitutionalization of state mental hospitals, many persons with mental illness failed to receive adequate treatment and community support.[4] Despite high hopes on the part of community planners, the systems of care failed this population largely because of inadequate tracking, lack of funds, poor community supports, or lack of integration of facilities (see Chapter 5).

California, among other states, exercised strict conditions under which a person could be committed involuntarily. For example, a person because of mental illness must be dangerous to himself or herself, dangerous to others, or gravely disabled. Initial detention of patients is limited to 72 hours; additional 14-day periods of detention require additional legal proceedings. The courts, which are inclined toward protection of civil liberties at the expense of treatment needs, have made it more difficult in recent years to hospitalize and retain persons with serious mental illness. Limited hospitalization periods, however, may prevent stabilization of a therapeutic regimen. Also, homeless patients may be discharged to the streets and may experience subsequent deterioration.

Few outreach teams existed in the early to mid-1980s.[5] Indeed, outreach is still seen as a relatively nontraditional approach, unfamiliar to many trained professionals and anxiety-provoking as well. Costs of outreach efforts are relatively high because they are labor-intensive. In addition, case finding of mobile, unstable clients makes treatment awkward and often ineffective.

Many of the homeless mentally ill become ensnared and are recycled through the criminal justice system (see Chapter 6). Panhandling, public intoxication, being a "public nuisance," and sleeping on the streets are examples of citable offenses. Nevertheless in many areas, as in Santa Monica, the tendency is to replace prosecu-

tion of nonviolent offenses with social service assessment and referral in the jail. Development of mandatory outpatient or community treatment programs is still in its infancy[6] (see Chapter 5).

Income maintenance is a major problem for the homeless mentally ill. To obtain disability benefits of any sort, one must undergo a complex application process involving long waiting lines, much red tape, multiple interviews, and repeated phone calls. Often a mailing address is required to receive aid. Without an advocate or a case manager, a disorganized or disoriented individual is at a major disadvantage (see Chapter 24).

Housing poses additional problems. Board and care homes often screen out those unable to follow their rules. Violence, assault, and rape are common hazards in "voucher" hotels. Patients with dual diagnoses of mental illness and substance abuse may be excluded from various shelters for either of these two diagnoses, even if they are not currently using drugs. In addition, many substance abusers will not comply with treatment program rules for abstinence, or they may be involved in illegal behavior.

Community-Related Problems

The public feels a striking ambivalence towards the homeless. Strong feelings and polarized attitudes exist among domiciled residents, business people, and service providers in the community.[7] Residents are very uneasy when they see dirty, disheveled individuals picking through their trashcans or in the library, sleeping with their heads on the thickly bound books on the tables. Merchants become upset when they discover someone huddled in their doorways, urinating in the street, or shouting at passers-by in front of their window displays. The community at large may feel threatened by aggressive panhandlers and may be uneasy when they see persons who are stuporous or passed out in the parks.

Many community residents resist establishment of services in their communities because they believe that the existence of such agencies only attracts more homeless persons into the area. On the other hand, some social service personnel argue that more services such as toilets, showers, food pantries, and shelters make it easier for the larger community to set limits on unacceptable behaviors. It is difficult to argue for community safety and aesthetics, however legitimate, at the expense of the most basic needs of homeless persons.

Helper-Related Problems

Anyone who works with homeless persons, whether providing clothing or mental health services, requires a particular blend of personal and professional characteristics. The clients served are a low-status, nonprestige group who often are stigmatized and feared by the general population. Outreach workers may experience a sense of nonaffiliation, especially when they work in a variety of host agencies. At times one must function autonomously; at other times one must shift rapidly from working with homeless persons to working with social service bureaucrats or highly placed community officials. This situation challenges the workers' adaptability and flexibility.

CLINICAL INSIGHTS GAINED FROM WORKING WITH THE HOMELESS

Initial Concerns

We were apprehensive that resistance by program staff members at the various outreach sites would interfere with our integration into the service network. Although we were funded privately, we feared being perceived as competitors. Nevertheless we were accepted gradually by all agencies that hosted our outreach effort. We were impressed by the dedication and the tireless efforts of many persons who work in this field, despite hazards ranging from body lice to emotional burnout.

Adaptations to Homelessness

Homeless persons make extraordinary adaptations to their circumstances, particularly after they have been homeless for some time. They seem to undergo an apparent "ego reorganization" or restructuring of their reality. For some individuals, for example, a sidewalk sleeping place might become a special address to the person dwelling there; a dumpster used as a residence might become an "open-air condo." After dark "the [Santa Monica] library is great . . . lots of books with thick, soft bindings to sleep on, and they let you stay until closing time." Strategies for panhandling were exemplified by one homeless man, who reported, "I send my woman [age 17] to ask for money at a fancy restaurant. . . . No one getting out of his Mercedes or Porsche and trying to impress his date can refuse a pretty face asking for food or money. . . . Sometimes she gets $5 a car."

It would seem to follow that earlier interventions among homeless persons would be more effective—that is, before the ego reorganization occurs and before secondary gains of the homeless lifestyle become highly valued.

The Homeless Person as Psychiatric Patient

Successful therapeutic intervention is difficult even with the cooperative psychiatric patient, who is an accurate informant and a reliable historian, signs release of information forms readily, and has a family support system ready to cooperate. In contrast, many homeless persons who say that they want help may report negative prior experiences with the mental health services delivery system; they are distrustful. Most of our clients reported negative experiences with psychiatric hospitals and antipsychotic medication. Not surprisingly, however, many responded to nonintrusive contacts and eventually often accepted some form of intervention.

Compliance with a course of medication is difficult for homeless persons. Often those who needed the medication most were least likely to accept it, much less to comply with a medication schedule. G. P., a 36-year-old Caucasian male, is a typical case illustration. He was first observed by members of the outreach team in spring 1986 at several of the free food facilities. He seemed to be responding to auditory hallucinations. He was moderately well groomed and he kept to himself, generally sitting apart from the others who were eating. G. P. carried a bedroll and a blanket and told us only that he was from Canada and had been homeless for more than 3 years. He was a "regular" at three of the food sites where our team worked. G. P. was pleasant but refused to speak with us. He said he would call the police and would have us arrested for intruding on his privacy.

By September, G. P. was observed to be increasingly disheveled, with torn and filthy clothes. Lice infestation was obvious in his hair and his beard; he scratched constantly. When marked weight loss became apparent and he refused to speak at all, it was decided to hospitalize him involuntarily on a legal hold, as gravely disabled. This procedure was effected through a joint effort by the Salvation Army, the police, the county mental health facility, and the St. John's Hospital psychiatric facility, with members of our outreach team coordinating the effort.

After delousing, milieu therapy, and treatment with a phenothiazine for 10 days, the patient signed out of the hospital against medical advice. He had been visited daily in the hospital by one of the team members. He contacted her 2 days after discharge at one of the outreach sites and stated that he was ready to return to Canada, a disposition that had been suggested previously. G. P. was lucid and coherent, and remained so while calling his father for funds for the trip. He entered a short-term psychiatric crisis resolution program, where he waited for the check from his father to arrive. Within the week he returned by bus to Canada.

This case illustrates a successful intervention with a deteriorated patient. Many like him may be helped through tailored interventions.

The Substance Abuser

A person with serious mental illness combined with alcohol or other drug use often is not welcomed by drug treatment programs because such persons regularly vitiate the treatment efforts of those motivated to help. Unless they are frankly assaultive (not a rare occurrence), these are the homeless who are least likely to receive intervention. Some remain under the freeway overpasses or on the beaches and are rarely seen by outreach workers.

Intuition and the Outreach Worker

Some outreach workers become remarkably intuitive about the homeless clients whom they observe while providing food or clothing. Often they can estimate where on the cycle of "decompensation—institutionalization—discharge—decompensation" a particular homeless mentally ill person is at any given time.

Goals of Intervention

A wide spectrum of goals exist for intervening with the homeless. These depend as much on the intervenor's philosophy as on the client's needs and accessibility. Some advocates try for a shelter or a home; others work to get the homeless into a job, on disability, or on general relief. Still others are more attuned to medical and dental care. Some are eager to induce the homeless to join unions or to be activists.

Regardless of the goal, however, the most difficult and most critical clinical issue involves establishing the basic trust required to develop an effective treatment relationship. This process may take many months and requires patience on the part of the worker because treatment results usually are characterized by small, incremental behavioral changes.

Networking

We worked with other outreach service providers and agency representatives to establish working relationships. We developed an outreach coalition meeting with medical, mental health, and social service outreach teams. These meetings provided a forum for discussing common clients, especially those who presented difficult management problems. Our goal was to develop an effective treatment approach, to avoid duplication of services, and especially to provide continuity of care for this elusive population.

Networking, however, also presents difficulties because differences in philosophical positions may interfere with the client's receiving aid. Two different strategies for obtaining income assistance, for example, are direct application to the county for benefits and joining a homeless persons' union to work collectively for benefits. Public- versus private-sector antagonisms often surfaced in these networking meetings. The main challenge of successful networking is to be able to work together for the good of the clients, despite divergent philosophies.

Community Applications of Mental Health Principles

There is a critical need for intervention by trained mental health practitioners at the community level. Both the general population and community officials, including the police, frequently lack a basic understanding of the nature of mental illness and substance abuse and often express ambivalence and hostility about homeless persons. "They get to spend every day at the beach . . . they drink a better brand of vodka than I can afford." Others have a different, if no more helpful, attitude: "They are crazy—you can't expect them to behave normally." Some of the homeless mentally ill, however, have described to us how they knew exactly where in the community (for example, at what shelters) they could act crazy and even could be violent and disruptive. Conversely, they also knew where they could not give in to their hallucinations or be intoxicated but were expected to be quiet and well-behaved in order to be served a meal, to remain in a shelter, or to avoid arrest.

SUMMARY

The St. John's Mental Health Outreach Project in Santa Monica, consisting of a team of mental health professionals, has operated in eight different community sites serving the homeless. The team offers consultation at these sites, consisting of mental health assessment and treatment including psychotherapy, psychotropic medication, and hospitalization where indicated. The team also makes referrals for medical care, social service assistance, food, clothing, and shelter.

System-related problems include the inability of hospitals to retain many chronic patients, cycling of clients through the criminal justice system, and the barriers and red tape connected with obtaining disability or welfare for the homeless. Available housing is limited and at times dangerous; persons with dual diagnoses are at high risk of exclusion from shelters and social services. Community-related problems include strong polarized and divergent attitudes among community residents, business people, and social service providers. Helper-related problems include difficulties of the staff in serving the low-status, nonprestige homeless population, fears for

personal safety, and concerns about becoming distanced from one's own psychosocial group and about nonaffiliation with other professional groups in the community.

Clients usually require frequent, nonthreatening attempts over time to build trust and even the beginning of a relationship. Long-term persistent outreach efforts that seemingly are resisted by homeless clients may result eventually in successful therapeutic interventions. By observing and tracking homeless clients over time, outreach team members can learn more about them and can document deterioration and behaviors that may require eventual hospitalization. Hospitalization of homeless clients, when required, is most effective in a location where they can be visited by outreach team members, who thus provide continuity for the relationship and further the development of trust.

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10

Mental Health and Other Human Service Needs of Homeless People

GARY A. MORSE AND ROBERT J. CALSYN

INTRODUCTION

A perusal of recent research reveals wide discrepancies in the estimate of mental illness among the homeless; mental health disturbance rates range from 5% to 95%.[1–6]

Such diversity in findings perhaps is not so surprising in a relatively new field of study, where the development of a dialectic process is evident. Historically, little attention was paid to the psychiatric status of homeless persons; the limited data available from earlier periods suggested that few persons in previous homeless populations exhibited severe mental health problems.[4] As homelessness has become recognized as a major and growing social problem, however, increased attention has been focused on the psychiatric aspects of homelessness. The landmark works by Baxter and Hopper[7–8] were particularly noteworthy for raising public and scientific consciousness concerning homelessness and for highlighting the existence of serious mental health problems. That work did not provide original, quantitative information on the nature and extent of mental health problems, but two subsequent psychiatric studies were influential in advancing the thesis that mental illness is rampant among the homeless. First, Arce and colleagues[9] reported a mental illness rate of

GARY A. MORSE • Department of Psychology, University of Missouri–St. Louis, St. Louis, Missouri 63121. ROBERT J. CALSYN • Departments of Psychology and Gerontology, University of Missouri–St. Louis, St. Louis, Missouri 63121.

84.4% in a Philadelphia shelter sample. Second, Bassuk[10–11] reported that nearly 91% of a Boston shelter sample were mentally ill.

More recently, the antithesis to the view of widespread psychiatric disturbance among the homeless has emerged. Snow and his colleagues[12] object to mass media and scientific reports portraying the homeless as predominately mentally ill. In their own research, Snow and associates reported that only about 10% of a street sample of 164 homeless adults "might be classified as having psychiatric problems of varying degrees of severity." They also reported that only 16% of a random sample of 767 homeless men were found to have psychiatric treatment histories; only 10% had ever been institutionalized, and most of these admissions were for substance abuse, not psychiatric problems.

These two polarized views of the mental health status of homeless people, represented most clearly by Arce's and Bassuk's work on the one side and Snow's report on the other, left the field in a state of controversy and debate[1,6,13] that has hindered the implementation of an effective public policy to eradicate homelessness.

Reaching some consensus on what percentage of homeless persons has significant mental health problems has important policy implications for designing treatment interventions for this population. If 85% to 90% of the homeless do have such problems, as suggested by Bassuk and Arce, then the mental health system (NIMH, state departments of mental health, and local community mental health centers) should be assigned the primary responsibility for serving the homeless population. If, on the other hand, most homeless people are *not* mentally impaired but rather are caught in a cycle of low-paying, dead-end jobs, as Snow and his colleagues maintain, then different societal institutions need to be mobilized to address the problem of homelessness in the United States.

In reviewing previous studies that attempted to estimate the extent of mental illness among the homeless, it is clear that a number of methodological and conceptual problems are inherent in previous works.

One major conceptual reason for the discrepancy in estimates of mental illness in the homeless is the lack of agreement among researchers as to what constitutes psychiatric disturbance. In the studies by Bassuk[10–11] and Arce,[9] for example, mental illness was defined by the diagnosis of any psychiatric disorder, including substance abuse and Axis II personality disorders. Other studies excluded personality disorders or alcohol and drug diagnoses from the reported rate of mental illness, thereby producing a much more moderate prevalence rate.[4] At the other end of the spectrum, Snow *et al.*[12] used much more restrictive criteria. In their field sample, a person was considered to be mentally ill if two of the following three conditions were met: prior hospitalization (although not all persons were questioned directly for this variable), designation by other homeless people as mentally ill, or blatant and overt psychotically bizarre behavior.

Rather than assuming a unitary underlying trait of mental illness or lumping together different concepts (e.g., prior hospitalization history and current symptoms), it seems more prudent to measure different categories of mental health status in a single study. Progress toward differentiating mental health status into more discrete and more meaningful variables is exemplified by Robertson's[6] recent work, which reviews studies separately by categories of mental hospitalization, psychological distress, and psychiatric diagnosis.

Even if researchers agree to measure all three indicators of mental health status, however, the different instruments chosen can result in somewhat different estimates. Robertson's[6] recent review, for example, cites seven different indicators of

psychological distress in seven studies and refers to three different diagnostic procedures or data sources used to determine DSM-III diagnosis in five different studies. Such diversity in assessment methods has contributed to the diversity of research findings.[6,10,13]

Difference in sampling techniques is the other major factor responsible for the widely divergent estimates of mental illness among the homeless. The existing literature has relied too often on nonrandom methods of subject selection, usually convenience sampling at a single site, instead of on random sampling across a broader universe of homeless settings. Even in studies that have tried to sample more than one homeless setting, the samples chosen are typically small, and no precautions are taken to assure that the sample is representative of the homeless population that frequents that setting. The lack of random representative sampling perhaps is the most critical methodological factor involved in the inconsistency of previous research.[10,14] Without adequate sampling procedures, it is difficult to be certain that the obtained results are representative findings and not chance results. Further, it becomes difficult to distinguish population findings from environmental factors or from subpopulation characteristics.

Finally, much of the previous research focused too narrowly on the presence or absence of mental disturbance, as if it existed as a dichotomous variable and as if it were the only problem that characterized the homeless. Alternative approaches are (1) to describe mental health status in greater specificity and (2) to assess the status and extent of other needs of homeless people.

Both of these approaches acknowledge, as others[7,13] have asserted, that the homeless are a heterogeneous population. Researchers therefore should devote greater attention to assessing the complexity of variables affecting the homeless and should attempt to determine whether the homeless can be differentiated into subgroups. Such attempts should yield useful information for policymakers, particularly in organizing services for homeless persons with differing needs.

Our study of the St. Louis homeless population attempted to address the limitations of previous research by (1) employing objective measures of both psychological distress and mental hospitalization; (2) using a stratified random sampling procedure; (3) asking questions about other needs that homeless persons might have; and (4) attempting to classify the homeless into meaningful subgroups.

METHODOLOGY OF THE STUDY

Participants and Sampling Strategy

A total of 248 persons (122 females and 126 males) who were receiving temporary housing in St. Louis area adult emergency shelters were interviewed for the study. The mean age of the participants was 30.60; 64.9% of the sample belonged to racial minorities (all but two were black); the mean education level was 11.20 years. Participation was voluntary; each respondent was paid $5 for the interview.

Thirteen of the 16 emergency shelters in the St. Louis agreed to participate in the study. On the basis of estimates from a previous study of St. Louis shelters,[15] the participating shelters served 96% of the homeless men and 79% of the homeless women in the area. Sampling for each gender group was stratified by each shelter, depending on the average monthly census of a given shelter. Participants in each shelter were selected randomly from the current shelter census through a random

numbers table, with the one constraint that persons interviewed previously were eliminated from consideration.

The interviewer approached the randomly selected individual and explained briefly the purpose of the study. During this time the interviewer also performed a covert assessment of the person's competency. Five persons were judged incompetent and were eliminated from the study. Ten additional persons declined to be interviewed. Participants were interviewed by a same-sex interviewer in the part of the shelter that afforded maximum privacy.

Measures

In addition to the demographic characteristics of age, sex, race, education, marital status, and occupation, we collected data on the history of homelessness, including the number of times homeless, the length of time since first homeless, and the number of months currently homeless.

We also administered the negative life events and physical illness scales of Moos and colleagues.[16] Past psychiatric history as well as involvement in current psychiatric treatment were recorded. We assessed psychopathology according to the Brief Symptom Inventory (BSI).[17] The BSI is the short form of the SCL-90, which a National Institute of Mental Health (NIMH) task force considered to be the best self-report symptom checklist.[18] Alcoholism was measured by the Short Michigan Alcoholism Screening Test (SMAST)[19]; drug abuse was assessed by questions adapted from the Periodic Evaluation Record, Community version.[20] We also asked clients questions about their criminal history.

We asked clients questions regarding their use of mental health services and other social services, including income assistance, housing, employment, and general health care.

We assessed informal social support with a modified version of the Arizona Social Support Interview Schedule.[21] Three scores from that instrument were used in the present study: total support available, total support used, and felt need for additional support. We also administered an alienation scale adapted from Bahr and Caplow's[22] study of homeless people. Self-esteem[23] and quality of life[24] were assessed with previously published scales.

RESULTS

Description of St. Louis's Homeless

History of Homelessness

Homelessness had become perpetual for many of our sample; mean length of time since first homeless was 32.82 months, mean duration of current homelessness was 14.65 months, and mean number of times homeless equaled 2.59.

Negative Life Events

Negative life events probably played an important role in leading to homelessness for the participants. In the year before they became homeless, the St. Louis

homeless people were exposed to significantly more negative life events (mean = 4.46) than Moos and his co-workers[16] found in the general population (mean = 1.35) or in a depressed patient sample (mean = 2.40). Unemployment (78.9%), loss of income (58.5%), debt (45.6%), being fired from job (35.9%), death of a friend (32.3%), and assault (28.7%) were some of the more common negative events for these people.

Psychiatric History and Symptoms

One-fourth of the homeless people had been hospitalized previously for psychiatric or mental disorders. In the great majority of these cases (73.8%), mental hospitalization preceded initial homelessness; this finding suggests that the mental health system had not provided adequate community support to maintain former patients in the community.

The mean number of prior hospitalizations was 4.1, although the range varied greatly, from 1 to 29 prior hospitalizations. The mean period of longest hospitalization was 5.6 months. The mean length of time since most recent hospitalizations was 49.2 months.

Almost one-half (46.9%) of the homeless people scored above the screening cutoff score of .72 on the global severity index of the BSI (mean = .84). Compared to a nonpatient population, our sample of homeless adults displayed elevated levels of psychiatric symptoms on all subscales of the BSI. Most marked were symptoms of paranoid ideation and psychoticism.

Despite the relatively high levels of current symptoms and hospitalization histories, only 15.3% of the sample were receiving current mental health service.

Alcoholism and Drug Use

In addition, 35.5% of the homeless people appeared to suffer from drinking problems or alcoholism, as determined by scores at or above the cutoff mark of an alcoholism screening test. Few of the homeless (5.7%) currently were receiving treatment for alcoholism or drinking problems, although an additional 15.4% had received treatment in the past.

Nonalcoholic, nonprescribed drugs had been used in the preceding month by about one-fifth (20.8%) of the homeless. By far the most frequently used drug was marijuana (used by 80.4% of those who used drugs).

Physical Health

About one-half (50.4%) of the homeless people reported having one or more physical problems that had been diagnosed in the previous year. The most common diagnosed health problems among the homeless were high blood pressure (16.9%), arthritis (10.9%), and anemia (10.5%).

Housing

Shelter, local, state, and federal agencies were assisting only 21.8% of the homeless sample in finding permanent housing.

Employment and Job Training

More than 90% of the sample were currently unemployed. The mean length of the current period of unemployment was 23.26 months. Only 20.6% of the sample were receiving assistance in finding a job from any type of agency or shelter.

Income/Financial Assistance

The amount of income in the previous week for 62.1% of the homeless was $0. The mean weekly income was $24.42. Only about 30% of the sample received any form of financial assistance.

Informal Social Support

The preceding data show clearly that the homeless population has many needs that are not met by the social service system. Moreover, the homeless also lack informal sources of social support. Three previous studies using adult women and undergraduate students[25–27] found that the mean amount of social support available for those samples was about twice as great as reported for this sample of homeless people. Similarly, our sample of homeless people experienced the same degree of alienation (mean = .72) as Bahr and Caplow's[22] homeless samples (means = .67 and .75) and were considerably more alienated than Bahr and Caplow's wealthy control group (mean = .33).

Identification of Subgroups of Homeless People

We conducted classification analyses to identify meaningful subgroups of homeless persons that would be useful in planning programs for the homeless. Two different classification systems, each believed to have value for service planning, were used to identify these subgroups. The first method classified the sample *a priori*, solely on the basis of mental health need, as will be described later. The second system classified the homeless sample *a posteriori* across a broad set of problems and needs that are experienced frequently by homeless people. Specifically, the cluster analysis was based on variables measuring service need in nine areas: physical health, mental health, interpersonal adjustment, social support, drinking problems, job skills, employment status, income, and self-ratings of need for permanent housing.

Differences among Homeless People as a Function of Mental Health Need

Because the results of our *a priori* classification based on mental health need are reported in detail elsewhere,[28] we will merely summarize the most important findings of that analysis here. The original sample was classified into three categories of mental health need: (1) normal (44.3%); (2) acute mental health needs, as indicated by a score above .72 on the global severity index of the Brief Symptom Inventory and/or by one brief previous mental hospitalization (35.8%); and (3) chronic mental health needs, characterized by multiple and/or lengthy mental hospitalizations (19.9%).

We found significant differences among the three groups on most of the homeless history variables. The number of months since first homeless was greater for the

chronic group (mean = 58.60) than for the acute group (mean = 26.35) or the normal group (mean = 27.03); similarly, the chronic group had more episodes of homelessness (mean = 6.13) than either the acute group (mean = 2.15) or the normal group (mean = 2.39). The chronic group also suffered more negative events in the year before first being homeless (mean = 5.43) than did the acute group (mean = 4.40) or the normal group (mean = 4.07).

We found only a few differences among the three groups in regard to the other human service needs. The chronic group had more problems with alcoholism, more physical health problems, and more contact with the criminal justice system than did the other two groups.

With regard to informal sources of social support, both the chronic and the acute groups reported needing more social support than did the normal group; there were no differences among the three groups, however, in support available or support used. Finally, although we found no significant difference among the three groups regarding alienation, the chronic group had a lower quality of life than did the other two groups.

In summary, the chronic mental health need group has somewhat greater needs than the other two groups, particularly as evidenced by the homeless history variables, alcoholism, and overall quality of life. As for socioeconomic needs, however, there were few differences among the three groups.

Empirical Identification of Homeless Subgroups

Although the results of the *a priori* classification by mental health status provided some meaningful differences among subgroups, the cluster analysis procedure provided additional information because we used data on other needs of homeless people in the subgroup identification process.

We performed cluster analysis on two split samples of the total sample (see Morse[29] for methodological details). Cluster correlations between these samples indicated cross-replication of four clusters that classified adequately 94.4% of the samples; 5.6% of the sample were unclassified. Table I displays the final cluster solution means (in their original metric) as well as the percentage of the sample in each cluster. Descriptions of each cluster subgroup appear next.

Subgroup 1. The first subgroup can be described as having average needs for a homeless population. This cluster, which contains a majority of the sample (53.2%), is not distinguished by markedly high or low levels of problems in any area relative to other homeless people. Rather, the subgroup shows the average needs of the homeless majority. Yet although the needs of this subgroup are average for homeless people, their absolute level of need is great in a number of areas, particularly permanent housing, employment, income, and job skills, For example, nobody in this subgroup was employed, and the mean weekly income was $10.08.

Subgroup 2. This subgroup constitutes 19.8% of the total sample and is distinguished most clearly in relation to the other homeless subgroups by high levels of drinking problems and need for alcoholism treatment. More than 80% of the members of this group are males. The alcoholic nature of this subgroup is reflected by the cluster means on the SMAST. Another method of characterizing the alcohol problems is to compare the subgroup members' scores on the SMAST to the established cutoff score on this scale that indicates alcoholism.[19] Such a comparison reveals that

Table I. Final Cluster Solution Means (Nonstandardized)

	Cluster variables											
Subgroups	Membership frequency	Physical problems	Psycho-pathology (BSIGSI)	Self-rating: mental	Interpersonal adjustment	Social support	Alcohol problems (SMAST)	Self-rating: alcohol	Occupa-tional skills	Employed	Income	Self-rating: housing
1	132 (53.2%)	289.00	.57	1.27	3.12	3.81	1.20	.42	5.59	0	10.08	5.90
2	49 (19.8%)	642.53	1.00	3.71	2.98	3.54	7.96	5.16	5.60	.04	12.92	5.76
3	41 (16.5%)	549.54	1.54	4.61	2.21	3.22	2.20	.83	5.76	.02	13.00	5.80
4	12 (4.8%)	266.33	.78	2.67	3.15	7.17	.50	0.0	5.00	.50	232.83	6.00

nearly everyone in this subgroup (98%) scored above the cutoff; this finding suggests alcoholism. Members of this subgroup also rated themselves very high in need for alcoholism treatment.

A secondary feature of this subgroup involved mental health problems. People in this subgroup tended to rate themselves as in need of mental health treatment; their BSIGSI scores also were elevated. This group also reported having experienced more life stresses in the year before initial homelessness and having the highest rate of prehomeless imprisonment (34%). Members of this group also spent less time in shelters than did any of the other subgroups.

Subgroup 3. The third subgroup, consisting of 16.5% of the sample, is characterized by mental health needs and interpersonal problems. The overwhelming majority (92.7%) scored above the psychiatric symptom screening cutoff; people in this subgroup also rated themselves as high in need for mental health treatment. The interpersonal adjustment of people in this cluster also tended to be poor. Needs and problems in other areas tended to be average for a homeless population. This group spent the most time of the four subgroups staying in shelters.

Subgroup 4. Unlike any of the previous subgroups, this subgroup is distinguished by its relative strengths rather than by its needs. Unfortunately, only 4.8% of the homeless people were in this socially advantaged subgroup. More than 80% of this group were females. Persons in this subgroup had a far greater weekly income ($232.83) and a higher rate of employment (50%) than most homeless people. This subgroup also was supported by a social network about twice the size of those for the other subgroups. Members of this group received more assistance in finding housing than did members of any of the other groups.

DISCUSSION

The descriptive results support the proposition that a significant number—but not the overwhelming majority—of the homeless have serious psychiatric treatment histories and current mental health problems. The rate of previous psychiatric hospitalization perhaps is the best current indicator for comparing results across studies. The 25% previous hospitalization rate found in this study is quite comparable with findings generally reported in the literature. In fact, this 25% rate is the exact midpoint of the range (15% to 35%) in studies reported in a recent review,[6] if one excludes studies of homeless mothers with children,[30] hospitalization rates combining psychiatric with substance abuse problems,[31] and samples biased toward the selection of mentally disordered persons.[32]

The *a priori* classification scheme determined that approximately one-fifth of the sample had chronic psychiatric needs, about one-third suffered crises or acute psychiatric problems, and the remainder had no major mental health service needs. These three categories constitute a rough and fairly simple classification system; more sophisticated models are worth pursuing in future research. Yet this model is still useful for showing that mental health needs vary in severity and type in the homeless population; this finding has implications for service delivery, as will be discussed shortly.

Both sets of information—psychiatric hospitalization rates and the threefold *a priori* mental health classification scheme—also emphasize that mental health is a

significant problem for many but not all of the homeless. This finding suggests that both of the extreme positions evident in the literature, represented by Arce[1,9] and Bassuk[10–11] at one pole and Snow[12] at the other are overstated. In sum, neither the arguments stating that nearly all of the homeless have significant mental health problems nor those that show that only a few of the homeless have such problems portray accurately the mental health status of the homeless.

Although it is clear that a significant number of the homeless have serious mental health problems, a question arises concerning the causes of psychiatric disturbance. Certainly a number of persons manifest serious psychological problems before they ever become homeless, especially in view of the finding that about 18%* of those in this study were hospitalized before becoming homeless. Yet it is also quite likely, as others[4,6] have suggested, that homelessness and its associated environmental and social conditions not only exacerbate psychiatric problems among those with preexisting disorders but also induce crisis and acute symptoms in other individuals, who may function normally under less adverse situations.** Much work needs to be done in illuminating the causal factors and processes by which homelessness affects mental health functioning. At present it seems reasonable to speculate that the low level of social support and the high level of stressful life events experienced by the homeless in this study contributed to their psychopathology.

IMPLICATIONS

Mental Health Services

The rate of psychiatric disturbance indicates clearly the need for additional mental health services to the homeless. The *a priori* classification results, however, suggest (1) that different kinds of mental health services will be appropriate for different groups of the homeless and (2) that a sizable minority do not need any special psychiatric intervention. Services targeted to the crisis/acute group should be less extensive and should be time-limited. Specifically, crisis intervention services, psychiatric medication, and indirect consultation and education services to shelter providers may be most cost-effective for this group. Those with chronic needs will require not only medication and counseling services but also the establishment of more intensive and more encompassing community support services. Intensive long-term case management and day programs also are needed.

Finally, for the chronically mentally ill homeless who require a more structured supportive environment, autonomous alternative settings similar to the lodge program of Fairweather and his colleagues[33–34] need to be developed. As Fairweather has demonstrated, such settings provide residents with a higher quality of life, complete with socially valued roles and activities, autonomy, and dignity, and at the same time are economically self-supporting.

Other Social Needs

So far we have discussed only the mental health aspects of the data. We do not wish to imply, however, that mental health is the only problem or even the most

*That is, 73.8% of the 25% with mental hospital histories.

**For an interesting alternative perspective, see Rousseau[44] and Snow,[12] who discuss psychopathology as an adaptive coping strategy for living on the streets.

important problem facing the homeless, nor do we believe that the mental health system is the sole social cause of homelessness. We found unmet human service needs and problems in a number of important areas, including permanent housing and temporary shelter, employment, job training, income, social support, physical health, substance abuse, food, clothing, and personal safety. Most of the homeless, including those with psychiatric problems, face many of these difficulties. Specifically, the cluster analysis results revealed that the majority of the homeless are characterized most accurately not by mental health problems but by high levels of need for employment, permanent housing, job skills, and income. Further, the mental health subgroup, although identified by markedly high levels of psychiatric symptoms and needs, also manifested these core socioeconomic needs for housing, employment, job training, and income. Therefore it appears reasonable to conclude that most of the homeless, including those with serious mental health needs, have a multifaceted set of problems. Basic socioeconomic requirements appear to be particularly important.

These results point to basic inadequacies in the social welfare system. The great majority of the homeless are far below the safety net of social assistance services. Few are receiving needed services, especially in such critical areas as housing aid, employment assistance, and financial help.

As well as illuminating a deficiency in the social assistance system, our results also suggest broader social causes of homelessness. Specifically, as Snow[12] and others have argued, employment and low-income housing problems are implicated as causal factors. Deinstitutionalization also appears to be a contributing causal factor, as evidenced by the 18% of the homeless in the current study who were hospitalized for psychiatric problems before ever becoming homeless. In sum, homelessness is a multidetermined social problem (for a more extensive discussion of the causes of homelessness, see Chapter 1).

Interventions to ameliorate and prevent homelessness also must be multidimensional. A number of mental health services are needed, as discussed previously. Yet assistance must extend beyond the mental health system to have a far-reaching impact on homelessness. Specifically, widespread employment, job-training, and low-income housing programs are needed, both to enable homeless people to attain a more stable social status and to prevent future cases of homelessness. Increased income assistance also will be necessary.

In order to provide the comprehensive services needed by the homeless population, the social service delivery system must be reorganized. Services for the homeless currently depend primarily on private and public shelters for most of their assistance. Unfortunately, shelters are organized only to meet the immediate needs of food and temporary lodging; the longer-term needs of employment, physical and mental health, and permanent housing go largely unmet. A better method of meeting these needs could be achieved through the development of a new type of organization, namely homeless resource centers.

Homeless Resource Centers

The principal mission of homeless resource centers would be to facilitate the provision of resources that are required for the comprehensive needs of the homeless, with particular emphasis on services and resources that are needed most to achieve nonhomeless status. The resource center is similar both to approaches taken with other populations[35–36] and to the conception of a comprehensive "clear-

inghouse" for homeless people, recommended long ago.[37] Implicit in this approach is the view that the highest-priority need is for social resources and support, not for personality reconstruction.

Direct service staff members of the resource center should be linkage specialists who are trained in individual and ecological assessment, service linkage, and advocacy techniques, and who have a working knowledge of relevant social service agencies and their organizational practices.[36,38] Staff members also should be trained in crisis intervention techniques.

Resource centers should be located conveniently within the ecological context of homeless people, with equal access to all. Initial contact with the resource center for homeless clients might occur as a result of referrals by shelter staff members, other homeless persons, or outreach contacts, or through walk-ins.

Upon first contact, a linkage specialist should perform a comprehensive assessment of the homeless person's human service needs. Priorities should be established, and a strategy should be developed for obtaining the needed resources. To expedite bureaucratic processing, the linkage specialist then would work with each client on the applications required by other agencies. Repeated follow-up visits would be scheduled; the same staff member would act subsequently not only as a case manager and a broker of services but also, as necessary, as a case advocate[39] to help the client obtain the needed resources. The staff member also should seek to provide emotional support to the client and to offer crisis counseling if warranted. Although regularly scheduled follow-up visits should be made, each linkage specialist should maintain flexibility to provide service in an open "encounter approach"[40] for persons whose needs and characteristics are not served well by traditional service-by-appointment schedules or by intensive contact with service providers.

Resource center staff members also should provide indirect and group services. In particular, they should pursue class advocacy[39] as needed to obtain resources. Staff members also may seek to organize homeless people into self-help and advocacy groups, such as those that have been successful elsewhere.[41–43] Finally, resource center staff members should provide consultative services to shelter staffs and should make outreach contacts within shelters.

Resource centers can be funded through any combination of federal, state, or local (e.g., city or United Way) funds. The resource center may be operated most successfully by a general human service agency rather than by a mental health agency, in keeping with the emphasis on the comprehensive range of problems facing the homeless.

The recommendations suggested here go far beyond the mental health field, but exactly this type of comprehensive approach is needed if the complex, multifaceted problems of all homeless people are to be addressed adequately. The policy changes needed to implement these and other recommended interventions are addressed in Chapters 25 through 27.

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III

Health

11

Health and Health Care of Homeless People

René I. Jahiel

INTRODUCTION

Information relevant to the health status of homeless persons is fragmented and has come forth only recently. Health programs focusing on homeless people were virtually nonexistent until the 1970s. Spurred by individuals who had become aware that homeless people were the most medically underserved people in their community, a few local health care programs with modest funding targeted homeless people and residents of single room occupancy (SRO) hotels in the 1970s.[1–3] Experiences gathered in such programs were reviewed in the first contemporary monograph on the health care of homeless people, which was published in 1985.[4]

In the early and mid-1980s, several local surveys of homeless people were conducted under sponsorship of varied agencies or institutions,[12–16] including the National Institute of Mental Health (NIMH).[5–11] Also in the mid-1980s, the Health Care for the Homeless Project was established by the Robert Wood Johnson Foundation and the Pew Memorial Trust in association with the National Conference of Mayors.[17] This program, a clinical demonstration program with a strong data collection component, supported demonstrations of ambulatory care delivery to homeless people in 19 large American cities between 1985 and 1989.[18] As the Johnson–Pew Program demonstrations were entering their final years, a new federal program, Title VI-A of the federal McKinney Act (McKinney Health Care for the Homeless Program), began to provide support to states or large cities for ambulatory care delivery to homeless people.[21] In 1987, Urban Institute researchers interviewed a

René I. Jahiel • Graduate School of Management and Policy, New School of Social Research, New York, New York 10011.

random sample of 1,704 homeless adults who used soup kitchens or shelters in 20 cities with a population of 100,000 or more.[20] In addition, throughout the decade, local studies targeted special populations or health problems among the homeless. In 1988, the National Academy of Sciences Institute of Medicine reviewed the recent empirical literature on health and human needs of homeless people in a monograph published late in 1988.[19]

This chapter is organized to provide an overview of recent literature concerning health status and health care of homeless persons in the United States. Empirical findings from national and local studies conducted in clinical and nonclinical settings are reviewed. The discussion is organized around the following questions: (1) What is the health status of homeless people? (2) To what extent do health problems precipitate or perpetuate homelessness? (3) To what extent and in what ways does the homeless situation increase the frequency, chronicity, and severity of health problems? (4) What are the health care resources and delivery systems that are available to homeless people? (5) How may the present health care system in the United States be modified to contribute to the prevention of homelessness or to the amelioration of health problems for homeless people?

HEALTH STATUS OF HOMELESS PERSONS

Available Literature

Information about the health status of homeless persons is derived from two types of studies: those based on samples of the homeless population and those based on samples drawn from homeless persons in treatment.

Population-Based Studies

Surveys of Homeless Persons. Recent surveys of homeless persons[5–16,20] are quite diverse with regard to their definition of homelessness, geographic site, sampling frame, and sample size. Nevertheless, these studies encompass a relatively restricted homeless population universe.[23] They seldom include people who are doubled up with other households; usually they underrepresent certain homeless groups including runaway youths, families with children, battered women (with one notable exception),[16] homeless people in rural areas (with one exception),[8] and homeless people in small cities or areas with low densities of homeless population.

Information was derived from personal interviews, an approach that presents certain problems. First, self-reports tend to highlight the health problems that are most salient in the respondents' minds either because of their recency or because of their functional or psychological significance. Furthermore, question structure may affect significantly the answers given. For instance, 4.4% of a sample of homeless adults reported a toothache or dental caries in response to an open-ended question, but 27% reported a toothache during the previous month when asked specifically.[24] Finally, homeless people often tend to underestimate the severity of their health problems, in part because of the implications of severe health problems for their self-image and their survival in their already dismal situation.[25–27]

The Baltimore Study. One population-based study in Baltimore[22] included a sample of 195 homeless adults, 131 of whom were in missions or shelters and 64 of

whom were in jails. In addition to self-reported information, the study included a thorough screening examination, including anamnesis, physical examination, and comprehensive laboratory work. A representative population-based sample is likely to present a truer prevalence of health problems in the population from which it was drawn than will clinical samples. Such comprehensive screening examinations, however, tend to highlight chronic conditions in contrast to acute ones; in addition, because of the thoroughness of the examination, they often show a higher frequency of relatively minor conditions than those that occur in studies based on clinical examinations or on self-reports.

Treatment Samples

Studies of persons in treatment (i.e., clinical studies) are likely to contain selection and diagnostic biases because they may underrepresent people who are in good health, who do not seek health care when they are sick, or who have access to other medical care. Furthermore, data extracted from clinical records tend to highlight the presenting condition and often are incomplete with regard to chronic and other conditions of the same patient. Two prominent clinical studies are outlined next.

Johnson–Pew Health Care for the Homeless Clinical Data.[18] The Johnson–Pew Health Care for the Homeless Program (Johnson–Pew Program) included 19 ambulatory care projects, each in a large U.S. city. The data were extracted from medical records of patients seen at program facilities. About 85% of the encounters were with patients who were homeless at the time of the visit.

The data base is large, containing 29,694 adult and child patients as of June 1986. The data include not only information contributed by the patient and recorded in the chart but also the results of physical examination, laboratory tests, and reports from other sites where the patient was treated.

McKinney Health Care for the Homeless Outpatient Data.[21] The McKinney Health Care for the Homeless Program (McKinney Program), which was implemented in 1988, was modeled after the Johnson–Pew Program but serves a larger patient population. Funded by grants from the Bureau of Health Care Delivery and Assistance (BHCDA) of the Health Resources and Services Administration (HSRA), the McKinney Program had 109 grantees in 41 states who provided 783,336 encounters to 231,068 homeless persons during calendar year 1988, its first year of operation (see Figure 1). About 30% of the patients whose family status was known belonged to homeless families, and more than 21% of the patients were homeless children aged 0–19. The current housing status of 132,254 patients included 46.7% in shelters, 10.7% in transitional housing, 11.2% in doubled-up households, and 12.7% on the street.[23]

Evidence

Homeless Adults

Self-Reported Health Status. In local studies, from 33% to 48% of homeless respondents reported their health to be poor or fair, compared to 18% to 21% in the general population. From 20% to 50% of homeless respondents reported a chronic health problem such as hypertension, arthritis, or diabetes (several studies are detailed in

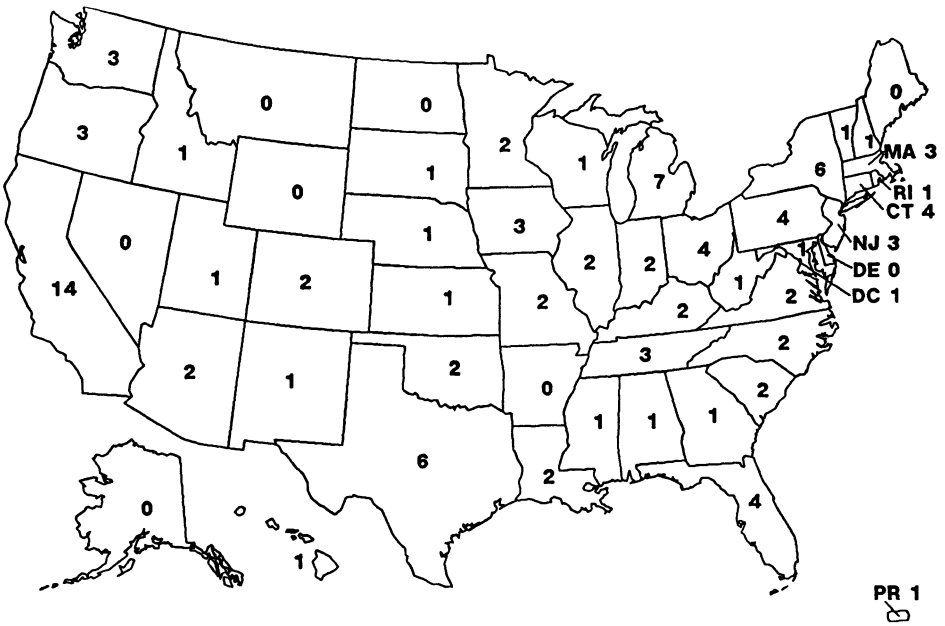

Figure 1. Distribution of McKinney projects across the United States.[21]

Table I). Some conditions found frequently in medical examinations of homeless people, such as skin diseases, infestations, or dental problems, were seldom mentioned. It may be that they are so common in this population that they are deemed not worth mentioning or that they have less salience than other conditions with more significant functional or psychological implications.

Medical Examinations. The Baltimore study shows the high prevalence of chronic physical conditions in a sample of homeless persons living in shelters or jails. The thorough search for pathology yields a high frequency of chronic conditions, including arthritis (28%) and cardiovascular problems (50%). Also, the dental disorders included missing teeth in half of the subjects and dental caries in one-third. Problems of the reproductive system were found in 64% of examined women, including dysmenorrhea or menopausal symptoms in 42% of the women. The skin conditions found in 57% of the sample included acne in 28%, cords, calluses, and fungus infections each in 20% of subjects, and dry skin in 26% of men.[22] These conditions are seldom a cause for a medical visit in low-income populations, and therefore they are more likely to be reported in population-based studies than in clinical studies.

Clinical studies tend to emphasize a single, primary reason for a treatment encounter rather than a thorough health evaluation. Therefore the Baltimore study is not directly comparable to the clinical studies. Nevertheless, reported prevalence was 2 to 10 times greater in the Baltimore study than in either clinical study for all chronic conditions except hypertension. On the other hand, injuries and acute respiratory infections were more prevalent in the clinical studies. As explained earlier, these differences were expected because of the differing emphasis in population-based screening and clinical examinations.

The number of diagnoses per patient in the Johnson–Pew Program increased

Table I. Population Surveys: Self-Reported Health Status

Senior author	Robertson[13]	Morse[5]	Roth[8]	Farr[9]	Rossi[14]
Location[a]	Los Angeles	St. Louis	Ohio	Los Angeles	Chicago
Year of survey[b]	1984	1984	1984	1985	1986
N[c]	238	248	979	374	722
Percentage male	77	50	61	96	76
Percentage black	30	64	30	29	53
Mean age	37	31	37	38	40
	Percentage responding affirmatively[d]				
Health: fair or poor	33.7				36.6
Health caused homelessness				3.9	
Health prevents employment	21.2	12.6	21.0	23.5	28.3
Any chronic illness	38.4	50.4	30.8	19.7	
Arthritis	4.6	10.9	5.1	3.8	13.5
Any neurological seizures	1.4		3.5		9.0
Hypertension	9.6	16.9	4.0	4.1	17.0
Peripheral vascular disease		11.5			
Chronic respiratory	3.7	4.8	2.9		
Digestive			2.7	4.0	
Genitourinary		6.9	0.9		
Diabetes, other endocrine	2.3		1.9	2.5	2.5
Anemia, other blood		10.5	0.7		
Injuries	9.9			21.0	9.0

[a]Location. Specifically, Robertson *et al.*'s survey was conducted in skid row of downtown Los Angeles and in western areas of Los Angeles, such as Venice; interviews took place in soup kitchens, day centers, shelters, and parking lots; sample was mainly a convenience sample. Morse's survey was conducted in 13 St. Louis shelters, with a probability sample that was stratified to have an equal number of men and women. Roth *et al.*'s survey was conducted in the state of Ohio, with a systematic sample of the different regions of the state and of urban versus suburban/small towns versus rural areas. A large number of sites was used to gain access to homeless people who were sleeping in the street, shelters, hotels, or doubled up with another household. Farr *et al.*'s survey was limited to the skid row area of Los Angeles, with a probability sample of homeless people in shelters, meal services, and congregating areas. The largest homeless women's facility in the area did not participate. Rossi *et al.*'s survey was conducted at night in probability samples of the streets and shelters of Chicago.

[b]Year of survey means the year the survey was completed.

[c]*N* is the total number of respondents. This is not necessarily the same as the number of respondents to each question.

[d]The denominators repesent the number of people who responded to the particular question.

with the number of visits or other encounters due to a combination of patient selection factors and the completeness of recorded diagnoses. For example, patients with several chronic illnesses may use medical care more often than other patients. In a given episode of illness, the attention of health professionals may be directed to the presenting complaints in the first visit; other problems may be investigated in follow-up visits. Conversely, a more thorough examination than usual at the first encounter might not only reveal several conditions but also trigger additional visits. On the other hand, many one-time encounters occur in large-scale single-disease screening initiatives (e.g., for hypertension) or for minor complaints such as a superficial cut or a head cold; in such instances the patient would not receive a general physical and laboratory examination. Finally, if there is a given probability that a certain condition will be recorded per encounter and if the probabilities of recording it at different encounters are at least partly independent, one would expect that the probability of recording the condition per patient would increase as the number of encounters with that patient increases.

Table II shows the prevalence of conditions in the Johnson–Pew Program study, first for all patients and then only for those patients with two or more encounters; the latter data are believed to be closer to the true prevalence of the condition in the

treatment population.[18] Nevertheless, although these prevalence figures are drawn from a national sample, it is still a sample that sought treatment, and findings cannot be assumed to generalize to the larger homeless population.

Comparable data from the McKinney Program study are figures based on all patients who had one visit or more (Table II). The prevalences observed in all patients in the two studies are generally of the same order of magnitude, but there are some differences. For instance, the prevalence of peripheral vascular disease (PVD) is greater in the Johnson–Pew Program. This finding might be compatible with the higher representation of individuals who live in the street in the Johnson–Pew Program because the conditions of life in the street are expected to aggravate PVD.

Table II shows the prevalence of diagnosed health problems in the Johnson–Pew Program, compared to a nonhomeless clinical sample (NAMCS) as reported by Wright and Weber.[18] The NAMCS data include a national representative sample of ambulatory care patients, regardless of number of encounters. The ratio of medical problems among homeless patients to those among NAMCS patients is compatible with the experience of physicians or other health workers who treat homeless people.

The prevalence ratios shown in the last two columns of Table II should not be interpreted as the risk of homeless relative to nonhomeless individuals because the distribution by age, sex, and economic status—factors that markedly affect the prevalence of many conditions—differ noticeably across the two clinical populations. Furthermore, differing utilization patterns in the two populations may affect findings. For instance, NAMCS patients are more likely to go to a dentist for dental problems; this tendency would explain the low prevalence of dental conditions. Domiciled people, as noted by Wright and Weber,[18] would treat their colds or other limited illnesses with medications without seeing a physician, whereas homeless people who cannot afford to buy their own medication may seek help from one of the Johnson–Pew facilities, thereby generating an encounter and a diagnosis.

Despite these various methodological problems, however, several features of Table II deserve notice:

1. One group of diagnoses is at least 10 times more frequent in the homeless sample than in the NAMCS nonhomeless sample, and its prevalence in the Baltimore sample is well above that expected in general population screenings. This group includes infestations (e.g., lice, scabies), seizures, peripheral vascular disease, dental problems, and undernutrition.

2. Respiratory infections (i.e., mild upper respiratory infections, severe respiratory infections, tuberculosis) were most frequently the primary reason for visits cited among the homeless and were two to five times more frequent than in the NAMCS sample.

3. Injuries occurred with very high frequency in the homeless sample and were second only to upper respiratory infections as the primary reason for visit. There are no summary data for injuries in the NAMCS study, but comparisons of specific injuries such as lacerations, burns, and fractures show that the homeless persons are much more likely to seek treatment for injuries.

4. The prevalence of several health problems that generally increase with age, such as hypertension, cardiac failure, chronic bronchitis and obstructive pulmonary disease (COPD), and chronic liver disease, are moderately higher in the homeless than in the NAMCS sample. Yet they would be expected to have a much lower prevalence in view of the relative youth of the homeless patients. The relative

prevalence of these diagnoses would be considerably higher in an age-normalized comparison of the two populations.

5. Cerebrovascular accidents and cancer have a lower prevalence in the homeless sample. Although the age differential undoubtedly accounts for at least part of the difference, other factors such as decreased survival or increased institutionalization of homeless people with these conditions may also play a role.

Inpatient Studies. Two studies of homeless people as inpatients of acute general hospitals provide another window on the health status of homeless people.[28–29] Not all homeless inpatients may have been identified because many may have given their last address or an address at which they receive mail or which they use for benefits. Nevertheless, these studies yield at least two salient findings. The first is the extremely high frequency of cellulitis, which is usually a complication of untreated or poorly managed trauma or local infections and is an unusual admitting diagnosis in domiciled populations. Cellulitis constituted as many as 24% of primary admitting diagnoses in the hospitalized homeless population. Second, other trauma-related diagnoses (e.g., lacerations, fractures, and head trauma) also were high, nearly 22% in one study.[28]

Mortality Studies. Most professionals who work with homeless populations agree that the mortality of homeless adults is considerably higher than among domiciled adults. Supporting empirical findings are rare, however. A mortality rate is the ratio of the number of persons dying during a given period of time (such as a year) to the number of persons in the population to which those who died belonged, multiplied by a fixed number (usually 10,000). One major difficulty with this approach, however, is that the denominator (i.e., the size of the homeless population) is not known. A second difficulty is that it may be difficult to determine from the death certificate whether the deceased person was homeless at the time of death. A search of the Swedish data on causes of death among men registered with the Bureau of Homelessness between 1969 and 1971 showed that 327 deaths had occurred in that homeless population, compared to the age-adjusted expected mortality of 87, yielding a 4:1 ratio. Among men aged 20 to 39, the observed expected ratio was 9:1. The largest differential was found for death from accidents, exclusive of suicide, where the ratio was 12:1.[30]

The Johnson–Pew Program provided some evidence that the death rate among its homeless patients was higher than expected age-adjusted death rates. Of the 87 patients *known* to have died by 1986, the cause of death was known for 61. There was an extremely high relative frequency of murder and accidents (39.3% of the 61 deaths) and a high relative frequency of drug- or alcohol-caused deaths (16.4%), both of which are far above expectations for the general population in the same age range. The case histories of the deceased suggested the disproportionate amount of violence in their environment, the contributing role of alcohol or other drug abuse, and insufficient access to health services.[18]

Homeless Pregnant Women

Many pregnant women are seen at ambulatory care centers for homeless people. An estimated 5.5% of women seen in 1988 at the McKinney Program facilities[21] and 9.8% of all women (and 11.4% of women seen two or more times) at the

Table II. Prevalence of Health Problems Detected by Medical Examination of Homeless Adults

		Percentage of individuals with health problem					Ratio of Johnson–Pew to NAMCS prevalence	
				Johnson–Pew[18]				
Organ system	Diagnosis	Baltimore[22]	McKinney[21]	All[a]	⩾2[a]	NAMCS[b]	All	⩾2
Skin	All	57.0	10.5					
	Acute, minor	28.0		9.8	13.9	5.0	2.0	2.8
	Acute, severe			2.7	4.2	0.9	3.0	4.7
	Infestations	10.0		3.3	4.9	0.1	33.0	49.0
Musculoskeletal	All except trauma	40.5		6.6	10.2	9.5	0.7	1.1
	Arthritis	28.0		2.7	4.2	3.7	0.7	1.1
Neurological	All	35.0		5.6	8.3	1.8	3.1	4.6
	Seizures	10.0		2.8	3.6	0.1	28.0	36.0
Cardiovascular	All	50.3						
	PVD	25.0	2.5	9.1	13.1	0.9	10.1	14.6
	HTN	17.0	9.2	10.4	14.2	8.0	1.3	1.8
	CHF	10.0		4.4	6.6	6.2	0.7	1.1
	CVA			0.1	0.3	0.7	0.1	0.4
Respiratory	All	40.0						
	COPD	20.0		3.2	4.7	3.2	1.0	1.5

	RI, mild			23.6	33.2	6.7	3.5	4.9
	RI, severe			2.2	3.4	1.0	2.2	3.4
	Tuberculosis		0.5	0.3	0.5	0.1	3.0	5.0
Mouth and teeth	All	67.5						
	Dental		7.5	7.0	9.3	0.3	23.3	31.0
Digestive	All	41.5	5.8	9.2	13.9	5.6	1.6	2.5
	Liver disease			0.9	1.3	0.3	3.0	5.3
Urinary	All	24.6		4.1	6.6	2.9	1.4	2.3
	Male GU	12.5		1.3	1.9	3.2	0.4	0.6
Female genital	All	64.0		11.3	15.8	7.3	1.5	2.2
Endocrine	Diabetes	4.0	1.4	1.8	2.4	2.7	0.7	0.9
	Others			1.4	2.2	1.6	0.9	1.4
Nutrition	Obesity	21.6		1.5	2.3	2.7	0.6	0.9
	Undernutrition	19.0	5.2	1.2	1.9	0.1	12.0	19.0
Hematological	Anemia	24.6	4.3	1.3	2.2	0.9	1.4	2.4
Sense organs	Vision/eye	16.0		5.0	7.5	5.5	0.9	1.4
	Hearing/ear	10.0		3.4	7.1	1.6	2.1	4.4
Injuries	All	5.1	7.8		23.6			
	Lacerations			6.3	8.6	1.2	5.3	7.3
	Burns			0.8	1.1	0.2	4.0	5.5
	Fractures			3.1	4.5	2.2	1.4	2.0
Cancer				0.4	0.7	3.5	0.1	0.2

Note. Abbreviations: PVD, peripheral vascular disease; HTN, hypertension; CHF, congestive heart failure; CVA, cerebrovascular accident; COPD, chronic obstructive pulmonary disease; RI, respiratory infection; GU, genitourinary system.
[a]All, all patients; ≥2, patients seen at least twice.
[b]NAMCS, National Ambulatory Medical Care Survey.

Johnson–Pew Program facilities until mid-1986 were pregnant.[18] In the latter program, more than 20% of women aged 16 to 24 were pregnant.[18]

Homeless Children and Youths

Perinatal Morbidity and Mortality. In a landmark study of deliveries among homeless women who gave a welfare hotel as address in New York City between 1982 and 1984,[31] 401 single births took place. The rate of low birth weight (below 2,500 g) was 16.3%, as compared with 11.4% in a low-income housing comparison group and 7.4% in the city as a whole. The infant mortality rate (number of deaths within the first 4 weeks of life per 1,000 live births) was 24.9 in the homeless group, as compared with 16.6 in the low-income housing group and 12.0 in the city as a whole. The differences in low birth weights and infant mortality between the homeless group and the low-income housing comparison group were significant.

Young Children. Results of clinical studies of homeless children under age 15 by the Johnson–Pew Program for 1985 and 1986 and by the McKinney Program for 1988 have been published.[18,21] Children constituted only 10% of the Johnson–Pew Program and about 15% of the McKinney Program patients,[21] in contrast with the estimated national rate of 25% of the homeless.[32] If we assume that the national estimate is accurate, the observed difference suggests that children are underrepresented relative to adults in the Johnson–Pew Program study.

There are some unexplained differences between the McKinney Program and the Johnson–Pew Program; in particular the prevalences of anemia and undernutrition are much higher in the McKinney Program. This difference may be related to any of several factors. For example, the Johnson–Pew Program data were collected in 1985–86, whereas data for the McKinney Program were collected in 1988. The health status of the homeless children populations may have changed during that interval. Also, differing diagnostic criteria may have been used in the two studies, especially with regard to the thresholds for malnutrition and anemia in children.

When the Johnson–Pew Program data for children seen two or more times were compared with NAMCS data for 1979,[18] the children in the Johnson–Pew Program had higher frequencies of all diagnoses than did the nonhomeless children. Diagnoses that were at least 10 times more frequent were skin infestations, seizures, and dental problems.

Johnson–Pew Program data collected through December 1987[33] also reported that children constituted 10% of their patients and that the prevalence of anemia and nutritional deficiency was about 2%. The excess prevalence of diagnoses in the Johnson–Pew Program data in relation to NAMCS was somewhat greater among children aged 5 and younger. As with earlier findings, an excess prevalence was noted for skin infestations, seizures, dental problems, and nutritional deficiency.

Homeless children have an excess prevalence of acute and chronic conditions over poor children,[33] who, in turn, have more health conditions than nonpoor children.[34–35]

Observers express concern about developmental, learning, and other disabilities in homeless children. This concern is based not only on expected damage to growing children due to conditions of homelessness[36] but also on early findings of increased prevalence of such disabilities. Acker *et al.* reported decreased height and weight as well as decreased linear growth in homeless children.[37] In a Boston study, 44% of homeless children aged 5 or younger in Massachusetts shelters had at least one

developmental lag.[38] In Boston, homeless children had a single developmental lag rate of 54%, compared to 16% in poor but domiciled children.[39] In St. Louis, 67% of children under age 5 in a shelter for homeless families had a language disability.[40] In the McKinney Program study, 5.6% of individuals under age 21 had a primary diagnosis of developmental delay.[21] This finding understates the actual prevalence because developmental delay often appears as a secondary diagnosis in children with other primary diagnoses. It is not possible on the basis of these studies to determine the role of previous life experience or of the proximate environmental conditions during examination and testing in producing the observed low scores. Nor is it possible to say whether observed delays would be reversible. Nevertheless, the presence of developmental delays of such high frequency is alarming.

Homeless and Runaway Youths. Homeless and runaway youths were estimated in 1988 by the National Conference of Mayors to account for 5% of homeless people,[32] but they constitute a highly invisible group and represent a higher proportion of the homeless population. These youths are subject to high rates of malnutrition, sexually transmitted disease, murder, and sexual assault.[41,43] About one-quarter of a Hollywood street sample of homeless youths reported their health as only fair or poor, and 66% reported health problems in the preceding 6 months. A majority had been victimized, including 12.5% by sexual assault and 42% by other physical assault. Almost half of the females had ever been pregnant (44%), 17% had become pregnant while homeless, and 11% were pregnant at the time of interview.[43]

Homeless youths attending a medical clinic in Los Angeles showed a significantly higher diagnostic rate of heart conditions, kidney failure, pneumonia, hepatitis, generalized lymphadenopathy, trauma, and rape than domiciled youths using the same clinic.[42] A relatively high prevalence of human immunodeficiency virus (HIV) infections was found in a clinical sample of homeless youths in New York.[45]

Distribution of Health Problems

We will give a brief overview of the association between demographic variables and health problems of homeless people before we consider the causal relations between homelessness and health status.

Age. Patterned associations of age with diagnostic prevalence are revealed in Johnson–Pew Program clinical data on homeless people seen two or more times.[18]

As expected, the data showed increased prevalence with age for arthritis, hypertension, heart failure, cerebrovascular accidents, COPD, chronic liver disease, and neoplasms. Furthermore, in most of these instances, the increase with age is independent of the effects of the other variables.[18]

After age 65 there is a sharp drop in prevalence of seizures, chronic liver disease, and, to a lesser extent, hypertension and diabetes, which may suggest high early mortality among homeless people with these conditions. Other health problems, which have a high frequency in the homeless population, have a prevalence that either is independent of age (e.g., skin disorders and infestations) or increases or decreases less than one would expect with increasing age (e.g., peripheral vascular disease and undernutrition or trauma, respectively). These findings suggest that the association of these diagnoses with homelessness is more important than that with age.

Gender. Several studies compared perceived health status in homeless men and in homeless women with mixed results. Although Robertson *et al.*[13] found more women than men reporting fair or poor health, other studies found no gender differences.[5,45,47] In studies that included medical examinations, the relative prevalence of specific diagnoses in men and in women was similar to that expected from studies of domiciled populations.[18,22]

Ethnicity. Ethnic distribution in the surveys varied considerably across sites (Table I). The representation of blacks in the local homeless sample, however, was always greater than in the general population in the same city. Hypertension, which generally occurs more frequently in young blacks than in young whites, was self-reported more often in the St. Louis[5] and Chicago[46] studies than in Los Angeles,[13] where the percentage of blacks in the population was smaller. The 1986 Johnson–Pew Program data showed that independent of all other variables in a regression model, blacks had higher rates of seizure disorders, chronic diseases in general, and hypertension than whites, and lesser rates of gastrointestinal ailments, trauma, PVD, and COPD.[18]

Alcohol Abuse and Dependency. Alcohol abuse or dependency was found in 73% of subjects in the Baltimore screening study[22] and in 38% of adults (47% of men and 16% of women) in the 1986 Johnson–Pew Program study. The frequency of alcohol or drug abuse as primary diagnosis was only 16.8% in the McKinney Program study,[21] but after the Wright–Weber correction for expected underreporting was applied,[18] the prevalence was adjusted to 38.7%.

The 1986 Johnson–Pew data suggested that alcohol abuse was associated independently and significantly with increased rates of liver disease, seizure disorders, hypertension, COPD, gastro-intestinal ailments, and trauma within that treatment sample. The frequency of these conditions also increased in association with alcohol abuse in domiciled populations.[18] The relationship of homelessness and alcohol abuse to these disorders was additive rather than synergistic.[48]

Other Drug Abuse. In the 1986 Johnson–Pew Program, the rate of drug abuse, adjusted in the same manner as alcohol abuse, was 13%. Drug abuse was associated independently with significantly higher rates of liver, cardiac, or peripheral vascular disease and of chronic physical conditions in general. Drug abuse also was associated with serious skin ailments and with autoimmunodeficiency (AIDS) or AIDS-related conditions. The rate of pregnancy among drug-abusing women was 26% higher than among other women in the sample.[18]

Mental Disorders. A study of three California counties of homeless respondents with severe mental disorder (SMD) reported lower perceived health status than those without SMD.[15] In Los Angeles skid row, perceived health was poorest among homeless adults with alcoholism or with alcoholism and major mental illness combined.[49] In another Los Angeles study, duration of depressed mood was a predictor of perceived poor health.[50]

The Baltimore screening study disclosed no statistically significant differences in the frequency of medical diagnoses between subjects with and without mental disorder, except for a higher rate of gastrointestinal disorder in women with major mental disorders.[21]

In the Johnson–Pew Program, nutritional disorders and seizures were 2.3 and

2.7 times greater among women patients with mental illness than among those without.[18] Diagnosed mental illness was related to higher seizure rates and lower trauma rates. The effects of mental illness and alcohol problems were additive but not synergistic.[18]

Other Factors. Patients of the Johnson–Pew Program who were members of homeless family groups had significantly less trauma and PVD than did lone homeless individuals.[18] In Ohio, more people staying on the streets or in shelters reported health problems than did those in hotels, in motels, or doubled up[8]; those who had spent the previous night in the street reported more chronic conditions than did those who had slept in shelters. In Los Angeles, perceived health status appeared to be related to having a chronic condition, having visited a physician for an acute condition, and alcohol symptomatology.[50]

Overview

Homeless populations are heterogeneous with regard to health status as well as other characteristics. A large number of homeless persons (in some studies, the majority) report good to excellent health and no chronic or acute health problems.

As a group, homeless adults have lower perceived health status than domiciled adults. In clinical samples, whether ambulatory or hospitalized, the health problems among the homeless differed markedly from those of the nonhomeless; the limited available evidence, however, suggests that homeless adults and children have more injuries and illnesses than the general population, after age is adjusted for, and that certain conditions are much more frequent in the homeless. Relatively few comparisons of health status indicators have been made between homeless and other poverty populations. Where this has been done—for instance, in rates of low birth weight or infant mortality—poverty populations had rates intermediate between homeless and general populations.

Persons in shelters or on the streets tend to have worse health status than those in hotels or doubled up. Limited evidence suggests that health status may be related to gender, age, ethnicity, alcohol or drug abuse, or mental disorder, as in domiciled populations. The very limited information suggests that mortality of homeless persons appears to be high.

HEALTH PROBLEMS AS FACTORS THAT CONTRIBUTE TO HOMELESSNESS

Although poverty and the lack of affordable housing are the major causes of homelessness, a large number of factors interact over a period of time to determine who becomes homeless and when.[7–9,51–55] Rosnow and colleagues grouped causal factors into three types: market factors (e.g., the housing and job markets), mediating conditions (e.g., history of mental illness, alcoholism or other drug abuse, or criminal conviction), and precipitating factors (e.g., displacement, loss of a job, loss of welfare or service support, household conflict).[7] Furthermore, Sosin *et al.*[53] suggest the value of taking into account distant as well as current factors. Bassuk[56] and others[53,57–58] suggest taking a lifelong approach dating as far back as childhood in order to understand the causation of homelessness.

Health problems clearly could play a role at several points along such causal networks, although their relative impact would be hard to assess. For example, if an

illness led to unemployment followed by poverty, to inability to find affordable housing, and eventually to homelessness, it would be difficult to gauge the relative impact of the initial health problem. Even in relatively simple situations, it may be difficult to assign a prime causal role to a health problem. For instance, an elderly woman who lives alone in an apartment in a building undergoing gentrification and displacement pressure develops pneumonia, is hospitalized, and returns to her apartment after several weeks to find that her things have been moved out and her apartment rented to someone else.[59] Depending upon one's perception of the situation, one might assign the principal reason for homelessness to the health problem, to the hospital that failed to provide sufficient social protection during hospitalization, or to the landlord's action.

The most common method for assessing causes of homelessness is asking homeless persons why they are homeless, but this approach places the brunt of the conceptual problem discussed above on the homeless person. More recently, comparison studies have been undertaken whereby homeless people and domiciled people in similar socioeconomic circumstances (except for having a home at the time) were interviewed, and their answers were analyzed to assess the association of homelessness with health problems.[53,58] This method yields association but not causal inference.

Two approaches that have more power for causal inference have not been used to a significant extent, namely qualitative studies and longitudinal panel studies of individuals or families who are at risk of becoming homeless.

Evidence

In recent survey studies of homeless people, health problems seldom were given as a reason for becoming homeless (Table I). They are mentioned, presumably as precipitating factors, in only two surveys—by 4% and 7% of respondents. There is some evidence, however, that health problems may play a greater role as predisposing factors. For instance, in the Boston survey,[6] where 7% of respondents cited health problems as primary cause of homelessness, an additional 16% cited health problems as reason for their unemployed status. Respondents in several studies report that health problems prevent employment (Table I).

The role of physical health factors in homelessness was assessed by the Johnson–Pew Program study and by the U.S. Conference of Mayors surveys.

In the 1986 Johnson–Pew Program study, a detailed case assessment and review questionnaire (CARQUEX) was filled in by a stratified probability sample from 13 projects. The CARQUEX data were derived from clients seen three or more times; this is a highly selected subpopulation, which is biased toward heavier users of services. Nevertheless, the chart reviewers assessed the importance of 22 factors as determinants of homelessness in adults. Chronic physical disorder was scored as being without importance in 78% of the cases, as having minor importance in 9%, as being of major importance in 10%, and as the most important factor in 3%.[18]

In the 1988 U.S. Conference of Mayors survey, city agency officials were asked, "What are the main causes of the problems of homelessness in your city?" Only 3 of 27 cities (Philadelphia, Salt Lake City, and San Juan) cited health problems and inadequate health care as a cause of homelessness.[32] Although expenses incurred for catastrophic illness have exhausted the resources of many people, especially elderly persons, and undoubtedly have forced some into homelessness, there are no data to estimate the number of people thus affected.

With regard to specific conditions, AIDS stands out. The problem of homeless people with AIDS surfaced as early as 1986, when a large number of AIDS patients had no home to go to, either because they had become impoverished or because of prejudice against people with that disease.[60] In a recent study of 268 hospitalized AIDS patients ready for discharge, 136 (15%) had no home to which to return. Similar numbers of patients were homeless at the time of hospitalization and had lost their homes while they were in the hospital.[61] HIV disease (the new term, which includes AIDS as well as other HIV-related diseases) may well become a prominent precipitating factor of homelessness, especially in cities such as New York, where 5,000 to 8,000 homeless people were estimated to have HIV disease in 1988.[62]

Overview

Physical health problems are relatively minor immediate precipitating factor of homelessness compared to factors such as lack of affordable housing, displacement, unemployment, or family conflict. As of 1986, health problems were identified as a precipitating factor for fewer than 5% of homeless adults and may have played some role in the chain of events leading to homelessness in fewer than 20%. HIV disease is the one physical health problem that may have precipitated homelessness in a large proportion of the cases, especially in cities with high prevalence of HIV disease.

HOMELESSNESS AS AN AGENT OF DISEASE

The phrase *agent of disease* refers here to a factor that increases the frequency, chronicity, severity, or adverse outcomes of disease. To test whether homelessness is such a factor, one first must define homelessness in this context, justify the causal inference tools that are used, and test whether homelessness in fact is an agent of disease.

Relevant to this discussion are three general aspects of homelessness that may be disease-producing or disease-enhancing: the extreme poverty of nearly all homeless people, the absence of the protective functions of a home, and the exposure to special environments such as shelters. In general, *homelessness* will refer to persons currently without their own home.

It is difficult to establish a causal link between homelessness and health problems because it is not possible to rely on the experiments or quasi-experiments that facilitate causal analysis. Instead one must rely on a combination of four approaches: survey and comparison studies, epidemiological inferences, pathophysiologic inferences, and health care inferences. Together these approaches may have considerable strength, despite the weaknesses of each when taken alone. For example, survey and comparison studies of homeless populations yield data on the relative frequency and severity of specific health problems, but they do not allow causal inferences. Yet they help to target certain conditions of high prevalence or incidence among homeless people, so that their relation to homelessness may be analyzed with epidemiologic or pathophysiologic approaches.

Epidemiologic inferences are based on knowledge of the causes of and contributing factors to disease. This method is used to identify causes (the "agents") in the environment, the ways in which the agents produce disease, the latency (i.e., incubation period) before the disease becomes manifest, and the special effects of specific agents on the body. The epidemiologic approach consists of showing

whether certain known agents of disease are associated with the experience of homelessness and whether homeless people show the effects of these agents.

Pathophysiologic inferences are based on knowledge of the reactions of the body (or host) to the disease agent and of how factors in the environment or in the host's past experience interact with the body's reaction to disease agents to change the outcome. An important concept is homeostasis—the ability of the body to regain an equilibrium that has been disturbed. The pathophysiologic approach consists of showing whether factors in the homeless environment or in the past homeless experience of the host prevent homeostasis or intensify harmful reactions of the body.

Health care inferences are based on the knowledge that certain conditions have a high likelihood of adverse outcome if left untreated or that certain diseases have an increased frequency or severity when preventive measures have not been taken. This approach consists of showing whether the homeless environment or the individual's past homeless life interferes with receiving needed preventive or therapeutic care.

Evidence

Evidence for excessive prevalence of *trauma* (physical traumatic disorders) in homeless people includes the high number of trauma-associated deaths, hospitalizations, and ambulatory care visits. Rape, in some areas, is reportedly 15 times more frequent than in the general population.[63] Although a high rate of trauma exists in some domiciled inner-city populations, the rate among homeless persons appears to be still higher. This finding is not surprising because (1) homeless people lack the protective function of a home[64]—a secluded environment with a door and a lock that keep out would-be attackers and allows sleeping in safety; (2) the homeless environment is rife with violence[65]; and (3) homeless people may be more vulnerable than others because of aging, peripheral vascular disease (which slows them down when running away), lack of sleep, depression, alcohol, illicit or medicinal drugs (which dull one's reactions), or being in an unfamiliar environment.

Thermoregulatory disorders such as heat stroke, heat exhaustion, hypothermia, and frostbite are much more common among homeless people than in the general population. This situation is due not only to increased exposure to elements in the street or in empty buildings, but also to dehydration, poor nutrition, untreated metabolic conditions, and the effects of alcohol use and inadequate clothing.[66]

Skin infestations with scabies or lice are far more common in the homeless than in the general population because of sleeping close to other homeless people and the poor hygienic conditions associated with lack of a home.[67]

Peripheral vascular diseases (PVD) have high prevalence. Venous stasis, with chronic edema, induration, and sometimes ulcers as complications, is the consequence of prolonged periods of standing, sitting, and sleeping with legs down.[68]

Bacterial or fungal infections of the skin have increased prevalence and severity in homeless people. Cellulitis, which is a common but mild disease in domiciled people when it is treated early, becomes a more severe condition in homeless populations. Indeed, next to trauma, it is the most common diagnosis in hospitalized homeless patients.[28–29] Factors associated with homelessness that appear to account for this condition are the greater prevalence of trauma; poor hygienic conditions secondary to the homeless environment, so that even a minor laceration has a greater risk of becoming infected; PVD with edema, which provides a hospitable culture medium

to the invading bacteria; and delay in obtaining treatment, which allows the infection to spread over large areas of the body or to invade the blood, necessitating hospitalization.

Diarrheal diseases used to be a major cause of infant mortality in the United States and remain so in many Third World countries. In the United States, small and easily contained epidemics continue to occur in settings such as day care centers for infants. Epidemics of diarrhea involving more than 10 persons occurred in 9 out of 73 (12%) shelters for battered women and their children; this proportion is higher than expected.[69] Causal features of such shelters may include poorly trained staff, close contact among homeless children, and infection via contaminated diapers or via the enteric–oral route.[70] The increased incidence of acute gastroenteritis among homeless people may be due to pathogenic bacteria such as *Shigella*, certain strains of *E. Coli*, protozoa such as *Giardia Lamblia*, or numerous viruses such as rotoviruses.

Food poisoning is a particular risk for homeless people who forage in garbage containers or are given leftover food. In general, food banks and soup kitchens are highly supervised and regulated to prevent food poisoning[71]; yet because of the large volume of food that passes through them, some food poisoning may be expected.

Infections and acute illnesses transmitted by the respiratory route are much more common in homeless than in domiciled people. The homeless environment itself may foster such infections. The space between beds in mass shelters and the ventilation are far less than recommended for the prevention of some infections. Several instances of diphtheria or of pneumococcal[72] or meningococcal[73] epidemics have occurred in shelters or in skid row areas.

Chronic respiratory infections, including tuberculosis, are prevalent. Infections with tubercle bacilli—revealed by the PPD skin test—as well as active tuberculosis have an increased prevalence in homeless people. There may be very high prevalence in certain shelters,[74–75] as well as in some single-room occupancy hotels (SROs).[76] For some individuals, infection may antedate homelessness because groups that have a high tuberculosis prevalence, such as alcohol or drug abusers, HIV patients, poor people, and immigrants, are overrepresented among homeless people (see Chapter 13). Tuberculosis, however, is a highly contagious disease, and the presence of unrecognized cases exposes other people in the shelter to infection. Indeed, many of the cases found in shelters are newly acquired,[77] and there is evidence of contagion occurring within shelters.[78] Tuberculosis is an easily controllable disease when chemotherapy is administered over a period of up to a year, but the conditions of homeless life often make it difficult to implement such a course of treatment. Thus homeless people are at double jeopardy. First, they are at higher risk of developing tuberculosis; then, once they have been infected, poor nutrition, lack of stable housing, and a stressful lifestyle reduce the likelihood that they will receive curative chemotherapy.[79] Another problem is the joint presence of alcoholism or liver disease with tuberculosis. Such a combination may complicate treatment because a chemotherapeutic regimen may be toxic to the liver; if such a regimen is used, very close monitoring of liver function is needed.

AIDS and other forms of HIV-related disease, which are transmitted mainly by sexual contact or by sharing infected blood (as in intravenous drug use with a common syringe), have an increased prevalence in homeless people.[45,62] In part this situation exists because AIDS at times is a cause of homelessness. The conditions of homelessness may promote the spread of HIV disease, in view of the increased frequency of rape and of unprotected sex (as suggested by the increased prevalence

of sexually transmitted diseases and the large number of homeless pregnant women)[18] and because of the high prevalence of illicit drug use among homeless persons. It is also possible that the various stresses of homelessness may help to precipitate AIDS in nonsymptomatic HIV-infected persons.

Chronic illnesses such as hypertension, cardiac failure, arthritis, chronic obstructive pulmonary disease and bronchitis (COPD), and (to a lesser extent) diabetes occur at a higher rate than expected in view of the relatively young age of the homeless population. The high representation of blacks in the homeless population may contribute somewhat to the higher rates of hypertension and diabetes. There is no *direct* evidence that these conditions contribute to homelessness, although they may well play a role by diminishing the individual's ability to compete in the labor market. Alternatively, homelessness may increase the severity of these diseases, transforming them from asymptomatic to symptomatic forms because of several factors including homelessness-associated stress, food rich in salt and carbohydrates from free meal programs,[80] and inadequate medical management of the condition.[81]

Perinatal morbidity and mortality are a problem because higher rates of premature births and infant mortality are reported for homeless persons than for domiciled people, even those below poverty level.[31] Several factors in the homeless situation contribute to this problem. For example, the prevention of threatened premature delivery in its early stage depends on bed rest,[84] something that is nearly impossible for the homeless woman to arrange. In addition, adequate caloric intake and limited salt intake are necessary to prevent, respectively, small-for-gestational-age babies and toxemia of pregnancy (pre-eclampsia). These requirements are usually not met by diets that may be available to homeless women.[36] Homeless women are exposed more to some infections that may cause fetal damage, such as toxoplasmosis, and to others, such as urinary infections, that may help to bring about premature birth.[36] Some homeless women who consume alcohol, crack, or other drugs during pregnancy are at risk of producing offspring with development defects. Finally, in view of the large number of special risks, as well as those shared with other pregnant women, homeless women have more need than any other group for good prenatal care, to which they have limited or no access.

Low immunization levels, which are widespread among homeless children,[33] place these children at risk of permanent damage from measles, whooping cough, or other preventable diseases.

Environmental hazards for homeless children include an increased risk of accidents in the homeless environments.[36] Furthermore, old layers of lead paint have been found in shelters for families with small children at the age when they are most susceptible to lead poisoning.[82]

Hazards to growth and development of children, including prematurity, poor nutrition, mother's intake of alcohol or drugs during pregnancy, infectious diseases in infancy, and lead poisoning, may put young homeless children at multiple risks of defective growth and development. When one adds the risks of parental neglect under the stress of homelessness, disrupted education, stress caused by lack of a home, and, in some instances, uncorrected visual or hearing defects, homelessness is clearly a terrible hazard to children and creates potentially irreversible effects.[33,36,82]

Overview

Evidence suggests that homelessness can be considered an agent of disease. The conditions discussed in the preceding sections are only some of those that are caused

or aggravated by homelessness. Homelessness acts in a multifactorial way, so that homeless people often are at multiple jeopardy from the effects of homelessness. Nowhere are these effects more marked and more damaging than in the case of homeless children.

The factors through which homelessness acts as an agent of disease must be identified separately, even though they often act in concert, so that preventive or remedial action can be developed. As discussed, factors include agents present in the homeless environment (e.g., agents of trauma, infectious agents, toxins), agents connected with the homeless situation (e.g., agents of PVD, infestations, heat or cold injury, inadequate nutrition, exposure to alcohol and other drugs, harmful effects of medicinal drugs, and, in various ways, stress), and deficiency in preventive or therapeutic care due to inadequate access or continuity of care.

Thus it is incorrect to assume, as is sometimes done, that the poor health of homeless populations is due only to inadequate access to care. Although access is inadequate (as discussed in the next section), this is only one of the harmful factors. To improve the health of homeless people, it is necessary to attack all the factors through which homelessness is an agent of disease: the physical environment of homeless people in the street and in shelters, nutrition in food services, the stress that homeless life imposes, the harmful habits promoted by homeless life, and inaccessible or poor preventive and therapeutic health care.

HEALTH CARE RESOURCES AND DELIVERY SYSTEMS

Health care of homeless people, as well as that of any other group, should be available, accessible, appropriately used, and appropriately delivered. Three main approaches are used to assess these features: surveys of homeless populations; ethnographic studies of homeless people; and, studies of the health services available to homeless people.

Available Literature

The survey studies referred to earlier[5–16] included questions about health services utilization, insurance and other medical coverage, and source of medical care. As pointed out earlier, the information comes directly from the homeless persons themselves and reflects their experience as they perceive it. The limitation of these surveys is that the samples may not be representative. Furthermore, in order to obtain information about many aspects of homeless life, the researchers may ask relatively few questions about health care. In addition, the wording of the questions and the closed-end format that sometimes is used tend to limit the responses to items preselected by the researchers.

In ethnographic studies, the information also comes directly from the homeless persons, but the self-report is not restricted by the interviewer's format, as it is in survey studies. Instead, the universe of items explored is structured by the subjects of the study or by the nature of the situation under observation; this arrangement allows for a much richer body of information. Ethnographic studies provide that information in the context of the ecology of the homeless situation, the processual development of that situation, and the perspective of homeless persons.[88] These studies, however, which are time-consuming and researcher-intensive, can be performed only with relatively few subjects.

Studies of health services available to homeless people may be based on clinical

documents or on actual observation. They reflect the perspective of clinicians or health researchers rather than that of homeless people.

Evidence

Barriers to health care experienced by homeless people can be divided into the external and the internal. They have been categorized by Stark as follows[89]:

External Barriers

Unavailable Services. Homeless people share with other populations a shortage of facilities or personnel. This problem, however, is much more acute for homeless people because they have far less money or available time for transportation to a distant health care site. Furthermore, the residents of certain localities, especially in suburban areas, refuse to allow the development of shelters or other facilities where homeless people could be served. This barrier to service availability is peculiar to homeless people.

Access Barriers: Lack of Funds to Pay for Services. Evidence of ability to pay is required by the majority of practitioners or facilities before the patient receives outpatient, inpatient, or even emergency services. Homeless people, being extremely poor, generally do not have the ability to pay even a small deposit. Furthermore, the great majority have no health care coverage. In two Los Angeles surveys, 81% to 89% of homeless people had no medical coverage of any kind; fewer than 10% were covered by Medicaid.[9,13] In a California survey, only 22% of homeless people with severe mental disorder and 9% of those without such disorder had MediCal (California's Medicaid) coverage.[15]

In the McKinney ambulatory care programs conducted in 1988, 76,799 of 229,068 patient charts included information about medical coverage. Of these, 74% had no medical coverage, 21% had Medicaid, and fewer than 1% had private insurance.[21] Although these data must be interpreted carefully because their representativeness is unknown, they suggest that the great majority of homeless people still have no medical coverage of any kind.

Some county or other public hospitals will take patients who have no coverage,[113] but they may try to be reimbursed eventually by their homeless patients. Furthermore, the lack of access to other facilities means that only a few facilities in the community or region are available to homeless people. This situation raises a problem of transportation.

Access Barriers: Lack of Transportation. Ambulance service usually is provided free of charge only in cases of true medical emergencies. Homeless people have to pay their way (or walk) to facilities that may be quite distant in order to meet their other health needs. Because they may have no money for the bus or other carriers and because their health condition may preclude walking long distances, transportation barriers play an important role in preventing the delivery of needed health care.

Lack of Adaptability of the Health Care System. The health care delivery system remains a provider-oriented organization. Homeless people have very strong time constraints because they must be present at food services at fixed times to get a meal, and at other sites to assure shelter for the night.[89] This situation makes it difficult to

attend clinics that operate only at certain times and that have long waiting periods and complicated intake procedures.[16] Admission criteria that limit services according to categorical diagnoses also may act as barriers when homeless people with multiple problems are refused services because of the complexity of their condition.[92]

Health Personnel-Related Barriers. Health personnel often share common misconceptions about homeless people and may be prejudiced against them. This feeling may be reinforced by the appearance of homeless people and by their inability (because of the requirements for survival in the homeless environment) to adopt the middle-class ways and values of the health care delivery system.[89] Health personnel often may feel frustrated by homeless people's lack of compliance with medication schedules or with other health measures. They may not realize that these measures may be counterproductive in the homeless environment (e.g., a medication that decreases one's alertness in an environment where one is always at risk of robbery or attack) or plainly impossible to implement because of financial constraints or other pressures of the homeless environment. Health professionals may adopt a "blame the victim"[93] attitude when faced with these problems.[94]

Lack of Accountability of the Health Care System. Homeless people often are treated with a lack of dignity[89] that is incompatible with accountability of the health care system to its clients. The quality control system of health care facilities seldom takes into account the question of the facilities ability to meet the special needs of homeless people.

Internal Barriers

Denial of Health Problems. Denial of the severity or even the presence of health problems has been documented in studies of homeless people[89–90] and SRO hotel residents.[95] This denial is due partly to the catastrophic consequences that the health problem might create for the fragile equilibrium of their lives.[95] It also may be related in part to the need for toughness in order to survive in the homeless environment and to the consequent development of a certain "macho bravado" that is incompatible with the weakness implied by illness.[89] The longer people have been homeless and the more integrated they are in homeless communities, the more they tend to underestimate their health problems.[90]

Fear of Loss of Control. In order to maintain their equilibrium as well as their carefully constructed psychological identities, homeless people must be in control of their lives.[95] They consider it too dangerous to relinquish such control to people who they believe (often rightly so) have no understanding of the obstacles or problems that homeless people face. Therefore, when an attempt is made to impose such control, often it is met with rebellion against authority.[89]

Fear of Providers' Actions. Homeless people also have much more specific fears, which, again, often are founded on reality. Undocumented workers, runaways, or others may be afraid to be sent to law enforcement officials.[16] Women may hesitate to obtain help for fear that their children may be taken away from them.[16]

Fear for Financial Resources. Financial pressures on the health care system make health facilities particularly eager to collect fees wherever there is any possibility of

doing so. Homeless people are aware of this situation and may be reluctant to use services for fear that collection efforts will impinge on their meager resources currently or in the future. One homeless man discharged after gall bladder surgery, who later found a job that paid low wages, had part of his salary deducted each month to pay for that surgery after legal action by the hospital.[89]

Personal Feelings. Homeless people feel the rejection implicit in the attitude of many providers. Often they either respond in kind or withdraw and stop seeking services. Furthermore, homeless people are aware of their appearance, their dirty clothing, and their lack of personal hygiene and feel self-conscious when they must expose themselves for physical examination.[89]

Resources Available to Homeless People

As discussed earlier, there has been progress in making health care resources available to homeless people and in removing some of the barriers. This progress has taken place in two steps, the Johnson–Pew Program of health care demonstrations (implemented mainly between 1985 and 1988) and the McKinney Programs (implemented late in fiscal 1987), a nationally supported grant program.

The Robert W. Johnson–Pew Trust/Health Care for the Homeless Program, which was influenced by the experience acquired in the care of homeless people at the St. Vincent Medical Center outreach programs,[1,4] provided $25 million over a 4-year period to 19 sites (about $1.4 million each) for community-based health care delivery programs to homeless people in large U.S. cities. Delivery sites usually were unconventional health settings such as community health centers, shelters, missions, or soup kitchens. The responsibilities of the programs were not limited to the provision of physical health care; the intent was to offer the services as a wedge into a much broader set of services needed by homeless people, such as benefits, jobs, housing, and food.[96] Thus the Johnson–Pew projects attempted to remove some of the barriers to health care, particularly financial and transportation barriers, by adapting the services to the needs of homeless people and by giving them a more accepting and more dignified reception. Although the evaluation of the program is not yet completed, it appears to have achieved at least some success in reaching these objectives.

The McKinney Act Health Care for the Homeless Program was established just as the funding for the Johnson–Pew projects was about to expire. The program funded these projects as well as 90 other projects, for a total of 104 grantees in 41 states (Figure 1). In the Stewart B. McKinney Homeless Assistance Act (PL 100-77)[97] Congress authorized $432 million in Fiscal Year 1987, of which $335 million were appropriated, and $616 million in Fiscal Year 1988, of which $364 million were appropriated.

This act is a comprehensive package of homelessness legislation in which each title or subtitle deals with a different need of or service for homeless people. Title VI-A created a Section 340 of the Public Health Service Act to fund and administer the Health Care for the Homeless Program, designed after the Johnson–Pew Program of the same name. The program was administered through the Health Resources and Services Administration (HSRA) Bureau of Health Care Delivery and Assistance (BHCDA). The McKinney Health Care for the Homeless Program was funded with $44.5 million, granted late in Fiscal Year 1987 to 109 projects in 43 states. About half were administered by existing community and migrant health centers; half were administered by nonprofit coalitions, inner-city hospitals, and local public health

departments, with starting dates effective January 1, 1988. Federal funding was supplemented by 25% nonfederal matching funds from private and local or state public sources in Fiscal Year 1988, increasing to 30% in Fiscal Year 1989.[98]

The McKinney Program projects were required to do the following:

- To provide primary health care, mental health care, and substance abuse services in locations accessible to homeless people
- To make referrals for mental health services if such could not be provided directly
- To provide access to emergency health services
- To refer homeless persons for necessary hospital services
- To assist homeless people in establishing eligibility for assistance and in obtaining services or benefits under entitlement programs
- To conduct outreach services.[21,98]

A critical feature of the program is its outreach:

> Health care teams provide care in shelters, soup kitchens, welfare hotels, campgrounds, through mobile vans, and on the streets. Most section 340 grantees report that they would be unable to maintain these outreach teams without section 340 funding due to budget constraints and increased demands from their ongoing patient populations (p 3).[21]

The McKinney Program projects markedly augmented the health services accessible to homeless people, but they did not, by any means, cover all geographic areas where homeless people live. As of the end of 1988, eight states had no projects (Figure 1): Alaska, Nevada, Montana, Wyoming, North Dakota, Arkansas, Delaware, and Maine. Furthermore, services were available only in certain sites in the states that contained grantees. Perusal of the list of grantees in 1988[98] shows that many areas had no local program, including Buffalo, Knoxville, El Paso, and other large cities. Furthermore, services were limited to one city and its surroundings in several states: Georgia (Atlanta), Mississippi (Jackson), North Carolina (Raleigh–Durham), South Carolina (Columbia), Louisiana (New Orleans–Baton Rouge), Wisconsin (Milwaukee), Minnesota (Minneapolis–St. Paul), New Mexico (Albuquer que), and Nebraska (Omaha). No services were listed for the western part of the states of Oregon and Washington. Relatively few programs, such as Pennsylvania's Rural Health Corporation, targeted specifically suburban or rural areas. Finally, even in cities where projects were present, certain areas were covered less than others, such as Queens or Staten Island (exclusive of mobile or hospital services) in New York, the large northeast section of Washington, D.C., and Pasadena in Los Angeles County. It is unclear how much of the population lives in areas covered by the present McKinney projects, especially because it appears that homelessness is not concentrated as heavily in the skid row or inner-city areas as was once believed.

The McKinney projects provided health services to slightly more than 230,816 persons in 1988 (eight projects had not yet reported).[98] Although this number is large in itself, it is relatively small when compared to the 2 million people who are estimated to experience homelessness (i.e., living in the streets or in shelters or hotels for homeless people) *in the course of a year.*[100] Furthermore, about 10% of the clients reported having spent the last night doubled up with another household.[21] This finding suggests a need for health care among the doubled-up population, conservatively estimated at 5 million people.[101–102]

Although homeless people undoubtedly are receiving health services at non-

McKinney Program sites, it is not known how many do so. The very poor health status of homeless people, together with their lack of coverage for health benefits, suggests that many still encounter formidable access barriers, even to services that are designed to provide care adapted to that population.

Overview

Homeless people still face considerable barriers to the delivery of adequate health care. They have greater needs for health care than do the general or even the poverty populations. In addition, their needs are more complex because of the interaction among disease processes caused by homelessness, lack of financial resources and of the protective functions of a home, an diminished formal and informal support networks. Diagnostic and therapeutic care directed to single conditions are needed, but the health services also must be prepared to deal with multiple problems in the same individual. Experience at the New York Children's Health Project has led to the definition of a "homeless child syndrome—immunization delays, untreated or undertreated acute or chronic illnesses, unrecognized disorders; school, behavioral and psychological problems; child abuse and neglect."[103] Such complex problems require an interested service system that can provide teamwork involving at least a physician, a nurse, and a social worker,[104] can adapt the services to the needs of homeless people, and can offer outreach, as well as dignity, sympathy, and understanding, to help overcome the internal as well as the external barriers to services.

This approach, initially developed at the St. Vincent Hospital Medical Center, has spread in two quantum moves, first in the 19 demonstration projects of the Johnson–Pew Program and then in the 109 projects supported by the McKinney Program grants. These programs, however, still serve only a minority of homeless people. Thus although the direction of the work is known, much remains to be done.

HOMELESSNESS AND THE HEALTH CARE SYSTEM

The health services for homeless people are controlled in part by the local service systems; these, in turn, depend upon the U.S. health care system, of which they are part.

Health Services Research and Development

Health services research encompasses studies of cost, cost-effectiveness, and cost-benefit analysis, regionalization of services, variation in the use of humanpower and technology, comparisons of different modes of organization of services, and assessment and control of quality of care. To my knowledge, these approaches have not yet been used to a significant extent in connection with services to homeless people. The steps that have been taken include demonstrations of various modalities of service delivery and assessment of the problems of service delivery and of the effectiveness of services.

The introduction of a new health services initiative in the community requires health planning. Redlener and Redlener[105] describe seven phases in the develop-

ment of a mobile health program for homeless children in New York City: (1) needs assessment, (2) liaison development, (3) program conceptualization, (4) funding identification, (5) pilot project, (6) operational phase, and (7) program enhancement.

Health policy research can be *descriptive* (i.e., describing the specific policies affecting the services and features of the services that may be related to such policies); *analytic* (i.e., assessing, on the one hand, the relationships of specific policies to features of services, and, on the other, the relationship of specific policies to political forces and economic constraints at various levels of organization); and *model building* (developing, initially, theoretical models of the projected effects of novel policies and, eventually, small-scale demonstrations of such models). Health policy development is initially a political process of formulating policies and convincing others to adopt them. Once the policies have become laws, a regulatory and administrative process is needed to implement them.

National Health System Analysis

This form of analysis, which is developed more highly in European countries than in the United States, assesses the relationships of specific problems to the structural aspects of the health care system. One approach involves comparative studies of the same problem in countries with differing health service systems. A recent example is a comparison of health services for homeless people in the United Kingdom and in the United States.[106–107]

The relationship of health and health care of homeless people to the systemic aspects of health maintenance and health care delivery is the least highly developed area of research discussed in this chapter. Most of what is available consists of case studies—the earliest stage in a research and development effort.

Organization of Service Delivery

As stated previously, the principles of service delivery for homeless people appear to be well established: outreach, adaptation of services to problems of homelessness, teamwork, multiservice intervention, and, for health care in general, regionalization of health care (the appropriate use of general or primary, specialized or secondary, and highly specialized or tertiary services). The experience of the Johnson–Pew and the McKinney programs offers an unusual opportunity to assess how, and to what extent, these principles of services are carried out in practice and what barriers to implementation exist. To date, little research has been conducted along these lines; much of the needed data, however, may be available or could be collected, in view of the structure of the programs.

Too much emphasis may have been placed on the actual tools used for delivery—mobile units, health stations in shelters, or clinics—and not enough on the two elements required to make any of these tools successful: adequate financing and planning or organization, including trained and motivated personnel. For example, although several mobile units for homeless people exist in the United States[98] and in the United Kingdom,[108–110] we found only one presentation on the planning that is needed to set up a mobile unit system.[105] Similarly, we found only one discussion on special training of personnel and adaptations of medical procedures to a mobile unit.[111] By contrast, the homelessness literature contains several detailed accounts on training interviewers for research projects. Studies of cost-effectiveness of different programs are missing.

Financing of Services for Homeless Persons

Health services for homeless persons are severely underfinanced. The total budget of about $45 million for Fiscal Year 1987 translates into $22.50 per person per year if one uses the estimate of 2 million homeless persons in the United States per year, or $45 if one uses the figure of 1 million. Either amount is only a fraction of the average real cost of health care per person per year. Yet appropriate care of homeless people requires greater funding than the average because of their more complex health problems. Thus the McKinney Program can serve only as a catalyst or an organizational framework for the delivery of care; it does not provide the financing needed to deliver that care. That financing must come mainly from Medicaid. As discussed earlier, however, only an estimated 10% to 25% of homeless adults have been covered by Medicaid during the past 5 years. This percentage can be improved only slightly by more intensive social work to obtain entitled benefits.[18] The majority of homeless people are not entitled to Medicaid because of the policies of their respective states.

Adequate financing of health care for homeless people requires at least one of several options. Medicaid policies could be reformed so that the federal government would make Medicaid funds contingent on eligibility of most homeless people. Because states in general contribute 50% of Medicaid funds, some states may decide not to participate in Medicaid after considering the fiscal impact of such a policy. In such cases the McKinney Act could be reformulated so that funding for the Health Care for the Homeless Program would be increased greatly, maybe tenfold. This arrangement, however, would encounter budgetary restraints at the legislative and executive levels. A final strategy for the passage of a national health insurance program must be constructed to provide the very poor, including the homeless, with health care without payment at the time of services.

Structural Barriers

The United States has partly a fee-for-service health care system, which is under financial constraints. These constraints exist at the individual level: an individual who cannot pay for care (out of pocket, through insurance, or through an entitlement), cannot obtain services, or has a difficult time gaining access to services.

Primary care physicians are reluctant to take on the care of homeless people in their practices. With some exceptions, the primary care system has not adapted yet to the provision of complex services with specially trained teams, such as homeless people need.[107]

The use of the community health center system for delivery of care, which was initiated with the first round of the McKinney award, is a starting point. There is an urgent need for research on organizational, planning, and training innovations that might be used in neighborhood health centers to enhance their role in delivery of care to homeless persons.

Another genuinely American system of delivery of care is the social health maintenance organization (social HMO).[112] Although the concept of the social HMO is still developing, and although the social HMOs that have been established for elderly people are still struggling to survive, the concept of a social HMO fits very well with the pattern of needs of homeless people. Such an organization would combine medical and social service intervention and planning at the preventive and therapeutic levels. It would deliver such services with a trained team of medical and

social service workers and with both social and medical resources and facilities. It is worth research and demonstration, initially with federal funds.

Environmental and Preventive Services

Finally, as discussed earlier, the physical and social environment is harmful to homeless people. Little, if any, work has been done on this matter. Research and development as well as new policies are needed to protect homeless people in their environment. This process would involve a thorough reevaluation of the environment of shelters and the development of alternatives or modifications that would remove or overcome the present hazards. Both the health and social service and the architectural and urban planning professions would be needed for this undertaking. Protection of homeless persons in the street would require involvement of the police as well as social workers and emergency medical services.

In summary, the health care and maintenance system has not adapted sufficiently to the challenge of homelessness to have a significant effect. Such adaptation requires, at minimum (1) an environmental safety and health approach to the streets and shelters, dealing with both physical and social hazards (e.g., crime, demoralization); (2) a preventive medical effort to provide homeless children with immunizations, development monitoring and remedial measures, and hearing and vision monitoring and treatment; prenatal care for pregnant women with opportunity for adequate nutrition and rest, including bedrest as needed; prevention of trauma through education and environmental measures; and prevention-oriented management of chronic diseases; (3) hospital discharge into convalescent centers for homeless people after surgery or other interventions that may require a follow-up period under protective conditions; and (4) Medicaid reform or other federal legislative reform to finance the integrated medical–social care of homeless people at such levels that all homeless people are served, as well as adaptation of the service delivery system to remove obstruction other than financial barriers to health care for homeless people.

These are only short-term approaches, however. In the long run, health promotion for the people who become homeless depends less on the medical care system than on social policies that would provide them with adequate incomes through jobs or, when that is not possible, through public support at a level of income that would enable them to afford low-income housing as well as basic necessities. Such policies also would ensure an adequate supply of affordable housing. Health insurance that prevents illness from becoming financially catastrophic also would be needed, as well as a comprehensive crisis management system.

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12

Strategies for the Delivery of Medical Care

Focus on Tuberculosis and Hypertension

PHILIP W. BRICKNER, JOHN MCADAM, WILLIAM J. VICIC, AND PATRICIA DOHERTY

INTRODUCTION

Medical disorders of homeless persons include the diverse conditions to which all human beings are subject in the urban United States. Esoteric diseases are noted infrequently, but those common clinical disorders that are exacerbated by crowding in shelters and by exposure to extremes of heat and cold, to dampness, or to the stresses of life on the streets are unusually prevalent. Examples include trauma, the broad range of infectious respiratory states, infestations with scabies and lice, and peripheral vascular disease.

The feasibility of creating health care services in the places where the homeless congregate is well established.[1–10] For health workers placed at locations such as shelters, food lines, and single room occupancy (SRO) hotels, diagnosis of genuine medical crises among the homeless is relatively easy, and treatment can be initiated simply by an ambulance trip to an emergency room. Effective care of patients with chronic diseases, however, is far more complex. This is a particular concern because medical illnesses that require long-term treatment occur in the homeless to at least the same degree as in mainstream society. Many homeless persons are alienated from established systems, fearful of doctors, and angry. Some are confused or demented, alcoholic, or psychiatrically ill. Often an approach by a health care worker is

PHILIP W. BRICKNER, JOHN MCADAM, WILLIAM J. VICIC, AND PATRICIA DOHERTY • Department of Community Medicine, St. Vincent's Hospital and Medical Center, New York, New York 10011.

perceived as intrusive and threatening.[11] Overcoming these formidable barriers to an effective therapeutic relationship is the first, essential step to care of sick homeless persons. Gaining and holding the confidence of these individuals also is required for obtaining a basic medical history, conducting an adequate physical examination, explaining a course of treatment, and assuring necessary follow-up care.

Diabetes mellitus, a common condition estimated to occur in up to 4% of the United States population,[12] exemplifies the problems of medical care for the homeless. Diabetics need an appropriate diet, regular injections of insulin or access to oral hypoglycemics, and monitoring of blood sugar levels. Yet although shelters may provide adequate food, they offer no special diets. Insulin, to remain potent, must be stored and handled properly, a hard task for the homeless diabetic. Pills carried in a bottle on the person soon are ground into a powder. Syringes and alcohol swabs are subject to theft, sale, or barter. Laboratory services are not found or paid for easily. Unless a consistent, organized health care program is made available and accessible, these patients face both the immediate and the long-term consequences of the disease. Even if diabetic coma is avoided, vascular complications are likely to present in 10 to 20 years. Stroke, chronic kidney disease, amputation of a leg, and/or blindness may leave the patient a helpless and expensive ward of the state.

Tuberculosis and hypertension are major clinical disorders that require consistent, long-term relationships between patients and health workers to ensure successful treatment. This chapter reviews clinical studies in homeless persons and considers treatment strategies.

TUBERCULOSIS

Before 1947, the year when streptomycin became available as an antituberculous antibiotic, the 5-year survival rate for persons with tuberculosis (TB) was less than 50%.[13] The disease now is perceived generally as a relatively uncommon infectious disorder, curable by a substantial armamentarium of therapeutic agents. During the last four decades, the modern era of treatment, sanitoria have closed; long-term care in hospitals has been replaced by ambulatory programs that have proved effective for many patients. In some instances, however, the current system makes it easy for patients to abandon treatment or to take their medications irregularly. For these persons, treatment failure or relapse often occurs; sometimes drug-resistant TB bacteria are involved.[14–15]

Table I. Tuberculosis Age Group Prevalence Rates, United States, 1984 (Cases of Disease per 100,000 Persons per Year)

Age	Prevalence
20–24	9.6
25–34	8.4
35–44	9.6
45–54	13.6
55–64	15.2
65 and over	23.2
Overall prevalence	9.4

Reference: Centers for Disease Control.[27]

Table II. Tuberculosis Case Rates by Race, 1984 (United States Total: 9.4/100,000)

White	5.8
Other	29.9

Reference: Centers for Disease Control.[27]

High indexes of tuberculous disease continue to be noted among the elderly, some minorities, recent immigrants from certain parts of the world, and substance abusers—all of whom contribute notably to the ranks of the homeless.[13] Older people have a markedly increased risk for TB, a consequence of exposure during childhood and adolescent years (see Table I). In the first decades of this century in the United States, TB was a common disorder. In 1900, more than half of urban high-school graduates had a positive tuberculin skin test, evidence of infection with the tubercle bacillus, although not of overt disease.[13] For those who have survived into their 60s, 70s, 80s, and 90s free of active tuberculosis, a variety of harmful factors may have an effect, particularly if they are homeless, lack adequate housing, or suffer from marginally acceptable nutritional intake. In such cases immunological defenses can fail; the previously dormant bacilli, held at bay and walled off for decades, may break out to produce active disease.

Members of some minority groups are unusually subject to tuberculous infection (see Table II). Some were born into poverty, were poorly nourished, and developed the disease because of substantial environmental exposure and reduced immunity. Others came to the United States from regions of the world where the condition remains epidemic. Of these, relatively few arrive with active disease. A substantially larger number may enter the country infected but without overt illness. Later, under the pressures associated with immigrant status, active tuberculosis may develop.

Alcoholism increases the likelihood of tuberculosis. This condition adds significantly to the potential for the disease in the homeless because abuse of alcohol in this group remains a concern in about 38%.[16]

Present Status: A Study among New York City Homeless Persons

Studies of New York City homeless persons and SRO hotel residents in the last 7 years provide an analysis of tuberculosis prevalence. In 1980, Sherman and associates carried out a tuberculosis survey in three Lower Manhattan SROs. Tuberculin skin tests were given to 191 people; 98, or more than half, had positive tests, and 18 (8%) had active disease, a diagnosis established on the basis of positive cultures.[17]

As a result of this study, a more substantial analysis of tuberculosis prevalence in New York's homeless population was undertaken. Men and women seen at clinics conducted by community medicine staff members of Saint Vincent's Hospital at four major shelters and 14 SROs were investigated (1) to determine the extent of the disease in this segment of New York City's homeless population and (2) to examine probable risk factors among those infected, including length of stay in shelter or hotel, race, sex, age, intravenous drug use, and human immunodeficiency virus (HIV) infection.

The intent of the program was to screen as many individuals as possible. Thus the selection process was not random but was biased toward those seen at shelter/SRO clinics or who appeared to staff to be ill. Between July 1, 1982, and April 30, 1986, 1,623 persons were screened; tuberculin skin tests were administered with

purified protein derivative (PPD) when deemed to be indicated. PPD was given to 1,590 persons. Another 114 had a previously known significant PPD reaction or a previous history of treated tuberculosis.

PPD-positive individuals were offered chest X-rays, sputum smears, and cultures for acid-fast tubercle bacilli. Persons diagnosed in the study as having active tuberculosis were confirmed as such by results of culture and/or biopsy.

Results

Of the 1,623 persons screened, 475 (34%) had a positive tuberculin skin test and thus were deemed infected; 114 (8%) had a positive skin test by history; and 73 (5%) had active disease. Thus a 47% rate of infection for the entire group was noted. Intravenous (IV) drug users had three times as high a case rate of active tuberculosis as non-IV drug users, 12% and 4% ($p < 0.001$), respectively.

Of the 73 persons with active tuberculosis, the diagnosis was determined in 63 instances by positive sputum culture, in 9 by biopsy, and in 1 by clinical criteria. Eighty-five percent of these individuals had pulmonary tuberculosis. The remainder of the cases were extrapulmonary.

Tuberculosis and Disorders of Immunity

The relationship of acquired immune deficiency syndrome (AIDS) to tuberculosis infection is becoming clear.[18–24] As of July 15, 1986, 22,792 cases of AIDS had been reported across the United States; 34% of the patients used intravenous (IV) drugs. About 35% of the total cases are from New York City, as are about 44% of the cases among IV drug users. The New York City Department of Health notes the following:

> Concurrent with the AIDS epidemic in New York City, from 1980–85, has been an epidemic of deaths in narcotic users which is probably related to infection with Human Immunodeficiency Virus (HIV). . . . Oral thrush, lymphadenopathy or other findings suggestive of HIV disease were found in . . . 56% of TB deaths. . . . Physicians treating intravenous drug users should be alerted to the frequent occurrence of fatal bacterial pneumonias and unsuspected disease caused by *Mycobacterium Tuberculosis* in this group.[21]

The patients with active tuberculosis in this study were reviewed for evidence of immune disorders. Fifty-one of the 73 (70%) with active disease showed no evidence of immune deficiency by initial history and physical examination, or during their course of observation. Seven (10%) had proven AIDS; 4 (5%) had AIDS-related complex (ARC). Five others (6%) revealed one or more risk factors for HIV infection along with generalized lymphadenopathy and thus are suspect cases. For 5 patients, insufficient information was available for comment about immune status. Of the 17 tuberculosis patients with definite or probable immune deficiency, 12 were IV drug users, 4 were homosexual, and 1 had both risk factors for AIDS.

Compliance in Treatment Plans

Compliance with tuberculosis treatment regimens, which may require taking medication over a period of 9 months or longer, proves difficult for many patients. In the general population of the United States, it is estimated that 23% to 31% of individuals fail to complete the indicated therapeutic program for this disease.[25]

Success in antituberculous therapy, if measured by the percentage of patients known to have converted sputum from positive for tuberculosis to negative within 6 months of starting treatment, actually fell across the nation from 88% to 75% between 1972 and 1983.[26–27] In the latter year, only 56% of patients in New York State had bacteriologic conversion of sputum.[26–27]

With this information in mind, the results of treatment among the tuberculosis patients in this study are noteworthy. Fifty percent either finished therapy or are in treatment now. The remainder failed to complete treatment, are lost to follow-up, or died. Of the eight deaths, one was from tuberculosis and seven from other causes, including trauma and drug overdoses.

This relative degree of therapeutic success, perhaps unexpected in a population of homeless persons, perhaps may be attributed to the consistent presence of physician, nurse, and social worker teams at the clinic sites in shelters and SROs where care is offered, and to excellent cooperation from the local health department.[28]

HIGH BLOOD PRESSURE

High blood pressure, a significant contributor to cardiovascular disease and death, occurs in nearly 60 million persons in the United States and thus is the country's most common chronic disease.[29–31] Hypertension is a treatable condition if appropriate attention is directed toward correctable underlying causes, a sensible approach to diet, and the consistent use of effective drugs over the long term. If untreated, however, hypertension is a powerful risk factor for stroke, blindness, kidney failure, and coronary artery disease. The value of antihypertensive treatment has become understood broadly during the last two decades. Through persistent efforts at screening large population groups and the institution of appropriate therapies, deaths from stroke have been reduced by 42% and from coronary artery disease by 25%.[32–38]

Although the United States population at large has been well served by vigorous case finding and blood pressure treatment programs, certain subgroups have not yet benefited. These include the homeless, who for a variety of reasons are alienated from the health care system. The genetic and environmental factors predisposing to the development of hypertension and to the aggressive course of hypertensive disease in some subpopulations continue to be investigated intensively and may be important co-factors in the condition among certain homeless individuals. For the entire homeless population, in addition, chronic stress is a distinct and common factor that may result in abnormal elevations of blood pressure.[39] Among the shelter and SRO patients contacted in a screening program by Saint Vincent's Hospital (New York) health care workers, hypertension was detected in 29.0% of 734 women and in 24.4% of 2,525 men (Table III). Fifty percent of this homeless population is black; among United States blacks, high blood pressure is known to be particularly common, and its vascular complications severe and accelerated.[31,40–41]

Black homeless men, a group that constitutes a significant component of the homeless population in general, may be at special risk for hypertensive disease. At shelters and SRO sites served by the Saint Vincent's Hospital SRO–Homeless Program in New York City, there has been a consistent trend toward the presence of a greater number of younger individuals; in the first 9 months of 1986, approximately 60% of all persons seen at on-site health care stations were black men, and a substantial majority of these were less than 45 years old. For those whose blood pressures

Table III. Hypertension[a] in New York City Homeless Persons, 1983–1986

Population screened	*N*	Percentage hypertensive
Black	3,259	25.4
White	1,633	25.8
Hispanic	505	29.8
Other	39	17.9
Men	2,525	24.4
Women	734	29.0

[a]Hypertension is defined as a resting blood pressure of greater than 140/90 mm mercury on one occasion or more.

were measured, 29% were hypertensive. Thus these young men carry a potential burden of at least 30 years of hypertensive disease. More than half were unaware of their elevated blood pressures.

An interesting distribution of hypertension prevalence was seen by Saint Vincent's Hospital staff members among New York City homeless men and women (24.4% and 29.0%, respectively). Young homeless women without a history of psychiatric disease develop hypertension at a rate equal to (or perhaps greater than) a similar group of homeless men. Two factors, one measurable and the other not, may affect the prevalence of hypertension, namely obesity and unusual daily stress. In a review of the incidence of medical disorders within the Robert Wood Johnson–Pew Memorial Trust National Health Care for the Homeless Program,[42] obesity was not listed among nine common maladies (perhaps because of deficient nutrition). Thus the effect of obesity on the prevalence of hypertension in the homeless is not substantive. On the other hand, the physiological correlates of stress are hypersympathetic, and blood pressure elevation would be anticipated.

The problem of hypertension in the homeless possesses some of the features of chronic disease management discussed for tuberculosis. Long-term therapy is required; compliance is difficult to sustain in the face of the challenges of daily living on urban streets. Control of hypertension becomes even more elusive because the disease is conceptual rather than symptomatic; thus disease management demands a trusting relationship between the patient and the health care team, a relationship difficult for the homeless person to affirm.

A hypertension control project conducted since 1983 in the SRO–Homeless Program of Saint Vincent's Hospital addresses specifically the detection, diagnosis, treatment, and control of high blood pressure among the medically underserved homeless. This project incorporates recommendations of the Joint National Committee 1984 Report.[31] Screening, performed by outreach medical staff at shelter or hotel health stations as a patient service initiative, includes a health history, weight and height measurements, and an examination based on the individual's present complaints. Patient participation is voluntary, although staff outreach is persistent, flexible, and timed according to the individual's ability to engage. Patients with borderline or elevated blood pressures (140/90 mm mercury or greater, at rest) are referred for diagnosis, most frequently to a Saint Vincent's Hospital clinic that has been organized and is attended by physicians, nurses, and social workers from the outreach teams. This hospital-based primary care clinic is a cornerstone of the SRO–Homeless Program and of the hypertension control project in that a special outpatient facility allows and extends health care continuity for the homeless patient.

Those with established hypertension (often coexistent with other medical problems) are offered treatment for blood pressure control through both nonpharmacological and pharmacological prescriptions. The patient's age, life habits, and additional risk factors (diabetes mellitus, alcoholism) determine an individualized regimen for blood pressure reduction.

Whereas the Saint Vincent's Hospital project uses fixed outreach health stations during daytime and early evening hours, other homeless health care programs, in New York and elsewhere, have been successful with mobile van units that serve both street people and individuals at small drop-in centers[43] and with systems that make treatment more easily available.[44] Most homeless persons follow a pattern of daily activity, despite their presumed transience. A consistent outreach team works within the structure of homeless existence; it is the patient who sets the tempo for health care intervention.

Treatment strategies against hypertension in homeless populations may make appropriate use of nonpharmacological approaches.[45] Biofeedback modalities, meditation, and aerobic exercise, however, which may have a general validity,[46] are impractical and unavailable to the homeless patient. Weight loss, usually achieved through small, regular meals of low total caloric content, is distinctly helpful in certain individuals with high blood pressure; it has possibly one-half the efficacy of medications.[45,47] In a small group of homeless hypertensive patients in the Saint Vincent's Hypertension Control Project, 85% achieved normal blood pressure through diet alone (Table IV). For most of the patients in this project, the antihypertensive regimen of choice is pharmacological treatment, with feasible dietary modifications in sodium, calcium, and calories.

The need for effective and affordable antihypertensive medication is evident; major studies have confirmed that simple rather than complex drug regimens are associated with better patient compliance and hence more consistent control.[48] Of 336 homeless patients prescribed antihypertensive agents in the Saint Vincent's Hospital Hypertension Control Project through June 30, 1986, 67.5% were well controlled in follow-up periods ranging from 1 month to 3 years (Table IV). The control rate is comparable to that observed in the general population.[48] In 216 project patients for whom detailed treatment information is available, the simple Step 1 regimens, whether diuretic or nondiuretic, were most beneficial in lowering blood pressure (Table V). Step 2 therapy was associated with hypertension control in 53.4% of patients; Step 3 therapy, in a very small treatment group, was associated with only 16.7% control. It is possible that patients requiring multistep regimens represent

Table IV. Treatment Modalities among Homeless Hypertensives[a]

Pharmacotherapy		Nonpharmacological therapy	
N	Control rate[b]	*N*	Control rate
336	67.5%	40	85.0%

[a]The patient group excludes those with systolic hypertension.
[b]Control is defined as the attainment of a blood pressure of 140/90 mm or less at any time after diagnosis *and* the most recent follow-up visit.

Table V. Treatment and Control of Hypertension[a] in Homeless Persons of New York City

	Controlled (*N*)	Uncontrolled (*N*)	Rate (%)
Diet alone	34	6	85.0
Pharmacotherapy			
Step 1 (diuretic)	61	35	63.5
Step 1 (nondiuretic)	26	15	63.4
Step 2	39	34	53.4
Step 3	1	5	16.7
Total	161	95	62.8

[a]Patients with systolic hypertension are excluded from this analysis.

cases of severe and therefore relatively treatment-resistant hypertensive disease. In the homeless population, however, it is equally likely that more complicated drug prescriptions are less well accepted and demand that the health care staff give greater attention to outreach and other methods to enhance compliance.

Education and consistent patient–staff interaction are essential for treatment compliance in the Hypertension Control Project. Didactic sessions for all staff members are held quarterly. After these sessions, appropriate individual patient education by the prescribing physician, the nurse, or the medical social worker can follow logically. This effort begins at on-site health stations but continues when primary care clinic visits are necessary. Information about blood pressure, its variation from day to day, and its treatability sometimes can reassure the patient and can limit diagnosis-related anxiety.[49] For the homeless person, short educational sessions have the effect of strengthening the patient–caregiver relationship. Blood pressure measurement, frequently part of the first interaction between a shelter client and a health care provider, not only is urgent in this stressed and undeserved population but also offers the opportunity for better health in individuals traditionally considered untreatable.

SUMMARY

Severe chronic illness is relatively commonplace in homeless persons. Tuberculosis and high blood pressure are pertinent examples. There is a major benefit to patients and to our larger society in establishing effective treatment methods. We have an excellent understanding of appropriate therapy for the two clinical conditions noted in this discussion. The challenge lies in developing viable systems through which homeless individuals, many of whom distrust or fear health workers, can be helped.

Factors of major significance that apply to this point include the need for health workers to feel and show respect for each homeless patient as a valuable individual person and the requirement that a health care program be designed to meet the particulars of each patient's life. Further, we should recognize that the traditional one-to-one physician–patient relationship often fails to detect and treat those at risk in this population. Health care probably will be provided most effectively by teams of nursing, medical, and social work professionals. In addition, in order to build trust, these teams need a liaison person, such as a former shelter resident, between themselves and their clients.

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IV

Alcohol

13

The Homeless Alcoholic
Past and Present

RUSSELL K. SCHUTT AND GERALD R. GARRETT

INTRODUCTION

Although homeless alcoholics constitute no more than 5% of the entire alcoholic population, no alcoholic subgroup has been studied more thoroughly over the past 50 years.[1] Homeless alcoholics have been visited by social workers, sociologists, anthropologists, psychologists, doctors and psychiatrists, urban planners, and public health officers. They have been studied and observed in the streets and on skid rows, in bars, jails, drunk tanks, and "bottle gangs." The body of literature resulting from these studies provides an extensive picture of the social, personal, and medical backgrounds of homeless alcoholics.[2]

At least three factors account for the attention paid to the homeless in alcoholism research. First, homeless alcoholics are in a situation where almost every complication—medical, social, and psychological—appears in its most critical form. Drinking histories and patterns among the homeless provide textbook cases of the dynamics of alcoholism and of the deterioration in social and personal functioning that results from it.[3–19] Second, homeless alcoholics are a convenient population to study. Historically this population has been concentrated on skid rows and in other blighted urban districts. Permissive attitudes toward public drunkenness and the many social service centers, missions, and cheap residential hotels in these districts have given them the character of "open laboratories." Finally, homeless alcoholics are the most distressed persons in the alcoholic population in terms of such basic needs as food, shelter, clothing, and personal safety.

RUSSELL K. SCHUTT • Department of Sociology, University of Massachusetts at Boston, Boston, Massachusetts 02125, and Department of Psychiatry, Harvard Medical School, Boston, Massachusetts 02115. GERALD R. GARRETT • Department of Sociology, University of Massachusetts at Boston, Boston, Massachusetts 02125.

This chapter draws on the extensive literature on homeless alcoholics as well as on the authors' research in Boston in order to describe alcohol-related problems among the homeless. We present estimates of the prevalence of alcoholism among the homeless, a description of the social patterns of homeless alcoholics, factors associated with the appearance of alcoholism among homeless persons, and patterns of service utilization.

ESTIMATES OF ALCOHOL ABUSE AND ALCOHOLISM

Forms of Measurement

Three major approaches have been taken to measuring drinking among the homeless: (1) general self-classification items, (2) indicators of the quantity and frequency with which respondents drink, and (3) checklists of problems experienced because of drinking. The specific approach taken may influence the estimate of alcohol abuse or alcoholism obtained (Table I).

Self-classification items ask respondents to rate the extent of their drinking in three or more categories. For example, Bogue's[4] study of Chicago's homeless, conducted in the 1960s, asked respondents to rate their drinking with one question: "How heavy a drinker are you? Do you consider yourself to be a heavy drinker, a moderate drinker, a light drinker, a periodic drinker, or don't you drink at all?" With this approach, 28% were classified as light drinkers, 24% as moderate drinkers, nearly 20% as heavy drinkers, and almost 13% as alcoholic derelicts. Bogue concluded that about 32% of his sample were early or terminal-stage alcoholics, and another 25% were incipient or borderline alcoholics.[4]

Quantity–frequency indices also are based on self-reported information but require respondents to deliver more specific estimates of their drinking behavior. It is assumed that respondents are less likely to supply false or distorted information on specific objective items than in one general self-classification. For example, Bahr[20] used three questions to construct a quantity–frequency index in his study of New York's male Bowery residents: (1) "What alcoholic beverage do you *usually* drink?" (2) "About how often do you presently drink, on the average?" (3) "When you drink about how much do you drink on the average?" Responses to these questions were used to create a standardized measure of beer-ounces consumed over a specific time interval. After making comparisons to the scores of known alcoholics, Bahr estimated that from 36% to 47% of the homeless were heavy drinkers or at least early-phase alcoholics. Bahr and Garrett[21–24] replicated this technique in a study of homeless women in the Bowery, in which about one-third were classified as heavy drinkers.

A third common assessment technique involves a battery of items that probe whether or not the respondent has ever had personal difficulties due to drinking, ranging from hospitalization or other treatment to job loss or accidents. Using a variant of this approach, a 1985 Milwaukee study classified 25% of a shelter sample and 21% of a street sample as alcohol or drug abusers.[25] One Boston study found that 35% to 45% of shelter users had ever been hospitalized for alcohol problems.[26] Roth and Bean[27] classified 21% of their Ohio sample as having alcohol problems. These individuals stated that they had gone to someone for help about their drinking at some time and had been drinking some or a lot in the past month.

Some recent studies of the homeless population have used less precise ap-

Table I. Results of Research and Clinical Studies on Prevalence of Alcohol Abuse and Alcoholism

	Site	Definition	Sample size (*N*)	Estimated percentage
Pre-1975 studies				
Bogue (1963)[4]	Chicago	Heavy drinking/problem drinking	613	32
Bahr (1965)[20]	New York City	Heavy drinking/quantity, frequency	194–196	36/47 (Q–F) 23/26 (S–R)
Bahr & Garrett[2,21–22] (1971, 1973, 1976)	New York City	Heavy drinking/quantity, frequency	52	32
Post-1975 studies				
Ropers & Robertson[44]	Los Angeles	Problem drinkers	107	25
MAHM, One-Day Census[45]	Boston	Alcoholism	970	45
Human Services Triangle[25]	Milwaukee	Substance abuse	237	24
Robinson[52]	Boston	Alcohol abuse	279	35
Wynne[34]	San Diego	Drinking problems	82	32
HUD[46]	Nationwide	Substance abuse	184	30
Fischer[47]	Baltimore	Substance abuse	51	20
Arce[48]	Philadelphia	Substance abuse	193	43
Barrow & Lovell[49]	New York	Substance abuse	676 (521)	43 (16)
Multonmah County[40]	Portland, OR	Daily drinking	131	35
Brown *et al.*[50]	Phoenix	Daily drinking/regularly	150 (195)	32 (26)
Crystal[51]	New York	Regular users	128	21
Boston Project				
Garrett & Schutt (1984–86)[26,43]	Boston	Self-report/quantity, frequency/problem drinking	500	35–45

proaches to estimate alcoholism. Although Mulkern and Spence[28] did not note variations in the specific questions used to measure alcoholism or alcohol abuse, they found that studies explicitly operationalizing alcohol abuse or alcoholism yielded a range of estimates from 29% to 45%. Studies using a simple measure of daily or regular drinking yielded estimates from 21% to 35%. Some studies have combined indicators of alcohol and drug abuse in a general measure of substance abuse, with prevalence estimated as ranging from 20% to 43%.[28]

Thus estimates of the proportion of the homeless who have alcohol problems vary with the specific measurement procedure used. The validity of specific procedures varies in turn with the specific population studied. Bahr and Garrett[23–24] found that quantity–frequency scores were correlated highly with self-classification scores among homeless women but were correlated more weakly with these scores among homeless men. Because the incidence of alcoholism is linked to a number of demographic variables (including age, race, and sex), estimates also can be expected to vary with the mix of these characteristics in any population.

THE SKID ROW SUBCULTURE

Although traditional skid row districts have been declining with the rise of urban renewal and the demise of single room occupancy hotels in larger cities, elements of the skid row drinking subculture remain intact. For many alcoholics, drinking continues to provide the major context for social interaction.[29–32]

Recent research has given relatively little attention to alcoholism among the homeless, but the classic skid row studies provide a fairly complete picture of their drinking and social patterns. Contrary to the popular image of skid row drinkers, only about one-quarter consume principally wine, whereas almost half prefer beer. According to one early study, the regular morning drink, a hallmark of chronic alcoholism, seems to be common among only about 6% to 10% of skid row residents.[4,31] Twelve percent stated that they had consumed such nonbeverage alcohols as sterno and shaving lotion.[42] Most skid row drinkers, particularly those who drink heavily, drink with companions.[4,20,31] Sharing a bottle of wine or whiskey and visiting bars are often the focal point for highly structured group interaction.[4,20,29,31]

Although the term *skid row* implies marked downward social mobility, both observational and quantitative studies of skid row inhabitants show that only a small proportion in fact enjoyed high social class status in previous years. Despite occasional media stories about professionals who "hit the skids" because of heavy drinking, skid row residents and other portions of the homeless population more often have experienced a more horizontal pattern of mobility involving movement from working-class or impoverished backgrounds to skid row.[1,3–4,33]

Few researchers have examined the extent to which alcoholism itself is an antecedent to homelessness. Both Bahr[20] and Garrett[33] compared heavy drinkers with other homeless respondents. Neither study established alcohol problems clearly as a factor that had caused homelessness. For example, the patterns of disaffiliation over the life course of homeless persons did not differ significantly between heavy drinkers and others, nor did the life histories of homeless persons who began drinking late in life differ from those of early-onset drinkers. The role of alcohol use as a device for adjusting to homelessness and to its related stresses, as well as its importance in causing homelessness, remains to be investigated through more sophisticated longitudinal research.

THE NEW HOMELESS POPULATION

The Prevalence of Alcohol Problems

In spite of variations in estimates due to differences in measurement procedures and population characteristics, virtually all major studies of homeless populations[3,4,15,20–23,34–36] have found that a substantial proportion of the homeless are afflicted with problems due to alcohol abuse or alcoholism. Moreover, the incidence of alcoholism among the homeless seems to have remained relatively constant over the past 30 years. The elements that have changed are the demographic characteristics of the homeless and the prevalence of health problems other than alcoholism.[26,37]

Table II summarizes demographic data from five studies of homeless populations. Although some differences are likely to be due to variation in the demographic composition of the cities studied, these results suggest important changes over time. The 1984 and 1982 studies in San Diego[38] and Ohio[39] report a population substantially younger than that found in Chicago in 1963.[4] A similar shift is apparent from the 1970 study of homeless women in New York City[33] to the 1985 study of homeless women in Oregon.[40] These figures also suggest increasing numbers of minority-group members and higher levels of education among the homeless. Shipley's restudy of Philadelphia indicates a similar pattern of change from 1960 to 1986.[37]

In recent years the policy of deinstitutionalization and the inadequacy of com-

Table II. Selected Demographic Characteristics of Homeless Samples, 1963 to 1985

Characteristic	Chicago[4] 1963	Ohio[27] 1984	San Diego[29] 1982	New York[33] women, 1970	Oregon[40] women, 1985
Sex					
Male	96	94	100	0	0
Female	4	6	0	100	100
Age					
29 or less	9	22	60	4	32[a]
30–39	11	25	23	20	35[a]
40–59	49	43	13	42	29[a]
60+	31	9	5	44	4[a]
Marital status					
Married	15	3	—	0	8
Never married	51	34	—	23	29
Separated	9	11	—	40	28
Divorced	11	45	—	29	29
Widowed	14	5	—	8	6
Other/NR	0	1	—	0	0
Race					
White	96	65	57	56	—
Black	2	30	19	44	—
Hispanic	—	3	—	0	—
Native American	—	—	—	0	—
Other/unknown	2	2	24	0	—
Education					
0–8 years	69	17	15	25	—
9–11 years	15	37	20	38	—
12 years/GED	11	30	24	29	—
13+ years	6	15	41	8	—
					—

[a]Categories not strictly comparable.

munity-based mental health facilities have increased the proportion of the homeless who are afflicted with psychiatric problems.[41–42] In some cases these problems are compounded with alcohol abuse. In addition, drug abuse, virtually undocumented before the 1970s, is now an established feature of the homeless population, accounting for as many as half of the homeless undergoing substance abuse treatment.[37]

Clients in a Boston Shelter

Data collected in our study of the homeless based on a large Boston shelter provide a detailed picture of the new homeless population.[43] (see Table III). Mental health problems appear to be common. More than one-third (35%) reported that they had been hospitalized at some time in the past for "a mental or nervous problem." Of these, almost half had been confined in a state hospital; just under one-quarter (23%) had been in a private psychiatric hospital. Although half of those previously hospitalized had been released within the preceding year, more than one-third (36%) had not been in a psychiatric hospital for at least 5 years. When previous hospitalization or other treatment, self-reports of current psychiatric problems, and a request for a mental health referral are combined, mental health problems appear to have been an issue for about half (53%) of the sample.

Half of the sample reported drinking daily (32%) or several times a week (19%), but 18% reported that they did not drink at all. One-quarter of the self-reported drinkers had their last drink on the same day as they came to the shelter; more than half had drunk last within the preceding 2 days. About 40% of the drinkers had ever been treated for alcohol use—59% of these in a public alcohol treatment program and 22% in a VA alcohol treatment program. For about one-quarter of the sample, alcohol use appeared in conjunction with indications of mental health problems. Nevertheless, one-quarter of the new guests reported no problems with either alcohol use or mental health.[43]

The sample was divided into four categories for comparison: those with alcohol problems only as defined by drinking at least a few times per week, reporting prior treatment for alcoholism, or requesting a referral for alcoholism services (25% of the sample); those with mental health problems only (27%); those with both alcohol and mental health problems (26%); and those with neither (23%).

Several factors are associated with indications of alcoholism, including age, gender, race, and drug use. Younger homeless persons (those under age 30) were least likely to report alcohol or mental health problems. Alcohol problems alone were more common among men, whereas mental health problems alone were more common among women. Nonwhites were somewhat less likely than whites to report either alcohol or mental health problems.

Alcoholics without evidence of psychiatric problems were more common among those who were married, those who were employed, and those who had been homeless less than 6 months. Persons with both mental health and alcohol problems, however, were more common among those who had been homeless at least 6 months and who usually had resided on the streets or in shelters. Drug abuse, more common in the alcohol group, also was associated with greater length of homelessness and with usually having resided on the streets or in shelters.

Use of street drugs was reported by a substantial proportion of homeless persons coming to the shelter. Almost one-third (30%) of those responding reported ever using street drugs, such as marijuana, amphetamines, barbiturates, cocaine, opiates, psychedelics, volatile substances, or tranquilizers; one-third of these re-

Table III. Sociodemographic Characteristics of Homeless Persons in a Boston Shelter, by Alcohol Status

	Alcohol problems only (%)	Mental health problems only (%)	Both (%)	Neither (%)	Total (%)
Age					
17–29	22	24	20	33	99[a] (49)
30–39	27	23	30	20	100 (66)
40–90	26	37	26	12	101[a] (51)
Sex					
Male	28	24	27	21	100 (135)
Female	11	40	20	29	100 (35)
Race					
White	27	28	27	18	100 (96)
Nonwhite	22	26	25	28	101[a] (72)
Marital status					
Married	31	19	12	38	100 (26)
Single	20	33	30	16	99[a] (69)
Divorced	23	21	34	21	99[a] (47)
Employment status					
Employed	36	36	7	21	100 (14)
Not employed	24	30	26	20	100 (102)
Months homeless					
0–5	25	32	24	19	100 (68)
6+	19	27	32	22	100 (73)
Usual home					
Own home	18	30	25	27	100 (63)*
Marginal	33	38	18	10	99 (39)
Street	21	17	38	24	100 (42)

*$p < .05$.
[a]Rounding error.

ported daily use. Only 14% of the drug users had ever been treated for drug use.[39] Street drugs were used most often by men and by those under the age of 40. Drug use tended to co-occur with alcohol problems.

SERVICE INSTITUTIONS

Historically, homeless alcoholics have circulated among a variety of service institutions throughout their careers on skid rows, including shelters, religious missions, soup kitchens, and welfare agencies. Before the 1970s, studies also revealed frequent inclusion of public jails and drunk tanks on the homeless alcoholic's circuit, sometimes as often as five times a month. A National Task Force Report stated that as many as two-thirds of all street crimes could be accounted for by public drunkenness.[32]

In the 1960s and 1970s, efforts to decriminalize public intoxication and to establish detoxification centers for public inebriates markedly altered the service circuit traveled by homeless alcoholics. In some cities an extensive network of detoxification facilities provided services that might include intensive medical attention, personal hygiene, individual and group counseling, and referral to long-term residential care facilities. Some shelters and social service centers implemented "drunk patrols," which roam the streets and frequent the locations where they are likely to encounter

inebriates. Detoxification centers thus operated as a net in much the same way as did jails before; it was not uncommon for homeless alcoholics to spend most of a year in their care. Neuner and Schultz,[30] for example, found that all of their 43 randomly selected chronic alcoholics in Minnesota had at least 20 admissions to detoxification centers. In contrast to jails, however, detoxification and treatment facilities often delivered urgently needed medical care and opportunities for rehabilitation.

Current legal problems were reported by 17% of alcoholics, 30% of the psychiatric problem group, and 46% of those with both psychiatric and alcohol problems, compared to 9% of those with neither problem. Repeated use of the shelter was more likely among those with either psychiatric (33%) or alcohol problems (40%) or both (32%), compared to those with neither problem (15%). Those reporting psychiatric problems were more likely than others to be receiving benefits (48% of those with only psychiatric problems; 39% of the dually diagnosed) and to have had contact with service agencies (74% of those with only psychiatric problems; 80% of the dually diagnosed). Alcoholics without psychiatric problems, on the other hand, were somewhat more likely than those with neither problem to have had contact with service agencies, but they were no more likely to receive benefits (21% vs. 20%).

CONCLUSIONS

Although estimates vary with the specific measurement procedure used, it is clear that alcohol abuse and alcoholism continue to affect a significant proportion of the homeless population. Homeless alcoholics have not been the focus of many recent studies, but an extensive body of past research still provides insights into their behavior and problems. In spite of the demise of skid row districts in many major cities, a continuation of traditional patterns is suggested by the propensity of homeless alcoholics to maintain some social ties, the overrepresentation of older white males in this subgroup, and their frequent legal problems and service agency contacts.[5]

The emergence of large numbers of individuals suffering from mental illness and drug abuse requires new perspectives on the homeless. Neither the findings of past research on skid row alcoholics nor past treatment approaches provide adequate guidance for policy making. In fact, alcoholics without mental health or drug abuse problems seem relatively advantaged. Those with indications of both alcohol abuse and mental illness, on the other hand, seem to have fewer social ties, to have been homeless longer, and to have more legal problems. Drug abusers, a younger subgroup among the homeless, also seem to have had less stable residential histories and greater experience of homelessness.

The substantial overlap among the alcoholic, the mentally ill and the drug-addicted subgroups among the homeless requires more flexible responses to alcohol abuse itself. The extremely damaging effect of alcoholism on physical health, self-esteem, and motivation also may mask even more fundamental health problems. Detoxification centers have become frequent way stations for homeless alcoholics, but they cannot provide the long-term treatment required for associated psychiatric and drug problems. The extensive past research on homeless alcoholics provides only a starting point, however valuable, for social policy in the present.

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Public Policy and the Homeless Alcoholic

Rethinking Our Priorities for Treatment Programs

JUDITH WILHITE

INTRODUCTION

Over the past decade, statistical reports have accumulated rapidly around the subject of homelessness in the United States. Yet even the best empirical research does not tell us the kinds of actions we should take and the moral principles upon which we should base them. Thus good data alone do little to resolve this troubling social issue. In the end, it matters less whether we count 3 million or 300,000 people as homeless than knowing what to do about any of them.

In the case of a homeless person who also has an alcohol problem, this is the situation we face today. It is an ethical dilemma in the classic sense of the term, for the policy trends that currently define problems of alcohol and drug abuse run counter to the policy trends that define problems of homelessness. Thus the values that guide our behavior toward one issue do not inform—and may even contradict—our behavior toward another, although we may be talking about the same person in each instance.

These contradictions inevitably make coherent policy for the homeless with alcohol-related problems difficult at best. Detoxification programs, typically the gateway to other treatment services, particularly exemplify the ethical dilemmas

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JUDITH WILHITE • InfoUse, 2560 Ninth Street, Berkeley, California 94710.

posed in treating those who maintain neither sobriety nor a home—in short, the homeless alcoholic. This chapter examines a few of these issues and their implications for program policy.

DECEIT, DISCREPANCY, AND DENIAL

A persistent concern with providing treatment services to homeless alcoholics is the doubt about their real motivation for seeking treatment and, once in treatment, their likelihood of success. Can people who lack such basic needs as food and shelter use rehabilitation services effectively? Alternatively, can people with a history of alcohol problems use food and shelter provisions for the homeless in the manner for which they are intended—that is, without using them merely to support their drinking habit?

Dishonesty and denial have long been taken on faith as basic attributes of the homeless alcoholic; therefore his or her request for help is usually suspect. The skid row literature of post-World War II, for example, equated homelessness with the tramp, an older stereotype of a schemer, a con man, and a usurper of social services. In this vein, ethnographers, especially in the 1960s and early 1970s, depicted skid row survival as a kind of "one-upmanship," whereby securing a "flop" for the night, as one social investigator put it, was a way for the "Skid Row alcoholic to play a game with the established (square) elements of society" (p 76).[1] Although these accounts may have been largely an attempt to change prevalent notions about homeless men as totally dependent and powerless, they tended to add to the perception of the homeless alcoholic as an untrustworthy client.

A rare challenge to this view as Bahr and Houts's article, "Can You Trust a Homeless Man?"[2] Their research included interviews with 400 men admitted to a shelter and social service center in New York City, which then were compared to information that these men gave during earlier intake interviews. The "discrepancy rates" between these responses demonstrated that homeless men were more likely to be inaccurate about dates and long-ago events because of age and mental disabilities than to be dishonest in their answers. Even so, the role of alcohol in discrepancies or dishonesty has been largely neglected in past research on homeless or skid row men.

In this regard, the trustworthiness of an alcoholic's word belongs almost entirely to the alcohol treatment field. Central to all psychological treatment rationales is the concept of "denial." Not quite deceit and not really mental impairment, denial is used to explain why most alcoholics do not admit their drinking problem readily or seek help for it easily. As Bean notes, the concept of denial has its origins in psychoanalytic literature and is only one of several defense mechanisms.[3] Denial is a disavowal of external reality; it differs from repression, a defense against internal impulses. In the nomenclature of ego psychology, denial is thought to be both common and normal in response to trauma. Traditional and popular psychology, for example, describe denial as the first stage of coping with a crisis. Translated into alcohol problems, however, denial is a more general and more static condition. According to Anderson, the denial in alcoholism is

> a shorthand term for a wide repertoire of psychological defenses and maneuvers that alcoholic persons unwittingly set up to protect themselves from the realization that they do in fact have a drinking problem. (p 22)[4]

In its simplest formulation, alcoholics (and often their families) "deny that alcohol causes any problems in their life" or that their "life is totally out of control"[5] because of their drinking. In more formal analyses, denial is a complex system of rationalizations, excuses, and defenses that maintain drinking behavior or self-esteem, a kind of "functional deafness" that protects the ego from being overwhelmed.[3] The "denial system" is automatic, progressive, and more difficult to penetrate over time.[4] It is thought either to precede alcoholism or to be a complication of it.[3] Whatever the source or definition of denial, however, it means that "information received from alcoholic persons themselves is not very reliable" (p 19).[4]

As Finn[6] noted, alcohol treatment professionals have tended to see the public inebriate's preoccupation with food and shelter as merely the denial of the *real* problem with alcohol. Recently, however, changes in alcohol treatment and shelter provisions have necessitated new rationales for the treatment of homeless alcoholics. Drunk driving offenses, for example, have greatly expanded both public and private alcohol treatment services. At the same time, the "right to shelter" movement emerged from advocates who have tended to minimize alcohol problems. In this new policy agenda, the homeless alcoholic either was used as a historical backdrop for the "new" homeless (i.e., families, women, and the mentally ill) or was viewed as a political pawn of conservatives who wished to attribute homelessness to personal pathology rather than to structural causes. Shelter advocates usually avoided altogether the subject of alcohol abuse among homeless persons because of its taint of unworthiness.[7] Although such grass-roots efforts were effective in making physical survival and basic needs more important in policy decisions, they have tended to make it easier to rationalize the exclusion of the homeless alcoholic from both shelter and treatment services.

Local policy planners, for example, increasingly view the use of detoxification programs by homeless people as a waste, if not an illegitimate use of services. Among the recent evaluations of homeless people in detoxification, Los Angeles county established a computerized "client tracking system" to count homeless persons' uses of treatment services.[8] An analysis of 3,986 homeless people admitted to social detoxification programs in the 1984–85 Fiscal Year showed that 68.7% were admitted once, 20% were readmitted to the same program or to another social detoxification program, and the rest, about 11%, went to longer-term treatment. These patterns led the investigators to recommend more county-funded alcohol-free living centers (AFLCs) to prevent the homeless, in essence, from making detoxification facilities their home.

Another study examined the accessibility of detoxification programs for those who were thought primarily to need cheap housing and food.[9] This study noted different service patterns than those in the preceding evaluation, but it drew similar conclusions: The homeless and the poorly housed were using detoxification programs to obtain room and board rather than treatment.

Studies on alcohol use in general also have begun to look more closely at the residential status of people in treatment. In one county, Robertson found that among the people in county treatment who had been homeless at sometime in the previous year, 55% said they had entered a program for a place to stay, compared to 11% of the nonhomeless in treatment.[10] A statewide study on public inebriates in California also showed housing to be a critical need.[11] This survey reported that 84% of those jailed for alcohol offenses had a home to go to after release; only 18% of those in detoxification programs were similarly situated. Further, when data from shelters

are compared with data from detoxification programs, more people in detoxification report housing problems than people in shelters report problems with alcohol. Thus, as the report concludes, housing should come first; otherwise alcohol treatment agencies will continue to be exploited as a shelter service.

It is difficult to argue with this policy prescription. Nevertheless, one must look beyond such large-scale solutions to examine their implications for public inebriates and homeless people currently in treatment programs, especially those in detoxification facilities.

RHETORIC AND THE REALITIES OF EXCLUSION

Two changes are apparent in the recent views of the homeless in alcohol treatment programs. First, the parameters for chronicity are different. That is, fewer repeat visits to treatment programs are needed to qualify as recidivism. The public inebriates in the *Easter* and the *Driver* legal decisions, for example, had more than 100 and 200 arrests respectively, which qualified them as chronic alcoholics.[12] Even recent treatment evaluations considered 5 to 10 admissions to detoxification within a year as chronic.[13–14] Now it seems that even one repeat visit to detoxification programs by the homeless is one too many.

Second, in contrast to the earlier skepticism and caution about a homeless person's request for services, the tendency now is either to accept the client's own assessment of material needs at face value or, alternatively, to reject out of hand a homeless person's request for alcohol services. Although these new rationales have appeared, medical detoxification services have declined dramatically, and other treatment programs have grown, particularly residential and outpatient rehabilitation services.[15] Further, between 1982 and 1984, public inebriates had the lowest rate of increase in service spending among all populations in treatment. Alcohol treatment services for youth and for the elderly, for example, increased by 110% and 74%, respectively; for public inebriates, by only about 11%.[16] Moreover, in California, expenditures for drop-in centers and sobering-up stations declined by about 58% between 1978 and 1984. Spending on detoxification declined by 44%.[17]

The direction in funding for detoxification and the public inebriate contrast starkly with that for shelters and the homeless. In 1984 the estimated capacity of emergency shelters in the United States was 111,000 beds, excluding detoxification programs and facilities for runaway youths.[18] This figure represented an increase of 21% within the year and a 41% increase over the previous 4 years. By 1988 the number of beds in shelters had tripled to 275,000.[19] Most of this increase has been in shelters for families.

Reports on alcohol consumption by the homeless in shelters show another trend. According to estimates of shelter operators, alcohol abuse declined in the mid-1980s. Between 1984 and 1988, national surveys of shelter providers by the Department of Housing and Urban Development (HUD) found a decreasing prevalence of reported alcohol problems, from a range of 27% to 67% in 1984 to a range of 31% to 39% in 1988.[18–19] In San Francisco between 1984 and 1985, self-reports of people in shelters showed a similar pattern.[20] Among the shelter providers surveyed, the proportion of clients reporting occasional and moderate alcohol abuse declined (see Table I). The percentage of people reporting none or severe alcohol abuse increased, however.

These numbers do not say much by themselves, but taken together with the

Table I. San Francisco Shelter Providers,[a] Client Self-Reports on Alcohol Abuse, 1984 and 1985

		Alcohol abuse							
		None		Occasional		Moderate		Severe	
Date	(*n*)	%	(*n*)	%	(*n*)	%	(*n*)	%	(*n*)
3/6/84	194	48.9	(95)	22.7	(44)	14.9	(29)	13.4	(26)
4/9/85	320	49.7	(159)	16.0	(51)	13.5	(43)	20.9	(67)

Reference: San Francisco Department of Social Services.[20]
[a]Shelter providers include St. Vincent de Paul, the Salvation Army, Hospitality House, and Episcopal Sanctuary.

general trends, people in shelters apparently have more pressure to drink less or at least to say they drink less. Other people in shelters, however, may have more extreme problems with alcohol abuse that are less responsive to this type of social pressure.

Furthermore, in the 1984 HUD survey of shelter providers, 84% reported that they refused admission to anyone who had been drinking.[18] Local studies also have noted that shelter programs have policies that refuse admission to those with a history of alcohol and drug problems.[21–22] Thus the increasingly heavy moral censure surrounding alcohol abuse, which never has been light, would make it less likely that homeless people would report either a history of alcohol abuse or current alcohol abuse as they enter shelters. Therefore, it should come as no surprise that more detoxification clients report housing problems than shelter clients report problems with alcohol.

At the same time, detoxification programs may also be changing in regard to admission practices. In San Francisco between 1981 and 1988, the records of a mobile assistance patrol service,[24] a service originally designed to redirect public inebriates from jails to detoxification facilities, suggest some effects from changing public and professional interest. Particularly noteworthy are the changes in the source of requests for service. Table II shows that the total number of people transported and their destinations (i.e., to a detoxification facility or a hospital) remained somewhat stable, but the origin of requests for assistance changed considerably. The major

Table II. San Francisco Mobile Assistance Patrol (MAP), Client Transportation, 1981–1988

		Percentage of clients identified by[a]					Percentage of clients taken to[a]		
Year[b]	(*n*)[c]	Hospital	Detox	Police	MAP	Public	Hospital	Detox	Other
1981	(17,247)	11	05	11	38	37	17	71	12
1982	(16,433)	11	08	12	42	28	17	72	11
1983	(15,039)	07	10	14	45	25	18	72	10
1984	(14,581)	04	41	09	32	16	20	71	09
1985	(23,113)	05	51	09	22	14	20	73	10
1986	(20,806)	14	49	11	23	16	20	70	10
1987	(19,633)	21	31	10	21	17	22	69	09
1988	(17,251)	23	33	09	19	16	22	68	10

Reference: San Francisco Community Substance Abuse Treatment Programs.[24]
[a]Percentages do not total 100 due to rounding.
[b]Fiscal year ending June 30.
[c]Number for clients identified for service; approximately 2% of calls do not result in transportation assistance.

sources of requests for transportation of public inebriates are hospitals, detoxification programs, the police, outreach by the mobile patrol, and calls from the "public." In 1981, outreach and the public accounted for about 75% of the calls. By 1985 a shift in the source of requests was noticeable; by 1988 only about 35% of calls came from outreach efforts or the public.

These numbers imply that regardless of the reality, problems of homeless alcoholics or public inebriates became a less urgent matter for public policy during the 1980s. In particular, between 1983 and 1984, when public attention became riveted on the "new" homeless, the "old" homeless may have been noticed less as a group who needed assistance.

A national opinion poll conducted in 1988 also shows the distinct discrepancy between the public response toward homeless "drunks" and toward other homeless populations.[25] Funded by advocates for the homeless (designed to capture the attention of presidential candidates in the election year), the survey reported that 78% of respondents believed that adequate food and housing are a "fundamental right for every man, woman, and child" and that 75% were willing to pay more taxes to bring this about. In contrast, the homeless who abused alcohol and drugs were rated "very undeserving" of any assistance provided to homeless people in general. This attitude seemed to be tempered by the fact that the majority of people (76%) believed that alcohol and drugs were not a very significant problem among the homeless. Instead, they believed that "tough economic situations beyond a person's control were to blame" (p 22).[25]

It is not readily apparent why this survey would seek to determine who was deserving among the homeless, but one inherent bias in the survey is clear: the unexamined popular belief that people with alcohol and drug problems are not in economic situations beyond their control. In an old phrase, they are the "undeserving poor."

A SOCIETY IN DENIAL?

More important, the homeless with alcohol problems may fare even worse than the undeserving poor of earlier times. When we view the public inebriate from the perspective of shelters for the homeless, we can see the tenuous place of the so-called "old" homeless in the rehousing strategies of the Stewart B. McKinney Act of 1987 (Public Law 100-7). As Langley Keyes (1988) noted,[26] the homeless with alcohol and drug problems fit somewhere between the "chronic" and the "situational" categories of funding.

> They will be the people whom local homeless systems will first ignore when pressure mounts to demonstrate success in placing people in permanent housing.[26] (p 18)

Therefore, this seems to be the difficult question: If detoxification programs have little tolerance for homeless people, and shelters have little ability to accommodate people with alcohol problems, where do homeless alcoholics belong? Alcohol-free living centers (AFLCs) have been proposed as a way to provide longer-term provisions for chronic homeless alcoholics by moving them out of their drinking milieu for longer periods of time than detoxification programs now provide.[27] But what about homeless people who will not or cannot stay sober, who fall off the wagon, or who do not choose to sign on with an AFLC program? For them we must ask: What is the role of detoxification for homeless people with long-standing alcohol problems if it is not connected with shelter?

According to the National Institution of Alcohol Abuse and Alcoholism (NIAAA), the working definition for a detoxification program implies but does not make explicit the use of shelter:

> Detoxification (or "detox") is a process of reducing the level of intoxication to zero in a supervised [24-hour] setting. Activities often included in detoxification programs include outreach, evaluation, referral, and the initiation of recovery activities (e.g., Alcoholics Anonymous meetings). (p 7)[28]

Contemporary discussions typically raise three objections to the use of detoxification programs by homeless alcoholics. First, there is the consideration of cost-efficiency: Detoxification programs cost more than basic shelter. If shelter is all a homeless alcoholic truly wants or needs, why expend additional funds for other services? In fact, shelter and "sobering-up" stations now are included as basic but distinct services for homeless people with alcohol and other drug problems.[28] The less shelters cost, however, the more reason there is to avoid them: They offer less staffing, less protection, and more warehousing. The more homelike the shelter, the more it costs. In this regard, the estimated upper ranges in the cost of shelter beds nationally have risen from $22 per night in 1984 to $42 a night in 1988 (unadjusted for inflation).[18–19] This increase is due largely to the increase in family shelters that typically provide more support services. According to social detoxification programs in one city, however, the per-unit cost for individuals has remained remarkably stable during this period, increasing from $37 to $38 per night.[23] Thus as shelters become more truly protective, the cost differences between detoxification and shelter programs tend to disappear.

A second argument used to defend diversion of the homeless from detoxification facilities is the fear that the program will ultimately take on the roles of other institutions. Are we converting detoxification into the new poorhouse by allowing the homeless to use it to meet a variety of needs? Yet it is not the housing problems of the homeless or of the public inebriate that stand in the way of their acceptance into most welfare, housing, or shelter programs. It is their status or their behavior as related to alcohol use. Thus, if the alcohol field does not attempt to understand the events leading up to homelessness as they relate to alcohol and find a way to intervene in this process, it is clear that no other institution will do so.

Finally, there exists a therapeutic sanction that tends to operate against helping or "rescuing" any practicing alcoholic. A special term, "co-dependent," is a warning label that one easily can be caught up in the addiction process by attempting to help the alcoholic. This special dispensation to maintain one's distance, however, has more literary than scientific merit.

These objections have perverse effects for the homeless with alcohol problems. In the end, they do not build more housing, create more jobs, or even improve health or family relationships. Rather they tend to contribute to a dialogue that excludes homeless alcoholics or inebriates in ways that differ from those characterizing other treatment groups. For members of other groups, entry into alcohol treatment is rarely a straightforward decision. Treatment professionals have become comfortable working with clients who enter their doors as an alternative to jail, to avoid being fired, or to keep their marriage or health intact. In fact, as Weisner and Room noted, "breaking through denial" and the threat of jail are now considered therapeutic mainstays in working with drunk driving offenders.[29]

If detoxification programs and other rehabilitation programs are used to protect one's economic well-being, family functioning, or even legal standing, why is the provision of food and shelter considered to be an illegitimate function of treatment

programs? Alcohol problems that pose an immediate danger to one's life, in which homelessness signifies a particular risk, are relegated inappropriately (and outrageously) to a back-burner social issue in today's alcohol and drug policy scene. If denial is the nature of the beast, it appears to be far more pervasive and more selective than psychologists or alcohol experts have conceptualized.

SUMMARY AND CONCLUSION

Homeless alcoholics are a dilemma for both shelter and alcohol treatment programs. The dilemma turns on the problem of providing assistance that will not ultimately prove harmful. This dilemma is not unique to the homeless alcoholic, but it is particularly acute in contemporary policies that place the homeless alcoholic between two social trends. One trend seeks to provide humane treatment to the homeless in the form of shelter; the other seeks to curtail alcohol consumption through increasing behavioral controls. The problems of the homeless alcoholic represent a painful contradiction between these two policy responses.

The question remains: What should we do about the public inebriate or "problem drinker" who is also homeless but is not yet on the road to recovery? On at least two grounds, it makes sense to provide detoxification services as a special program for homeless people with extensive histories of alcohol abuse. First, detoxification is more than "three hots and a cot." It carries expectations, offers services, and sets goals based on the belief that a person, homeless or not, eventually can overcome dependence on alcohol or drugs. We simply do not know enough about who will or will not eventually maintain sobriety to reject the "chronics," however they may be defined. In this regard, the effects of the more liberal use of the term *chronic* for homeless people, as well as the decreasing amount of support services for public inebriates, seems to signify that we are assigning more impoverished people with alcohol problems to a state of hopelessness as well as homelessness.

Furthermore, for many people, detoxification takes place in the privacy of their home. The homeless have no such alternative. In addition, homeless clients tend to have more serious alcohol problems and longer histories of heavy drinking than do domiciled clients. As Enos Gordis of the National Institute on Alcohol Abuse and Alcoholism[30] notes, cognitive impairment from heavy, prolonged use may make it difficult during the first weeks of abstinence to benefit from treatment.

> For the most severe alcoholics, serious brain impairment is a common complication, occurring in about 10% of patients, and can take the form of alcohol amnesiac disorder—Korsakoff's psychosis—which is characterized by short-term memory impairments and behavioral changes that take place without clouding of consciousness or general loss of intellectual abilities. (p 6)[30]

Thus detoxification may be appropriate for longer periods or more frequently, particularly for homeless clients in order to help them gain a more solid footing on abstinence and maintain housing. Without such a distinction, AFLCs are likely to fill with the same clients as use traditional housing programs: those who can maintain sobriety because they are cognitively—rather than morally—more capable of doing so. In this respect, for some, chronicity should be considered the rule; spontaneous remission, the exception.

The criminal justice system that jails the public inebriate and the welfare system that may coerce the poor into abstinence operate according to a moral economy that provides basic food and shelter, if only grudgingly, as part of their institutional traditions.[31] These older systems appear to be supplanted increasingly by a moral

triage for the homeless alcoholic and the public inebriate in alcohol treatment programs. This development appears to be a worse fate than the old distinctions between the deserving and undeserving poor, for now, as a public policy issue, these individuals are invisible. The fact that they are here in our midst—perhaps in increasing numbers—is a tragedy that cannot be denied indefinitely.

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V

Special Populations

15

Gender, Racial, and Age Variations among Homeless Persons

DEE ROTH, BEVERLY G. TOOMEY, AND RICHARD J. FIRST

INTRODUCTION

The discovery of homelessness as the social problem of our times has spawned a number of important studies of homeless people, some more empirical than others. Most of these works are based on small- to medium-sized samples, which thus prohibit much descriptive analysis of subpopulations within the methodological parameters of the same sample, the same instrumentation, and, most important, the same definition of homelessness. The Ohio Study, which included 979 interviews with homeless people, provides an opportunity for such analysis. Although no study of homeless people to date can claim a truly generalizable sample procedure, this study provides one of the most representative because of its broad definition and its comprehensive sampling design. The research included a wide range of types of homeless people; the size of the sample was large enough to conduct meaningful comparisons of subgroups.

Knowledge of the variations that exist in the homeless population on such basic dimensions as sex, race, and age is critical from two standpoints. First, this type of knowledge is useful as a basis for demythologizing the many stereotypes that exist about homeless people. Second, this type of descriptive information is essential for

DEE ROTH • Office of Program Evaluation and Research, Ohio Department of Mental Health, Columbus, Ohio 43266-0414. BEVERLY G. TOOMEY AND RICHARD J. FIRST • College of Social Work, Ohio State University, Columbus, Ohio 43210.

developing programs to ameliorate the suffering of homeless individuals and to attempt constructive societal solutions for this growing social problem.

LITERATURE REVIEW

In the last decade, the interest in homelessness has grown with the burgeoning numbers of homeless people and with the emergence of the issue as a social problem. This new problem followed the well-established pattern of knowledge development that is evident in the literature documenting the emergence of most social problems.[1] First, in-depth qualitative case studies were made, and journalistic exposes were published.[2–6] Then polemic papers were written urging action on behalf on the newly discovered needy. Theoretical and analytical "think pieces" began to be presented at conferences and in journals.[7] Next, cities initiated small studies to document the problem and to describe the homeless in their geographic areas.[8–9] As attempts to understand the causes of the problem increased, more focused studies were conducted to determine the relationship between homelessness and other social deficits such as unemployment, poverty, loss of low-income housing, alcohol abuse, and mental and physical disabilities.

In view of the inherent difficulties of sampling, these studies provide valuable but often nongeneralizable findings. Further, the studies usually are limited by sample size to rather simple analyses. Only a few published works offer comparisons of homeless men and women in the same study.[10–11] Studies of the minority homeless population are not generally available. Although many studies note minority group status, they typically have not examined similarities and differences between white and black homeless people. Some publications on the elderly homeless exist, and others focus on the very young homeless, but again there is a general dearth of studies large enough to analyze by age.[12]

A report on homelessness in Chicago prepared in September 1986 examined 722 homeless people who lived on the streets and in shelters by race, gender, and age. In a bivariate split on age, this sample was disproportionately black in both gender groups under age 40; the over-40 age group was half white and half black in both genders. This study is consistent with other findings showing that more males than females are homeless (70% to 80%), most homeless people are young (median age 39), and the women are younger than the men (median age 34 to 40).[13]

The major analysis of the homeless issue has been developed in the mental health field.[14–17] Mental health professionals are concerned with that portion of the homeless population that can be classified as seriously mentally ill. They have faced the dilemma of identifying and serving mentally ill individuals among the homeless population without applying the label to *all* homeless people.[18] Because mental health research and literature have been the most highly developed in the field, there is a serious concern that mental health problems among the homeless population will be overemphasized and that the other issues and causes, such as unemployment and housing, will be forgotten.[19–20]

No major population-based studies of homelessness have been published to date based on the sample size reported here. A national study evaluating 19 Robert Wood Johnson and Pew Memorial Trust demonstration projects that provide health care for the homeless, currently conducted by Wright,[21] offers the best possibility of comparative analysis of subgroups among the homeless population. Early reports suggest, however, that problems in defining who is homeless may make that study

less comparable to the Ohio study, but nevertheless it will expand the knowledge of homeless, near-homeless, and marginally housed people.

STUDY METHODOLOGY

The data reported in this chapter were gathered in a large study of homeless people funded by the National Institute of Mental Health and conducted by the Ohio Department of Mental Health in conjunction with a statewide team of university researchers from different regions in Ohio. Face-to-face interviews were conducted with 979 homeless persons, 186 of whom were women and 793 of whom were men, in 19 counties across the state. Counties were selected through a combination of purposive and random sampling methods, such that major urban areas, small-city areas, and rural counties were drawn.

The research team developed a definition of homelessness to include a range of living conditions in which homeless people might be found. The sampling plan was designed to include individuals at each of the following levels of homelessness:

- Limited or no shelter, any length of time. (Examples: under bridges, inside door stoops, in cars, in abandoned buildings, in a bus station or an all-night cafe, or in any public facility.)
- Shelters or missions operated by religious organizations or public agencies, any length of time. These facilities are specifically for homeless people, are run on a drop-in basis, and charge no fee or a minimal fee. (Examples: Salvation Army, Volunteers of America, Open Shelter of Columbus.)
- Cheap hotels or motels when actual length of stay, or the intent to stay, is 45 days or less.
- Other situations that do not fall into the first three categories when the actual length of stay or the intent to stay is 45 days or less. (Examples: staying with family and friends, living in tent cities, having spent a night in jail.)

On the basis of these definitions we decided that the following kinds of people were not to be considered homeless: battered women living in shelters for battered women; people who lose their jobs because of cyclical reasons or traditional plant closing and move into relatives' or friends' homes while they are unemployed, understanding that they may regain their jobs at some future date; people living in shacks on property that they own; and travelers who are forced to accept shelter for the night because of a lack of money but who have come from a permanent home and are going to a permanent home. Further, it was necessary to put a cap on length of stay, or intent to stay, in the two latter categories to discriminate between people who move in and out of those settings and those who tend to live there more permanently.

The survey instrument contained items to assess individuals' mobility, reasons for homelessness, prior work history, current work and sources of income, use of social services, psychiatric hospitalization, social support, physical and mental health, substance abuse problems, general well-being, and demographic characteristics. We assessed current mental health status with 10 scales from the Psychiatric Status Schedule, developed by Robert Spitzer and his colleagues[22–23] and used widely in psychiatric epidemiological research. These scales measure a wide range of symptoms representing subjective distress, reality testing disturbance, and behavioral disturbance. In the analysis we combined the scales into two indexes, a psychi-

atric severity index and a behavioral disturbance index; scores on the former indicated the overall level of psychiatric impairment in the individual.

Interviewers were selected for their ability to engage subjects, to be comfortable in settings where homeless persons could be found, and to develop rapport with them. All 42 interviewers had at least a bachelor's degree, and most had considerable social science training. Interviewers received extensive training in approaching homeless people, engagement strategies, the use of random subject selection methods, probing techniques, and administration of the Psychiatric Status Schedule. While in the field, interviewers maintained contact logs of all encounters, documenting characteristics of those who refused or were unable to be interviewed. Subsequently we ascertained that the overall refusal rate for eligible subjects was only 10% and that demographic characteristics of those who were approached but were not interviewed successfully did not differ substantially from characteristics of individuals who were included in the study.

This research yielded a more comprehensive picture of homelessness than that provided in prior work. Homeless people were found in both urban and rural areas of the state; they were engaged successfully in interviews in a wide range of homeless conditions. Information obtained from respondents covered a broad range of topics and provided a cross-sectional picture—of homeless women as well as homeless men, of black as well as white homeless people, and of all age groups in the population—that planners and policymakers can use in designing appropriate programs.

FINDINGS

This analysis is designed to further our understanding of homeless persons by making comparisons by age, race, and sex. The groups are examined on demographic characteristics, patterns of homelessness, and problems common to homeless people. In the racial comparisons, only blacks and whites are described; 48 subjects (5% of the sample) were classified in other racial categories and are not included in this analysis. Twelve subjects (1%) were deleted in the age calculations because the age data were missing.

Demographic Characteristics

Table I presents descriptive demographic information on the homeless people interviewed. The total sample was predominantly male, white, and young; 35% were under 30 years of age, and only 29% were age 50 or older. The two racial groups had similar proportions of women, but there were fewer women and blacks in the older categories. The median age for the total sample was 34, but the men in the sample were older than the women (medians: 35 and 28), and the whites were older than the blacks (medians: 36 and 33).

Half of the homeless people interviewed had less than a high school education. As might be expected, in general the older homeless people were less educated; homeless women similarly were lacking in education. Black homeless people, however, were more likely than whites to have completed high school (51% versus 43%).

Most homeless people were unmarried at the time of interview; either they never had been married or at the present time were separated, divorced, or widowed. Women were more likely than men to be married (23% as compared to 8%).

Table I. Demographics of Homelessness

	Sex			Race		Age			
	Total (N = 979)	Male (N = 793)	Female (N = 186)	White (N = 639)	Black (N = 292)	18–29 (N = 340)	30–39 (N = 270)	40–49 (N = 164)	50 and over (N = 193)
Sex									
Percentage male	81.0	—	—	79.7	81.9	71.8	83.0	84.8	92.2
Percentage female	19.0	—	—	20.3	18.2	28.2	17.0	15.2	7.8
Race									
Percentage white	65.3	64.2	69.9	—	—	65.3	55.9	69.5	75.6
Percentage black	29.8	30.1	28.5	—	—	28.5	38.9	28.0	20.2
Education									
Less than high school graduate	54.4	52.6	62.4	56.7	48.6	49.4	43.7	62.2	71.0
High school graduate	30.4	31.3	26.9	26.8	37.3	37.1	38.5	21.3	16.6
At least some college	14.5	15.4	10.2	15.8	13.4	12.9	17.8	15.2	11.9
Marital status									
Married, living together	11.1	8.3	23.1	12.8	7.2	14.7	10.4	12.8	4.1
Separated, widowed, divorced	43.3	44.6	38.2	46.3	37.3	24.1	45.9	52.4	66.3
Never been married	44.7	46.4	37.6	40.7	53.4	60.6	43.0	34.2	29.0
Median age	34	35	28	36	33	24	34	44	57
Veteran status									
Yes	31.7	38.5	2.7	35.4	23.3	18.5	28.9	45.1	48.7
Vietnam veteran	8.5	10.3	0.5	8.0	9.6	2.9	19.3	12.2	0.5
No	67.9	61.2	96.8	64.5	75.7	80.9	70.4	54.9	51.3

More blacks and homeless people under age 30 had never married; older homeless persons were more likely to be separated, widowed, or divorced.

Interviewers asked homeless subjects whether they were veterans and whether they had served in Vietnam. One-third of the total sample stated that they were veterans. Over one-quarter of the veterans and 9% of the statewide sample had served in Vietnam. More men, whites, and older homeless persons were veterans. Vietnam veterans were concentrated in the 30 to 50 age categories, and a higher percentage of blacks said that they had served in that war. Age precluded the youngest persons in the sample from having served in Vietnam. Blacks in the sample were younger, and there were more veterans in the older groups; these conditions could explain why there were fewer veterans in the black sample.

Patterns of Homelessness

Because of the sampling methods and the size of this study, we obtained a wealth of information on the various ways in which people live while they are homeless. Subjects were asked about how they became homeless, how long they had been homeless, and how they met their needs while homeless. The information presented in Table II describes the patterns of life in the homeless condition. The median number of days homeless in the total sample was 60. Women and blacks interviewed had been homeless an average of 1 month; whites and males averaged 90 days homeless. Older homeless people showed a clear tendency to be homeless for longer periods of time. The oldest group contained men who had been "on the streets" for years and who thus raised the median number of days in this group. These are primarily men who have been described as transients, or who fit the stereotype of homeless persons as drifters or chronic alcoholics. Blacks averaged a shorter period in the homeless state. This finding may reflect a pattern of alternately returning to a place considered home for short periods and reverting to the homeless condition.

Not surprisingly, the study found many more homeless people in the urban areas but established that a proportion of the homeless population also lives in rural areas. The urban homeless population differs from the rural on several demographic characteristics. Rural homeless people were more likely to be female and white than were the urban homeless group. The rural homeless group also included more young people—often women who had left home but could not manage on their own. Because services and social values are more sympathetic to dependent women than to dependent men in rural communities, homeless men appeared less likely to be able to survive in these areas. Only a small proportion of Ohio's black population lives in rural areas; thus it is not surprising that few black homeless people were found in the rural sample.

Homeless people were found to seek shelter in a number of different places in addition to the standard missions and community shelters. As the definition of homeless used in this study implies, homeless people can be categorized by the degree to which they appear to be exposed to the elements. On the basis of information about where the subject had slept the previous night and whether he or she had stayed in a shelter or mission in the past month, we defined the following three categories of homeless persons:

- Street people: People who had had limited or no shelter the previous night and who had not used a shelter for the previous month.

Table II. Patterns of Homelessness

	Sex			Race		Age			
	Total (N = 979)	Male (N = 793)	Female (N = 186)	White (N = 639)	Black (N = 292)	18–29 (N = 340)	30–39 (N = 270)	40–49 (N = 164)	50 and over (N = 193)
Homeless type									
Street	14.2	15.6	8.1	15.7	12.0	10.9	12.6	17.7	19.2
Shelter	57.4	58.8	51.6	55.7	61.6	50.3	55.2	64.0	67.4
Resource	24.7	21.8	37.1	24.3	24.0	35.3	27.4	15.9	10.4
Median days homeless	60	90	35	90	30	43.5	60	120	150
Type of county									
Percentage urban	80.7	83.9	67.2	72.9	96.2	73.5	83.0	84.8	87.1
Percentage rural	19.2	16.1	32.8	27.1	3.8	26.5	17.0	15.2	13.0
Time in county									
Permanent resident	39.6	41.2	36.6	33.3	54.5	38.2	44.1	39.0	36.3
Longer than 1 year	23.9	22.3	30.7	26.3	20.9	20.9	18.5	18.3	40.4
Less than 1 year	35.8	36.4	32.8	39.9	24.0	40.3	36.3	42.1	22.8

- Shelter people: People who had slept at a shelter either the previous night or within the last month.
- Resource people: People who stayed in inexpensive hotels or motels or with family and friends for short periods and who had not used a shelter in the last month.

In the total sample, 14% were classified as street people, 57% as shelter people, and 25% as resource people (36 others could not be classified). As might be anticipated, men were more likely than women to be street people, and women were more likely to be resource people. Women are less frequent users of shelters, possibly because fewer shelter beds are available for women. Blacks used shelters more than whites, were similar to whites in their use of other resources, and were less likely to live on the streets. The analysis by age supports some of the long-standing images of homeless people; the older homeless people in our study appeared to fit these stereotypes. They were more likely to live on the streets or to use shelters; they were less likely to be connected to family and friends or to financial resources.

Homeless people typically are perceived as highly mobile, but this study does not support that contention. Overall, 40% of our sample had been born in the county in which they were interviewed. Another 24% of the sample had lived in the county of interview for more than 1 year. Only about one-third of those interviewed had moved recently to the county of interview. The most significant finding here is the difference between ethnic groups: Blacks were much less mobile than whites; 55% of the sample were interviewed in their county of birth. Fewer than one-quarter of homeless blacks had changed counties in the last year. Age also had some effect on mobility. Although some elderly homeless people had moved recently, twice as many of the youngest homeless people had come to their county of interview within the last year.

Problems of Homelessness

The subjects were asked to state why they had become homeless. For each subject, a single, most important answer was identified. As Table III shows, economic factors were reported most often for all subgroups; almost half of the reasons fell into this type. Family conflict and family dissolution were the next most frequent reasons cited. These reasons were not combined in this analysis because we suspected that they might reflect different dynamics; for example, young people may have left the family home because of parent–child discord, whereas one would have had to be married or in a state like marriage to perceive the family as dissolving. Other reasons cited included drug and alcohol abuse, a preference for a mobile lifestyle, and deinstitutionalization. Of all reasons, economic factors were noted most often by men, blacks, and individuals in the 30–39 age group. Family conflict was identified more often by women, blacks, and persons in the youngest homeless group; family dissolution was noted less often by blacks.

In view of the economic reasons for homelessness, sources of income were of interest. About two-thirds of the sample had had some source of income in the last month. Welfare was the most common source; earnings were second. Not surprisingly, men had more earnings, and women had more welfare. Blacks had a pattern similar to that of women. With age, both welfare and earnings declined as primary sources of income, whereas Social Security increased.

Fifty-nine percent of the sample admitted to having been in jail. Real differences were noted in the subgroup analysis: Women were much less likely than men to

Table III. Problems of Homelessness

	Total (N = 979)	Sex: Male (N = 793)	Sex: Female (N = 186)	Race: White (N = 639)	Race: Black (N = 292)	Age: 18–29 (N = 340)	Age: 30–39 (N = 270)	Age: 40–49 (N = 164)	Age: 50 and over (N = 193)
Reasons									
Economic factors	48.0	49.7	40.9	46.5	51.4	44.4	54.1	45.1	49.2
Family conflict	13.3	10.0	27.4	12.1	16.8	20.8	10.7	7.3	8.3
Family dissolution	8.0	7.6	9.7	9.6	4.1	7.4	8.2	8.5	8.3
Other	30.7	31.4	20.4	30.5	26.0	26.8	24.8	34.8	32.6
Any income in past month	63.4	61.7	71.5	64.2	62.0	67.1	62.2	58.5	64.3
Primary source of income									
Welfare	23.8	20.6	37.6	20.5	30.8	31.8	24.4	19.5	14.0
Earnings	17.1	17.9	13.4	18.5	12.3	20.0	19.6	12.8	11.9
Social Security	12.7	13.1	10.8	13.9	11.6	5.6	10.0	13.4	27.5
Other	10.0	9.8	9.7	11.0	7.2	9.4	8.1	12.8	10.9
Has been in jail	58.5	65.1	30.6	61.8	54.5	48.2	57.8	68.3	68.9
Ever had a job	87.3	88.1	83.9	91.5	80.5	84.1	87.0	88.4	93.8
Psychiatric hospitalization	29.9	29.9	30.1	31.3	29.5	24.1	32.2	33.5	34.7
Psychiatric symptomatology	30.8	29.8	34.9	33.0	26.7	31.8	31.1	32.9	25.4
Behavioral disturbance	53.7	58.0	35.5	49.0	63.0	47.1	55.2	57.9	57.5
Problem drinking	20.8	24.1	7.0	23.0	16.4	12.1	18.9	28.0	32.6
Physical health problems	30.7	28.6	39.8	33.2	28.1	34.5	27.4	36.0	42.0
Social support									
Family can count on	36.0	35.7	37.1	36.8	35.3	42.7	34.4	28.1	34.2
Friends can count on	41.0	39.3	47.8	45.9	31.9	52.4	37.8	28.7	36.8

have been confined for breaking the law. Blacks and the youngest group also seemed to have less involvement with the criminal justice system than whites and older homeless people.

A number of questions were asked to gain an understanding of the causes of homelessness and the factors that might suggest remediation of the condition. Work patterns are important because they indicate the possibility of a return to independence. Eighty-seven percent of the subjects had been employed at some time. Again, further analysis revealed the expected differences: 15% to 20% of women, blacks, and the youngest homeless people had never held a job. These results may reflect the biases in the society and the disproportionate impact of unemployment on these minority groups, but they also point to differences in rehabilitation strategies needed for these groups.

Responses about the use of alcohol and about help-seeking behavior related to alcohol problems showed that about one-fifth of the sample were problem drinkers; men, whites, and older homeless people were represented disproportionately with this problem. Chronic or acute physical health problems that needed medical attention were identified by about one-third of the total sample; women and older homeless people reported much more need for care.

The mental health needs of homeless people were a major interest of this study. About 30% of the sample reported having been hospitalized at some point in their life for a psychiatric disorder. This proportion did not vary by gender or race, but it did vary by age. Older homeless persons were more likely to have been hospitalized, but these percentages may reflect the fact that commitments to psychiatric hospitals were made more easily before the mid-1970s more than they indicate differences in rates of psychiatric disorders. A similar percentage (30%) was assessed as having some psychiatric symptomatology, as measured by four scales of the Psychiatric Status Schedule (PSS).[23] Slightly more women than men evidenced psychiatric problems; more whites than blacks were assessed as having these problems. In addition, the oldest age category of homeless people contained the lowest percentage with psychiatric problems. Using five scales from the same instrument, we found that 54% of the total sample had serious behavioral disturbances. As might be expected, men were more likely than women to have these disabilities. More blacks than whites were identified with behavioral problems; homeless people over age 30 were more behaviorally disturbed than members of the youngest group.

It is well accepted in this society that individuals seek help with life problems from family and friends. One of the most revealing findings of this study is that a high proportion of the homeless population lacked this resource. Only slightly more than one-third of the homeless sample reported that they had family and friends on whom they could count for help. (For comparison, in a needs assessment of the general rural population in Ohio, more than 90% of the group sampled said yes to these questions.[24]) Contrary to what might be expected, women had only slightly more support than men; blacks had levels of family support similar to those of whites but had less support from friends. The young more than the old had family and friends to count on; the 40- to 49–year-old age group reported the lowest levels for both of these types of help.

Homeless Women

Homeless women can be found in both urban and rural settings. The picture of homeless women that emerges in this analysis is that of young, dependent indi-

viduals unable to manage their lives. Although economic factors predominate as reasons for homelessness, women are twice as likely as men to be homeless because of family conflict and family dissolution. They are victims of social values that limit women's preparation to gain independence and to earn their own living. Almost two-thirds did not complete high school; one-fifth have never held a job. They have more physical health problems than men, only slightly more psychiatric problems, and substantially fewer behavioral and drinking problems. It seems clear that homeless women are able to obtain more of the types of minimal resources that enable them to live outside the shelter system, primarily welfare and the support of friends. These are insufficient, however, to enable them to achieve independence.

Homelessness among Blacks

In general, black homeless people in this sample were younger than whites, had a better education (more than half were high school graduates), were less mobile, and were less likely to have been married. Economic reasons were primary in their explanations of their homelessness; they were less likely to have had income from earnings in the last month. Furthermore, almost 20% had never had a job. These data would seem to support the contention that blacks suffer more than whites from unemployment even when they have more education and would appear to be better prepared for work.

Black homeless people reported more use of the service system than whites, as evidenced by their greater use of shelters and the greater receipt of welfare as income. Contrary to social expectations, black respondents reported less psychiatric hospitalization, less jail detention, and fewer alcohol problems than whites. The PSS screening tool found less psychiatric symptomatology in the black sample, but the behavioral scales showed a disproportionate number with behavioral disturbance. This finding could reflect the types of behaviors measured, such as inappropriate affect or appearance, disorientation, memory impairment, and speech disorganization. Another cautious speculation that might explain some of the difference registered in this item is that the interpretation of blacks' behaviors by white interviewers may have affected the assessment, even though the PSS was developed to counter that possibility.

Finally, black homeless people reported being homeless for a shorter period of time than whites. When we view this finding in conjunction with blacks' higher reported percentage of family conflict, we can conjecture that they may move from the homeless condition to living with family for periods of time. They showed no greater support from family than did whites and reported fewer friends to count on. They also were much less mobile; this finding also could suggest that they returned to family to reduce the lengthy periods of homelessness seen on average among white males.

Age Variations

The homeless population can be broken into age groups that reveal distinctive differences. The youngest group (under 30) made up more than one-third of the homeless sample. These individuals were the most likely never to have been married; half were high school dropouts. The largest proportion of homeless women belonged to this age group (28%), as did the largest proportion of rural homeless (27%). This age group was more mobile than others and had more support from

family and friends, although family conflict was reported as a reason for homelessness more commonly in this group than in the others. Not surprisingly, they had the shortest average time homeless and were most likely to use resources for shelter. This group had the fewest problems with alcohol, the least history of psychiatric hospitalization, the least behavioral disturbance, the fewest physical health problems, and the least likelihood of having been in jail.

The oldest homeless people (over age 50) also had some distinguishing characteristics. This group was the most predominantly male, contained the lowest proportion of blacks, and had the longest median time of homelessness. The data suggest that the stereotypic skid row alcoholic belongs to this group. Almost one-third of this group had alcohol problems; the greatest proportion of street people belonged to this group; and behavioral disturbance as measured by the PSS was substantial. These scales measure some behaviors that are symptomatic of alcohol abuse (e.g., speech disorganization, memory impairment). As correlates of age and social trends, the greatest proportion of veterans belonged to this group, as did the least well-educated respondents. This category also included the largest proportion of those who had held a job in the past and of those who had been in jail. Most of these older homeless individuals were disconnected from marriages: Only 4% currently were married and, two-thirds were separated, widowed, or divorced. This group included the lowest percentage of permanent residents, but few who were highly mobile. Generally they had moved to the county of the interview more than a year ago. They were users of the shelters; nearly one-third were recipients of Social Security and pensions and almost half had physical health problems.

The most isolated age group appeared to be the 40- to 49-year-old category. This group perceived the least social support from family and friends, had the highest mobility rate, contained the lowest percentage who had earned some income in the last month, and had limited earnings and welfare benefits. Their problems included alcohol abuse and behavioral disturbances at rates similar to those in the oldest group, with more psychiatric symptomatology.

The homeless people in their 30s were distinguished as the best educated and the least mobile. Almost two-thirds of this group had lived in the county in which they were interviewed for more than 1 year. These variables are related to race and the fact that the greatest proportion of black homeless people (39%) belonged to this age group. The Vietnam veterans were highly represented as well; they composed nearly 20% of the group. In psychiatric hospitalization, psychiatric symptomatology, and behavioral disturbance, persons in this group were similar to members of the older two groups, but they had fewer alcohol and physical health problems. Economic difficulties were most significant in explaining their homelessness, as compared to other age groups.

DISCUSSION

Perhaps the most important findings of this research are that homelessness is a multifaceted issue, that homeless people have a variety of problems and needs, and that the homeless population contains subtypes that need to be distinguished so that the phenomenon of homelessness can be understood more fully. The analysis in this chapter suggests that homeless women and men are substantially different, whereas homeless blacks and whites are less so. As might be expected, age makes a great deal of difference in the characteristics of homeless people and in the types of problems

they have. Thoughtful policymakers and service providers in various arenas need to see and understand the diversity in the homeless population as a foundation for developing service strategies and societal solutions for this very difficult social problem.

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16

Homeless Veterans

Comparisons with Other Homeless Men

DEE ROTH

INTRODUCTION

Knowledge about the homeless population in the United States has expanded rapidly in the past 5 years because of a substantial increase in research on the topic. Faced with an increasingly visible social problem, a number of cities have commissioned studies about homelessness to help them understand the dimensions of the dilemma and to provide information that might point to solutions.[1] In addition, the National Institute of Mental Health (NIMH) has funded a number of studies in an attempt to elucidate the connections among mental illness, mental health policies (particularly deinstitutionalization), and homelessness.[2] Most studies to date have yielded findings about the overall homeless population, although the NIMH-funded research also has provided in-depth information about homeless people who are mentally ill.

Virtually all of the research in the past 5 years has shown the homeless population to be a very diverse and heterogeneous group. In a few studies, however, sample sizes were sufficiently large or were designed specifically to produce information about important subpopulations within the homeless group such as minorities, women, children, or veterans. Such information is critical for planners and service providers, who must struggle with making existing service systems more responsive to the needs and problems of homeless people or who seek to develop new services to assist special groups within the homeless population.

This chapter presents data on homeless veterans, gathered as part of a comprehensive study of homelessness in Ohio. Data on homeless veterans' demographic

DEE ROTH • Office of Program Evaluation and Research, Ohio Department of Mental Health, Columbus, Ohio 43266-0414.

characteristics, patterns of homelessness, and problems and patterns of use of social services will be compared with data on the same variables for nonveteran homeless men.

STUDY METHODOLOGY

The data reported in this chapter were gathered in a large study of homeless people funded by the National Institute of Mental Health and conducted by the Ohio Department of Mental Health in conjunction with a statewide team of university researchers from different regions in Ohio. Face-to-face interviews were conducted with 979 homeless persons, 186 of whom were women and 793 of whom were men, in 19 counties across the state. Counties were selected through a combination of purposive and random sampling methods, such that major urban areas, small-city areas, and rural counties were drawn.

The research team developed a definition of homelessness to include a range of living conditions in which homeless people might be found. The sampling plan was designed to include individuals in each of four categories of homelessness, including living on the streets, in shelters or missions, in cheap hotels or motels for short stays, and in other conditions (see Chapter 15 for a more detailed description).

The survey instrument contained items to assess respondents' reasons for homelessness, mobility, prior work history, current work and sources of income, use of social services, psychiatric hospitalization, social support, physical and mental health, general well-being, and demographic characteristics. Current mental health status was assessed with 10 scales from the Psychiatric Status Schedule, developed by Robert Spitzer and his colleagues[3–4] and used widely in psychiatric epidemiological research. These scales measure a range of symptoms representing subjective distress, reality testing disturbance, and behavioral disturbance. In the analysis, we combined the scales into two indexes, a psychiatric severity index and a behavioral disturbance index; scores on the former indicated the overall level of psychiatric impairment in the individual.

FINDINGS

Because of the large number of interviews and the comprehensive nature of the methodology and sampling plan, the Ohio study is capable of yielding meaningful comparisons of subgroups within the homeless population, including veterans and nonveterans. Nearly one-third of the 979 homeless respondents in the Ohio Study—310 individuals—stated that they were veterans. Almost all of these respondents (305 or 98.1%) were men; only five women in the study said they had been in the military. Data reported elsewhere[5] show substantial differences among homeless people associated with gender; therefore the comparisons in this chapter were drawn between male homeless veterans and nonveteran homeless men.

Demographic Characteristics

Contrary to what some other studies have reported, veterans were not substantially overrepresented in the male homeless population in Ohio. Veterans made up 39% of the homeless group and accounted for 36% of the general population of Ohio

Table I. Demographic Characteristics of Veteran and Nonveteran Homeless Males

Characteristic	Veterans (N = 305)		Nonveterans (N = 485)		Homeless men (N = 790)	
	No.	%	No.	%	No.	%
Race						
White	222	72.8	287	59.2	509	64.4
Black	67	22.0	169	34.9	236	29.9
Hispanic	9	3.0	21	4.3	30	3.8
Other/unknown	7	2.3	8	1.7	15	1.9
Total	305	100.1	485	100.1	790	100.0
Age						
18–29 years	60	19.7	183	37.7	243	30.8
30–39 years	78	25.6	144	29.7	222	28.1
40–49 years	73	23.9	66	13.6	139	17.6
50 years and older	93	30.5	85	17.5	178	22.5
No answer	1	0.3	7	1.4	8	1.0
Total	305	100.0	485	99.9	790	100.0
Median age		42		33		35
Education						
Less than high school graduate	141	46.2	276	56.9	417	52.8
High school graduate	90	29.5	155	32.0	245	31.0
At least some college	73	23.9	49	10.1	122	15.4
No answer	1	0.3	5	1.0	6	0.8
Total	305	99.9	485	100.0	790	100.0
Marital status						
Married, living together	27	8.8	39	8.0	66	8.4
Separated, widowed, divorced	183	60.0	171	35.3	354	44.8
Never married	94	30.8	273	56.3	367	46.5
No answer	1	0.3	2	0.4	3	0.4
Total	305	99.9	485	100.0	790	100.1

males age 16 and older in the 1980 census.[6] Twenty-seven percent of the homeless veterans said that they were in the military during the Vietnam War, exactly the same as the percentage of Vietnam veterans in Ohio's general veteran population.

As Table I shows, nearly three-quarters of the veterans in the sample were white, and one-quarter were nonwhite. In contrast, the nonveteran group was 60% white and nearly 40% nonwhite. The Vietnam-era veterans fall between these two sets of percentages, with 65% white and 35% nonwhite. Substantial differences exist in the ages of the two groups; the veterans' median age was 42, nine years older than that of nonveterans. The largest concentration of veterans is found in the 50 years and older category, whereas the largest concentration of nonveteran homeless males occurs in the under-30 age group.

Homeless veterans are better educated than their nonveteran counterparts; 53% have at least a high school diploma. Only 42% of the nonveteran group are similarly educated. The disparity is most pronounced among those with some college educations; veterans constitute 60% of this group and account for 76% of all homeless college graduates.

Sixty percent of homeless veterans were either separated, widowed, or divorced; nearly one-third had never married. These two categories are almost reversed for nonveteran homeless men: More than one-third were separated, widowed, or divorced, and 56% had never married. Certainly some of this difference is due to the higher median age of the homeless veteran group. The distribution of marital status categories in the overall homeless population differs dramatically from

Table II. Problems of Homelessness for Veteran and Nonveteran Males

Characteristic	Veterans (N = 305)		Nonveterans (N = 485)		Homeless men (N = 790)	
	No.	%	No.	%	No.	%
Major reason						
Economic factors	161	52.8	230	47.4	391	49.5
Family problems	50	16.4	89	18.4	139	17.6
Alcohol problems	29	9.5	40	8.3	69	8.7
Like the lifestyle	24	7.9	29	6.0	53	6.7
Other	41	13.4	97	20.0	138	17.5
Total	305	100.0	485	100.1	790	100.0
Has been in jail		71.5		61.2		65.2
Physical health problems		31.2		27.2		28.7
Problem drinking		29.8		20.6		24.2
Psychiatric symptomatology		32.1		28.5		29.9
Behavioral disturbance		53.1		60.8		57.9

the distribution found in the general population, and even more so for veterans. U.S. Census figures for 1980 show that 81% of all Ohio male veterans over age 16 were married, 11% were separated, widowed, or divorced, and only 8% had never married.[7]

Patterns of Homelessness

Patterns of homelessness did not differ substantially between veterans and nonveterans. The median number of days homeless for both groups was 90; the great majority of both groups (86% of veterans and 83% of nonveterans) were interviewed in urban counties. Most homeless people in the Ohio study were found to be long-term residents of their counties. This finding was slightly more true for veterans; 65% had lived in their counties for longer than a year, compared with 61% of nonveteran homeless men.

Problems of Homelessness

Economic problems were cited as the primary reason for homelessness by half the overall sample. As shown in Table II, economic factors were slightly more prominent for veterans, but there were no major distinctions between veterans and nonveterans in the causes of homelessness. The greatest contrasts between the two groups are found in the percentage who had been in jail (72% of veterans and 61% of nonveterans) and in the percentage who had drinking problems. The study was not designed to yield a clinical diagnosis of alcoholism, but the principal investigator worked with researchers at the National Institute for Alcoholism and Alcohol Abuse to construct an index of "problem drinking" from two items on the questionnaire: the amount of drinking that had taken place in the previous month and whether the respondent at any point in his life had had to go to someone for help about a drinking problem.[8] Thirty percent of the veterans were classified as problem drinkers, in contrast to only 21% of other homeless men; almost all of the difference was explained by the variable of having sought help previously for drinking.

Veterans were slightly more likely to report having physical health problems

that needed medical attention. One-third of veterans were found to be psychiatrically impaired; one-half showed signs of behavioral disturbance. The nonveterans had a somewhat lower percentage of persons with psychiatric symptomatology, but a higher percentage with behavior disturbance.

Resources and the Use of Social Services

As a first step in constructing ameliorative solutions, it is important to understand the strengths and resources of homeless people and the ways in which they are already interacting with the social service system. Contrary to the image projected by the popular media, homeless men in Ohio were not a totally destitute group who lacked connectedness with either family or friends. As shown in Table III, more than 60% of both veterans and nonveterans had had some income in the past month, but the primary source of that income differed somewhat between the two groups. Nonveterans were more likely to rely primarily on welfare or earnings, whereas veterans' primary source of income tended to be divided fairly evenly among welfare, earnings, Social Security, and others. Within the "others" category, 12 veterans (4%) stated that their major source of income was a pension. One-quarter of each group had worked for pay in the past month, but more veterans (94%) than nonveterans (85%) had ever held a job. Interestingly, 6% of veteran respondents apparently did not regard military service as prior employment. More veterans than nonveterans (40% vs. 33%) said that they had family on whom they

Table III. Resources and Use of Social Services for Veteran and Nonveteran Homeless Males

Characteristic	Veterans (N = 305)		Nonveterans (N = 485)		Homeless men (N = 790)	
	No.	%	No.	%	No.	%
Any income in past month	195	63.9	293	60.4	488	61.8
Primary source of income						
Welfare	54	17.7	109	22.5	163	20.6
Earnings	49	16.1	93	19.2	142	18.0
Social Security	44	14.4	60	12.4	104	13.2
Other	48	15.7	31	6.3	79	10.0
Ever had a job		93.8		85.2		88.5
Worked in the past month		26.6		25.4		25.8
Social support						
Family can count on		39.7		33.4		35.8
Friends can count on		38.7		40.0		39.5
Use of services						
Shelters		66.6		54.0		58.9
Community kitchens		67.5		66.8		67.1
Hospital emergency rooms		26.6		20.8		23.0
Welfare services		37.4		39.8		38.7
Community mental health centers		12.8		9.3		10.6
Psychiatric hospitalization						
Never been hospitalized	198	64.9	344	70.9	542	68.6
Been hospitalized	104	34.1	133	27.4	237	30.0
Veterans hospital	54	17.7	6	1.2	60	7.6
General hospital	31	10.2	66	13.6	97	12.3
State hospital	58	19.0	90	18.6	148	18.7
No answer	3	1.0	8	1.7	11	1.4
Total	305		485		790	

could count for help; about 40% of both groups stated that they could count on friends for help.

We noted some interesting differences between veteran and nonveteran homeless men in their use of the array of available social services. Higher percentages of veterans use community soup kitchens, hospital emergency rooms, and community mental health centers. The largest difference, however, is that shelters are used by a substantially higher proportion of veterans (67%) than of nonveterans (54%). Approximately one-third of veterans have had a psychiatric hospitalization, 7% more than among nonveterans. Further, as shown in Table III, veterans have been hospitalized in more types of psychiatric inpatient settings: Slightly over half have been in a Veterans Administration hospital, well over half have been in a state hospital, and nearly one-third have been hospitalized in a general hospital psychiatric ward.

DISCUSSION AND COMPARISON WITH OTHER STUDIES

The overall picture of homeless veterans that emerges does not differ greatly from that of nonveteran homeless males. Veterans tend to be older and better educated and are more likely to be white. These demographic patterns also have been reported by Robertson and Abel in Los Angeles and by Schutt in Boston in their studies of homeless veterans.[9–10] Almost no homeless men in either group are currently married, but veterans are more likely to have been married in the past and to have lost that relationship through death, divorce, or separation. Both Robertson[9] and Schutt[10] noted this pattern, but Schutt found a higher percentage of veterans who had never married.

Economic problems, unemployment, and work histories are similar for both groups, and most homeless men had some, although limited, resources: current work or other income or support from family or friends. Although veterans had higher rates of physical health problems and psychiatric symptomatology, differences in the Ohio sample were not massive. Studies in Los Angeles and Boston produced similar conclusions. Although rates of current psychiatric symptomatology were nearly the same for veterans as for nonveterans, a higher percentage of veterans had had psychiatric hospitalizations. Robertson and Abel also found greater rates of prior psychiatric hospitalization in their studies.[9] A factor that may be related to higher rates of psychiatric hospitalization is the higher rate of alcohol problems among veterans. Current standards for admission to state hospitals in Ohio prohibit admission for a primary diagnosis of alcoholism without substantial psychiatric problems, but criteria were less stringent several years ago and even today may be less stringent for Veterans Administration hospitals.

Homeless veterans do seem to differ from other Ohio homeless men in their reliance on the social service system as a means of survival. Veterans tended to use almost all available services at greater rates, particularly shelters. One might speculate cautiously that veterans' tour of military duty exposed them to a system of services that civilians typically do not experience and that subsequently they have sought out community services for assistance with their homelessness. Schutt, however, found greater use of the service system only in the case of shelters in his study in Boston.[11]

Although some consistent demographic profiles and patterns of problems for homeless veterans seem to emerge from the Ohio study, they lack sufficient explanatory power to enable us to draw conclusions about causality or to devise effective

service strategies. As is the case with the homeless population in general, homeless veterans are a diverse group with complex problems. Policymakers and service providers must work to understand meaningful subpopulations within the veteran group in order to develop programs that will succeed in alleviating their homelessness.

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The Elderly Homeless

SUSAN LADNER

INTRODUCTION

Popular views of the homeless used to conjure up images of aging alcoholic men, estranged from family and friends, who lived lonely and unstable lives in poor downtown areas.[1] Most studies of the homeless in the 1960s and 1970s were conducted in skid row areas; they reported that many more of the men studied were over age 65 than under age 30.[2] Today, older white male alcoholics no longer form the predominant group among the homeless. They have been displaced as the majority by large groups of unemployed adults, families, poorly educated youths,[3] the deinstitutionalized mentally ill, and poor elderly adults who are unable to find permanent, low-rent housing.

The elderly who are homeless constitute only a small percentage of the total homeless population.[4] According to recent studies, those age 60 and older account for only 3% of the homeless in St. Louis,[5] 4% in New York City,[6] 6% in Los Angeles,[7] 7% in Portland, Oregon,[8] and 8% in San Francisco.[9]

Although the percentage of elderly persons who are homeless is low, there are many whose social marginality, lack of financial resources, or chronic ill health causes them to be seriously at risk of homelessness.[10] Not only are most of the elderly afflicted with chronic conditions, but they are more likely to be poor if they live alone or with nonrelatives than if they live with families.[11] Recently, the number of elderly persons living alone increased almost three times as much as the growth rate of the elderly in general.[12] In addition, the relatively small percentage of homeless elderly persons can be increased at any time by the failure of the safety nets that currently prevent persons at risk from losing their housing. For example, almost 20%

SUSAN LADNER • National Academy Foundation, 660 Madison Avenue, New York, New York 10021.

of New York City's elderly[13] have an annual income of $5,000 or less, which places them at risk in an especially tight housing market.

The very presence of even a few men and women over age 60 in homeless shelters or on the streets indicates a failure of the traditional human services and benefits systems. The aged homeless are of special concern because of their vulnerability to victimization while on the streets and in shelters, their frailty due to poor physical health, and the reluctance of community senior centers to accept them as participants. Thus the characteristics of the elderly homeless must be examined and their special programmatic needs must be assessed to provide for adequate and appropriate community housing, social, health, and mental health services within existing service systems developed specifically for the elderly.

CHARACTERISTICS OF THE ELDERLY HOMELESS

Detailed data[6] on the characteristics of New York City's public shelter clients are available from interviews conducted on 8,061 clients between November 1982 and December 1983. Of these, 353 were age 60 or older. Although these characteristics may not necessarily represent those of the homeless aged 60 and over living on the streets or in small privately operated shelters in New York City, a sketch of the elderly homeless based on these data is useful because of the large number of persons studied. The data are derived from interviews based on an intake instrument used in the 14 public shelters for single, adult homeless men and women. All information collected on the intake forms was self-reported by the clients without external verification.

All shelters studied offered dormitory-type sleeping arrangements, three meals, some recreational activities, and social services. Several of the shelters also provided medical and mental health services and work experience programs. The nine men's shelters ranged in size from 111 to 816 beds; the five women's shelters ranged from 45 to 200 beds.

The elderly were underrepresented among shelter clients when compared with the city's general population (4% versus 18%). Of those in the shelters who are over age 60, almost 60% fall into the 60- to 64-year age group, compared to the 27% of New York City residents over age 60.

Sex and Ethnicity

The majority of aged shelter clients are men (67%), although nearly equal proportions of women (8%) and of men (5%) are age 60 and older. The ethnic composition of the clients varies by age; fewer whites are found among younger clients. Among the aged, more women are white (40% versus 34% for men). The aged were most likely to be black (49%) and white (40%), with few Hispanics (9%); the youths (18- to 21-year-olds) were predominantly black (70%), with some Hispanics (21%) and few whites (9%).

Marital Status and Family Background

Lifelong patterns of disaffiliation popularly attributed to the homeless are not evident among the elderly in the shelters. The elderly are more likely than the general shelter population both to have been married and to have spent their childhoods in traditional family settings.

Elderly clients were more likely to report that their primary childhood setting was with both parents (69%, compared with 40% for 18- to 21-year-olds). The elderly also were less likely to have been in foster care (9% versus 2%) or in other institutions (3% versus 1%) than were 18- to 21-year-olds.

Shelter Referral and Reason for Stay

The majority (60%) of the elderly cited their eviction from previous housing because of lack of funds as the reason for their shelter stay, whereas 24% were evicted because they were no longer welcome by other tenants.

Discharges and referrals by hospitals and jails directly to shelters occurred more frequently for the elderly than for other shelter clients. Whereas most shelter clients entered the shelters on their own or on a friend's advice, the elderly were likely to have been referred either by a hospital or by the police. An additional 9% of the elderly came to the shelter because they could not find any housing on their release from the hospital or other institution.

The elderly were most likely to be living in shelters because they had lost their previous independent housing. During the 3 to 6 months before their shelter stay, most of the elderly had lived independently either in their own apartments, in single room occupancy (SRO) buildings, or in rooming houses. More than half had lived independently just before moving into a shelter, and one-quarter had lived with family or friends. About half of the elderly (47%) also reported that they had stayed in a shelter previously.

Psychiatric and Substance Abuse Problems

Elderly residents reported fewer psychiatric and drug-related problems than did other shelter clients, although they reported similar alcohol use (see Table I). Fourteen percent of the elderly reported having a current psychiatric problem, and 15% had been psychiatric inpatients at some time. Few (5%) of the elderly reported any drug use; fewer than 1% of the elderly acknowledged current drug use. Regular drug use at some point in their lives was reported by 3% of the elderly.

The elderly were no more likely than the other shelter clients to report alcohol problems. About half of the elderly reported no past alcohol use. The elderly males, however, were three times more likely than the elderly women to report alcohol abuse.

Barriers to Independent Living

Although almost half of these elderly shelter clients received benefits such as SSI, they still lacked sufficient funds to support themselves in stable housing. In addition, low educational levels, limited marketable job skills, and poor health were serious barriers to supplementing benefits with additional income from jobs.

More than one-third of the elderly had only an elementary school education, compared to 14% of the total shelter population. Yet one-quarter of the elderly had graduated from high school. The elderly females had achieved higher educational levels than the males; more were high school graduates (55% versus 31%), and more had attended college (25% versus 9%).

Even though most of the elderly had been members of the work force in the past (only 4% had never worked), their work experiences were mainly in unskilled and

Table I. Selected Characteristics of Elderly Clients in 14 New York City Public Shelters, 1982–1983

Characteristic	Age 60 or older (N = 353)	Total shelter sample (N = 8,061)
Demographics		
Male	67%	88%
Single	40	69
Referred to shelter		
From hospital	11	5
By police	16	8
Most recent residence		
Independent	55	39
With family or friends	25	40
Mental health		
Current psychiatric problem	14	20
Ever psychiatric inpatient	15	22
Substance use history		
Ever used alcohol	53	57
Current regular alcohol use	13	12
Ever used drugs	5	22
Regular drug use at some time	3	17
Barriers to independent living		
Did not complete high school	74	71
Current medical problems	57	37

semiskilled jobs. Most had worked as unskilled laborers (43%) or in semiskilled positions (24%). Four percent of the elderly and 9% of the total had worked in clerical or technical jobs.

Current medical problems were reported more frequently by the elderly than by others. More than half (57%) reported current medical problems, and about one-third (32%) were currently patients at medical clinics. In addition, a significant minority of elderly clients reported that their physical problems prevented them from working (27%), more than double the proportion for other residents.

Summary Profile

Data from New York City adult shelters provide a profile of the elderly homeless. A shelter client is most likely a poorly educated black male in his 60s who spent his childhood with both parents and has been married. Before coming to the shelter, he lived on his own in an apartment from which he was evicted because of lack of funds. Although he probably received benefits such as SSI, he still could not afford housing. He worked in the past as an unskilled or a semiskilled laborer; most likely he attributes his current inability to work to his chronic medical conditions. He is less likely than members of other age groups to suffer from psychiatric or drug use problems, although he is equally likely to report current and past alcohol use.

POLICY IMPLICATIONS

Housing

A range of housing options with easy access to services is an immediate need of the elderly homeless. As single room occupancy hotels (SROs) and rooming houses

are torn down during urban renewal, the elderly often are displaced and their informal support systems and social networks are destroyed.[14–15] In city neighborhoods with easy access to services such as laundromats, cheap restaurants, and public transportation, low-rent hotels and rooming houses that are well maintained to ensure habitability are important housing options for elderly persons who are both interested in and capable of independent living. Subsidized housing with built-in access to social services enables the elderly to live independently for longer periods. In addition, enriched housing programs, such as small units of decentralized group-living arrangements, are necessary for those whose impairments require the provision of coordinated daily services.

Institutional Contact

Some of the homeless and the at-risk elderly are unable to live independently. They may have conditions that require special services available only in hospitals, nursing homes, domiciliary care facilities, or psychiatric or substance abuse programs. Policies from these programs must be changed to ensure that the elderly are not discharged until adequate residential services are located; discharges never should be made directly to shelters. In addition, reimbursement policies must be adjusted to remove incentives either for early discharge or for discharge without housing referrals.

Existing Service Systems

Residential, health, mental health, and social services already available in most communities must be adapted to meet the special health and social needs of the elderly homeless. In order to help prevent homelessness, they also must be accessible to the elderly whose financial and social marginality and poor health put them at risk of long-term or permanent housing loss. Once the homeless and the at-risk elderly are assured access to an appropriate network of community programs, shelters can be used only as emergency and temporary services rather than as substitutes for permanent housing and support programs.

Generally, the basic services needed by the homeless and the at-risk elderly are already provided in most localities. These include (1) subsidized housing with easy access to, or on-site availability of, social and health services; (2) entitlement counseling and advocacy services; (3) health and nursing services directed at preventing deterioration and improving chronic medical conditions; (4) recreational programs emphasizing the development and maintenance of socialization skills; and (5) adequate transportation services ensuring linkage with shopping, recreational, and clinical services as well as with informal social networks of neighborhood storeowners and service providers.

Senior Centers

Senior centers, funded either by Title XX of the Social Security Act or by Title III of the Older Americans Act, are community resources providing services aimed at the physical, emotional, and social needs of those age 65 and older. Usually senior centers provide the well elderly with daytime activities, including lunch, and focus on socialization and personal development.[16]

Senior centers should be viewed as essential community resources for the elderly. Those in neighborhoods with high concentrations of homeless or at-risk el-

derly persons should be restructured to accommodate the integration of the homeless into the community. Selected centers should be restructured into therapeutic rehabilitative and supportive programs with activities designed to engage the homeless elderly and those at risk and should encourage them to interact with the other participants. Temporary 24-hour shelter as well as housing and entitlement assistance could be established in some centers to help prevent the homelessness of those with recent housing losses or improper hospital discharges.

In addition to providing recreation, entitlement counseling, advocacy, and meals, services in these restructured centers could include case assessment and management, showers and clothing, housing assistance, health consultation, and formal admission arrangements with local health and mental health programs.[3] Staff members would receive special training directed at understanding the homeless and those at risk and at encouraging their acceptance by the other participants.

Social and health services must be a priority in order to move the elderly from the streets and shelters. At the same time, the potential homelessness of those at risk must be prevented by ensuring the availability of financial, case management, and housing services. As existing community programs move to guarantee that they are accessible to and appropriate for the homeless and for those at risk, homelessness among the elderly will be reduced.

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VI

Homeless Women

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Homeless Women
Beyond the Bag Lady Myth

ESTHER S. MERVES

INTRODUCTION

Women constitute one of the fastest growing groups among the homeless persons in the United States, but their existence, needs, and concerns have rarely been an object of investigation. Historically their very existence on skid rows was denied. Today, although their presence among the homeless has grown, little attention is devoted to them because they are less numerous than homeless men, their needs are thought to be less great, and their worthiness as service recipients is questionable.

Whereas the economy is more likely to be blamed for homelessness among men, a woman is more likely to be blamed personally for her failure as a marriage partner or parent. A homeless woman is more of a social outcast than a homeless man because she violates the stricter prescriptions of the proper role for women.

The presence of homeless women is often perceived as unsightly and threatening, although the public is usually more concerned with the safety and welfare of the women themselves than with their potential threat to the public order.[1] Public attitudes toward the homeless usually reveal fears of contamination. Other observers have suggested that at the root of public concern are societal attitudes regarding what constitutes a suitable lifestyle for women.[1] Because homeless men are more readily accepted, homeless women seem to be more "out of place."[1] Thus they can survive as long as they or their very presence do not annoy nor offend anyone. Homeless women must seek safe places where they can remain inconspicuous and anonymous. For women with children, such invisibility takes active maneuvering, especially at night.

This chapter will review the literature on homeless women in four parts. The

ESTHER S. MERVES • Department of Sociology, Kenyon College, Gambier, Ohio 43022.

prevalence of women among the homeless and the variety of women who are homeless are discussed first. Next, the causal factors and the conditions contributing to female homelessness are reviewed, including a focus on the marginalization of women in the housing market.[2] The third section reviews the more recent empirical research on homeless women, and the conclusion focuses upon strategies for change.

WOMEN AMONG THE HOMELESS

Myths and Stereotypes: Homeless Women as Bag Ladies, Prostitutes, and Bad Mothers

The myths and stereotypes about homeless women are an important starting point because they reflect the social images and conceptions from which popular opinion is formed and because they affect service delivery. The popular stereotype of the bag lady has contributed greatly to the misunderstanding of the plight of homeless women and to the refusal to acknowledge the situation. The mysterious elderly woman carrying her bags, which perhaps contain a bankbook worth millions of dollars, is one popular myth. Bag ladies also are regarded as psychological misfits who allegedly refuse any offers of assistance.

Of course the reference to homeless women as "bag ladies" is gender-specific. All women carry bags or purses, but homeless women do not have kitchen cupboards or closets in which to store their belongings.[3] The negative reference signifies women's alleged attention to minute details. Although excluded from the romanticized world of the homeless man, the "bag lady" as an eccentric oddity has gained popularity to the point of being exploited for commercial gain. Examples cited by Hirschfield include a company printing shirts with a picture of an elderly homeless woman whose picture had been published earlier in a photography book.[4] Bloomingdale's Department Store has featured a "bag lady look" emphasizing layered, oversized clothes, and recently Tiffany's presented an image of a homeless woman next to an expensive piece of jewelry.

The 1979 report on homeless women by the Manhattan Bowery Corporation has been cited often as one of the most substantive documentations of homeless women to date.[5] It suggests that the value of the label *shopping bag lady* is limited because it does not reveal less-known connotations, such as constant vulnerability to crime, street hazards, and the elements.[4]

In contrast to the stereotypic bag lady, younger, single homeless women may be seen as loose and immoral women who "deserve what they get." The myth that a homeless woman will prostitute herself is so strong that female shelter residents routinely complain about being asked, "How much?"

Although a homeless woman with children may arouse more sympathy than a woman alone, her suitability as a parent may be questioned. The homeless woman who seeks housing assistance may find herself in jeopardy of losing her children because failure to provide a home may be grounds for a charge of child neglect. Homeless mothers have reported that their children were removed from them and placed in foster care when they applied for Aid to Families with Dependent Children. Ironically, despite public sympathy for the children, many cities lacked shelter space for families, especially during the early 1980s.

Related to these stereotypes are the notions that the majority of homeless women are alcoholics or disaffiliates who have no contact with existing service systems.

Although these notions are contradicted by both quantitative and ethnographic research, such stereotypes persist, suggesting that homeless women are to blame for their personal choices and failures. Furthermore, the stereotypes of the homeless woman as bag lady, prostitute, or negligent parent tell us little about the meaning of their experience or why the number of homeless women is growing.

The body of research on homeless women also is growing; much of it is devoted to dispelling myths. Rich and detailed portraits of the plight of homeless women have been sketched, including the discrimination, the stigma, and the dangers that they face. To date much of this material has been in the form of testimonials, photographic essays, and diaries, which supplement more traditional surveys of the population.

Prevalence of Women among the Homeless

In 1978 the mere presence of women and children among homeless people in a society was considered an indication of widespread social disorder and instability, usually resulting from famine or civil war.[6] Today's social disorder is of a different sort, which will be discussed below.

As is true for homeless populations generally, the enumeration of homeless women is plagued with difficulty. For women the problem is compounded by the fact that they are less likely than homeless men to be in places where the homeless are counted. Thus we suggest that any enumeration of homeless women is likely to underestimate their numbers. Furthermore, the estimates of the numbers of homeless women vary not only by the method and definitions of homelessness used in the estimates but by family composition as well.

Enumeration is complicated further for women because of the difficulty in distinguishing single women from those heading families and from those with spouses. For example, on the basis of a national survey of homeless shelters made in 1984, HUD estimated that one-third of shelter residents were women and family members[7–8]; a more focused estimate on women, however, is not offered.[7–8]

Finally, enumeration is affected by the definition of homelessness used. The HUD report cited, for example, excluded domestic violence shelters from its survey; this exclusion obviously affected the resulting estimates of prevalence.

Nevertheless, one HUD report estimated that 16% of the homeless are individual women.[7] In the 1986 U.S. Conference of Mayors' report on homelessness in 25 cities,[9] single women were estimated to constitute between 4% and 37% of the homeless population among those surveyed. Furthermore, four of the cities surveyed (San Antonio, St. Paul, Salt Lake City, and Washington, DC) reported that the number of homeless single women had increased in recent years.[9]

Some researchers estimate that one-half of all the homeless are women.[10] The Manhattan Bowery Corporation estimates that from 6,000 to 6,500 individual women are periodically homeless in New York.[1] In 1984, Crystal calculated that the number of women in New York City shelters had increased 28% from 1983, compared to an 18% increase for men, and estimated that women constitute 12% of the New York City shelter population among individuals.[11]

Prevalence of Homeless Families

Estimates of women among families also are problematic. For example, in the 1984 survey of emergency shelters nationally, HUD estimated that one-third of shelter residents were women and family members.[7]

The report concluded that the most significant difference in the homeless population was the growing number of families with children; 85% of the cities noted an increase in this group.[9] In the 1986 U.S. Conference of Mayors' Report on Homelessness, families were estimated to constitute between 4% and 80% of the homeless population in the 25 cities surveyed.

The Children's Defense Fund has documented the epidemic growth of homeless families in major United States cities.[12] In New York City the number of families has tripled in 2 years; the prognosis is an estimated 110,000 families as potentially homeless.

The Children's Defense Fund characterizes a typical homeless family as composed of a single female head of household with more than one child. Their report cites an increase in the number of battered women and children seeking shelter, as well as a recent increase in two-parent families seeking shelter.

The Massachusetts Department of Human Services reported that 75% of the state's homeless are families headed predominantly by women.

In sum, the estimates of the numbers of homeless women vary not only by the method and the definitions of homelessness used but also by family composition and by the geographic area under consideration. Nevertheless, one finds consistency among the numerous reports, newspaper accounts, and local studies that document the astronomical increase in demand for food and shelter; these demands are no longer considered as an emergency but as chronic and long-term. In December 1983, even the popular magazine *Glamour* reported that the number of homeless women and children was expected to reach record levels and urged readers to volunteer and to write national agencies for help.

Types of Homeless Women

Women are found among the homeless as individuals, as family heads, as spouses, as victims of domestic violence, as former or current psychiatric patients, and as physically disabled persons. Shelter residents include women of all ages, races, ethnic groups, and social backgrounds. Although some hold professional degrees, others were employed as factory and food service workers, secretaries, domestic workers, and nurse's aides. Many were abused as children. Others were abused by their own children, husbands, and boyfriends, and now by strangers on the street.[10] Many were victims of urban renewal, gentrification, and a deinstitutionalization process that left them with no community care arrangements. Thus there are many subgroups among homeless women, just as there are among homeless men. What is peculiar to women is the way in which gender and work structures combine to produce homelessness.

It is not altogether clear how one should separate women into the various subgroups because the subgroups are not mutually exclusive. The most common division, however, is between individual women and women heading families, although an individual woman may have children who are not in her custody, who are grown, or who are in other arrangements. Shelter programs usually segregate homeless families headed by women and homeless individual adult women. It is ambiguous whether the term *single woman* denotes family structure or marital status. To avoid this ambiguity, the term *individual woman* is used here to denote a homeless woman unaccompanied by children. *Female householder* denotes a woman who heads a household, whether or not children are present in the household. In other words, a female householder is a single head of household or of a family.

One local study in Ohio sought to sample the variety of homeless women in terms of demographic and relevant social categories. A sampling matrix of 15 theoretical categories was used, including single women, married women with spouses and no children, single parents, married women with spouses and children, minority women, victims of domestic violence, women who were previously institutionalized or in need of related services (physical/mental), and women who were previously incarcerated, young, elderly, homeless for the first time, chronically homeless, nearly homeless, recently homeless, and refugees.[13]

In other words, the range of homeless women goes well beyond the representation of stereotypic bag ladies. Perhaps, as Marin suggests, "the word 'homeless' can be applied to so many different kinds of people, with so many different histories, that it is almost meaningless."[14] Hopper and Hamberg discern at least 10 different subgroups of homeless persons.[15] Women are mentioned explicitly as the category of single women, although adult women also would seem to be implied clearly in the other categories: single-parent households, victims of domestic violence, psychiatrically disturbed and physically impaired, elderly and near elderly, legal and undocumented immigrants and Native Americans, and formerly (two-parent) working families. The remaining subgroups included single men, ex-offenders, and youths.

CONTRIBUTING FACTORS

The Social Context

Factors such as unemployment, depletion of low-income housing, and inadequate social welfare benefits are specified as causes of today's homelessness. When we add gender to the analysis, we see that working-class women are particularly vulnerable to homelessness because of the pervasive influence of a patriarchal social system that defines women first and foremost as wives and mothers. Women's social position in the family and the labor market make poverty and subsistence living a reality for increasing numbers of women, especially minority and working-class women. Therefore *both* gender and class analysis are necessary conceptual frameworks in understanding why women become homeless.

Homeless women often face discrimination. For example, a shelter program may offer different services to homeless men and to homeless women, or they may not offer any services to women. (Differences in available services will be discussed in the next section.) It is necessary, however, to examine the social position of women in the general population to understand the discrimination they suffer when they are homeless.

The nuclear family model remains so strongly dominant that the growth of female-headed households, both with and without children, is regarded as a deviant demographic explosion. The proportion of households headed by females (both family and nonfamily) has increased dramatically from 15% in 1950 to 27% in 1980.[16] Women are also increasingly heads of families, from 9% of all family households in 1950 to 15% in 1980. Similarly, the number of nonfamily female households has grown from 3 million in 1950 to 12.8 million in 1980[16]; approximately one-half of this nonfamily group are elderly women.

Few analyses exist to examine the causes of female homelessness, but Slavinsky and Cousins[10] offer some explanations for the increasing numbers. First, changes in the economy and in public policies may have a greater impact on women. Second,

women's salaries are lower than men's and have not kept pace with men's, especially as the cost of living has increased.[10] Furthermore, the authors state:

> Many divorced or widowed older women are unable to compete in the current job market and regardless of whether or not they have been employed outside the home, older women are the largest population group drawing minimum Social Security benefits in this country. In urban areas unfortunately, those who must live on minimum Social Security benefits are frequently forced to choose between food and shelter; the minimum benefit simply does not stretch far enough to cover both.[10]

Work and Family Structures

Neither the structure of the labor market nor current social policies reflect the social realities of women who are increasingly heading households, both with and without children, or who live alone as widows for many years after the death of a spouse. Women's growing participation in the work force has neither removed nor reduced the inequalities in wages and earnings between men and women. When women enter the labor market on a discriminatory basis, their substandard wages force them to face economic hardship if they become the sole support of their families. Females' earnings as a percentage of males' earnings has remained the same (59%) since 1960, but the absolute dollar gap nearly doubled between 1970 and 1981.[17] In 1981, the average woman working full time could expect to earn $8,000 less than the average man.[17] These averages still do not reveal the extent of disparities between male and female earnings. Women are greatly overrepresented among low-wage workers; they are paid less consistently even in traditionally male occupations, even when their educational levels and job titles are similar to those of men.

Another significant and often-overlooked gender difference is life-cycle earnings, the pattern of earnings over time.[17] Women who have never married and who do not have children have flatter earnings curves than do their male counterparts.[17] Women cannot look forward to steadily rising incomes; their earnings rise very little from the start and peak much sooner than those of men.[17] Because the stereotypical image of the unemployed worker is a male, women displaced from their jobs remain a hidden reality, even though women account for two of every three persons whom the Labor Department characterizes as "discouraged workers."[18]

The impact of family dissolution and divorce is grave for women, especially for minority women with children, whose income as a proportion of white single parents' income was 60% in 1981.[19] The divorce rate in 1981 for black women was 289 per 1,000 married, for Latin women, 146, and for white women, 146.[19] Furthermore, the rate of remarriage among white women is higher than for women of color, as is the possibility of receiving greater amounts of court-awarded child support. Even so, the median child support payment for all women ordered by the courts covers less than one-half of the actual costs of raising children, and in about one-half of the cases, women do not receive the court-ordered payments.[20] A divorce or a separation often means increased hardship for women, a decreased standard of living, and the loss of existing social support networks. Often a woman must relocate the family to less expensive accommodations, facing a tight rental market and discrimination in securing housing. Where she is able finally to afford and obtain housing will have consequences for obtaining health care, education, and other amenities.[20]

Poverty and Poor Housing

Housing for women *per se* has gained attention only recently; typically, gender has not been considered an important factor in the literature on housing. After all,

the American dream of a detached, single-family dwelling embodies the nuclear suburban family, not the single female parent or the elderly divorcee or widow. When gender is added to housing analyses, however, women form the largest subgroup of the poorly sheltered population; single parents and elderly women are most vulnerable to being cost-burdened. (The term *cost-burdened* is defined as paying more than 30% of income for rent or more than 40% for mortgage and maintenance costs.)[16] Of the 23 million American households with housing problems (defined as problems with physical structure, overcrowding, or affordability), females (either as single-person households or as heads of families) total 10 million, or 40% of this total.[16] Yet female householders represent only 27% of all American households.

I would like to suggest that homelessness among women can be viewed on a continuum, beginning with those who are housed poorly and are extremely vulnerable economically. One in two female householders (as single-person or single-parent households) earns less than 50% of the national median; female heads of families in particular have more than a 50% chance of facing a housing problem in the areas mentioned above.[16] Housing discrimination persists toward women with children, especially those receiving public assistance. Few women have accumulated capital or have established credit; thus they are faced with living in insecure arrangements. Their housing is vulnerable to sale, rent increases, and conversions.

In 1980 female households (i.e., single-parent or single-person households) earned a median income of $8,931, whereas the national median was $19,074, and the median for married couples was $25,106.[16] Furthermore, in 1980, 72% of female householders earned less than $15,000 compared to only 24% of married couples and 40% of the nation as a whole.[16]

Nationally, the rate of poverty in 1984 for female-headed families was 34.5%, five times the rate for all other families.[21] In female-headed families of black and Spanish origin, the poverty rates were 51.7% and 53.4%, respectively.[21] The impact of these rates is seen clearly in the dramatic child poverty rate: 16% of all white children, 39% of all children of Spanish origin, and 46% of all black children are poor.[21] The Ohio Senate Task Force on Female Single Parents summarized the hardship of single parents by noting that the American dream had become a nightmare. In its statewide survey of single-parent households, the task force reported that 20% of their sample responded that they had been homeless at one time.[22] This is an important point, as homelessness is often conceived as a final status. It may be more likely that the use of shelters, food pantries, and meal programs represents "economies of makeshift."[23]

Only 6% of all female householders earn enough to purchase a new home at a median price of $93,000, whereas 40% of married couples could assume this expense. As a consequence, women are more likely to be renters; in 1981 they constituted 40% of all U.S. renters, an historic high.[16] Single female parents and elderly female renters were twice as likely as other American households to have a housing problem with physical structure or overcrowding and were three times more likely to be cost-burdened.[16]

Even among the 48% of female householders who owned homes (compared with 65% of all American households), women were still more likely to be cost-burdened and to live in inadequate dwellings. Seventeen percent of female homeowners were cost-burdened, twice the national average.[16] About one-third of female homeowners lived in physically inadequate housing, five times the national rate.[16]

Many of the same factors operate to produce homelessness among males, but the meaning and impact of these factors on working-class women can be distinguished. Women as a social group are particularly vulnerable to economic insecu-

rity because many women are economically dependent on others. With the growth in all varieties of female-headed households, this social problem is exacerbated, especially when coupled with the cuts in social service budgets and with the crisis in low-income housing.

Social Service Budget Cuts and Homeless Families

Cuts in social service budgets have been an important cause of family homelessness. The Children's Defense Fund reported that major causes of family homelessness include economic problems such as unemployment, the high cost of basic necessities, and cutbacks in federal social services.[12]

A research project on 61 homeless families, conducted in 13 cities in Massachusetts in 1983, documented the direct impact of federal budget cuts since 1981.[24] The most important factors contributing to family homelessness were insurmountable shelter debt and extreme poverty. The important aspect of this study was the direct impact of federal policies on the financial stability of these families. As documented extensively in the report, average monthly shelter costs before homelessness far exceeded their incomes.

Budget cuts affect female-headed families so adversely because these families rely heavily on social welfare programs as a result of their low income and their family responsibilities. A recent study by the Bureau of the Census found that 70% of female-headed families receive benefits from one or more means-tested or non-means-tested programs.[21] For example, one-third received Aid to Families with Dependent Children. In this program, among others, funding has been reduced substantially. Between 1980 and 1985, some 4 million people were dropped from means-tested programs.[21]

Women also constituted one-half of those employed in public service jobs before the budget cuts ended the CETA program in 1981.[18] The Work Incentive Program of job training for AFDC mothers was cut by one-third.[18] Both elderly women and female-headed families bore the brunt of the cuts in programs for low-income persons.

In 1982, after the first year of the Reagan administration, census data revealed that the real after-tax income of female-headed families fell more sharply than that of any other group in the country.[18] The Center on Budget and Policy Priorities reports the following:

> Female-headed households with children lost nearly $3 billion in real cash income in 1982—which was an average loss of over $425 for every female-headed household with children in the nation (the loss is even larger when the numerous reductions in non-cash benefits such as food stamps, day care services, and low income housing are added in). The Census data provide hard evidence that income and resources are being even more unevenly distributed than before between female- and male-headed households.[18]

Disaffiliation: A Call for a New Interpretive Framework

Disaffiliation, based on a psychopathological model, has a long history in the literature on homelessness.[2] During the 1960s and early 1970s, much of this literature focused on disaffiliation as an explanatory factor. This perspective, however, was developed in male skid row populations with a high prevalence of alcoholism; recent studies have questioned its applicability to homeless women.[11] Bahr and Garrett's 1969 study, for example, which focused on middle-aged and elderly wom-

en, found that shelter residents were less affiliated than more stable and more affluent women.[25]

These findings fit well with the literature on aging, but their emphasis on personal failure rather than on socioeconomic forces is problematic. Affiliation was measured by whether one lived alone, was employed, and/or belonged to voluntary associations. These variables are related strongly to one's socioeconomic position. As noted in a report from the Manhattan Bowery Corporation, elderly homeless women may be an extreme example of the effects of social and economic forces that work on middle-aged and elderly single women in general.[1] Elderly women, however, do not represent the homeless female population, and "bag ladies" represent only a small subgroup. Disaffiliation does not explain the social forces that produced the form of homelessness witnessed today. On the contrary, disaffiliation may be a consequence rather than a cause of homelessness.

Recent research also has demonstrated that homeless women do have other types of affiliations, such as with children, friends, and other social networks. We know very little, however, about the type and extent of these networks. More than one-half of the women in Crystal's sample of shelter women in New York City had substantial ongoing involvement with at least one child.[11] This finding differs substantially from the findings on homeless men. Crystal concluded that many women do not fit into the disaffiliation perspective, which assumes a lack of involvement in aspects of social living, such as ongoing relationships or parental roles or the internalization of societal norms and values.

This finding is reinforced by the numerous portraits of homeless women that reveal that they share the conventional values of American life and suffer greatly because of their profound disappointment or disillusionment with the cherished institutions of family and work. Other studies have documented homeless women's frustrated desires for conventional relationships and their intense conflicts following coercive sexual encounters.[26] In sum, the literature on disaffiliation has no relevance to the experience of homeless women, as individuals or as parents. We turn now to the research on the experience of homeless women to explore alternative theoretical framework.

CURRENT RESEARCH ON HOMELESS WOMEN

Why Study Homeless Women?

As mentioned above, the most widely circulated statement about homeless women is their statistical appearance among the homeless. The homeless man has been an object of sociological inquiry for the last 80 years, as in extensive studies of hobo life, contemporary portraits of the migratory "tramp," and the demise of this phenomenon.[27] A commission to study homeless men was initiated in the first decade of the twentieth century, but there was no female equivalent to the men's bowery. In the words of Nels Anderson, author of the classic 1923 study, *The Hobo*, "Tramping is a man's activity."[28] Of course, the words *tramp* and *bum* have different social meanings for women and for men. A female *tramp* is not homeless but is sexually promiscuous, traveling not from place to place but from man to man.[3] The language, the symbolism, and the romanticized world of the homeless man were never extended to women. In 1979, Caplow noted that homeless women were somewhat of a sociological mystery.[29]

Like the term *shopping bag lady* as a negative female reference, other attributes of homeless women may be gender-related, especially in some of the interpretations of those behaviors by researchers. It has been noted, for example, that homeless women may disguise their appearance or behavior as survival strategies in order to be so repellent that nobody will want to come near them.[30] This strategy is not unlike any woman's decision to dress nontraditionally to avoid being harassed by men. When homeless women tell interviewers that they want to be left alone, this statement is often interpreted by researchers as pathological rather than as ruggedly independent, as in the case of romanticized homeless males. These references and interpretations are informed by social norms; they point to the relevance and necessity for research focused on homeless women.

Homeless women have been the subject of two recent photographic books, which are sensitive portrayals and serve to dispel myths.[3,30] Both document such causal factors as unemployment, unavailability of affordable housing, a sudden crisis (e.g., fire, crime, illness, eviction, or death), inaccessibility of public assistance (due to inability to negotiate bureaucracy, to provide extensive documentation, or to keep appointments), domestic violence, and the lack of income. These accounts portray vividly the problems in the social service system and call for an understanding of what it means to be a woman who has lost her home.[30] Shulman notes, "As one begins to understand the extremely tenuous circumstances in which these people live, the less mysterious become their bags, less strange their behavior, and less invisible their lives."[3]

Demographic Differences between Homeless Women and Homeless Men

The findings from the more recent literature on homeless women reveal some significant differences between homeless men and homeless women, although the findings generally are based on local studies in large urban areas. In their 1974 study, Baumohl and Miller found that the homeless women were younger, less educated, and more likely to obtain income from legitimate sources than were their male counterparts.[26] In 1984, Robertson and Cousineau reported that homeless women were less likely than homeless men to have completed high school (42.6% vs. 32.8% for men).[31] Bahr and Garrett, however, found in their shelter sample that the women were better educated than the men. They also found that the women were poorer, younger, more frequently black, married, more apt to have children, or informal liaisons, and more frequently from a broken home in the family of origin.[25]

Crystal analyzed data from the intake instrument for New York City public shelters in 1982.[11] He also conducted interviews with 213 shelter women and found that the women were less likely to be single (60% compared to 71% of the men) and more likely to have been married. Women also were more likely to have grown up in an institutional or foster-care setting; 20% of the women and 13% of the men had not lived with either parent during childhood.

Mental Health

The mental health status of homeless persons is a source of major debate among the groups invested with making or debating such determinations; that literature will not be reviewed here. It is sufficient to say that the problems are theoretical, conceptual, operational, and methodological. Of concern here are the reported associations of mental illness with homeless women.

Robertson found a consistency among the various empirical studies, which

suggested that homeless women have higher rates of psychiatric hospitalization than homeless men (25% to 35% vs. 13% to 30% respectively).[32] She also cited a study of runaway youths that found that one-third of the adolescent females in the sample reported at least one suicide attempt, in comparison to 15% of the males.[32]

The association between women and mental illness has a long history in the psychiatric literature and has been critiqued extensively in the feminist literature. One must interpret these findings in this context. In Crystal's study of New York City shelter men and women, the author found not only a higher incidence of psychiatric treatment among women but also a much lower incidence of jail or prison records (21% for women and 44% for men).[11] This findings suggests that the social roles assigned to men and to women may legitimate different forms of behavior and expression for men and for women.

Although homeless people as a group have higher rates of psychiatric treatment that the general population,[32] the difference between homeless women and nonhomeless women is unclear. Rates may differ less than certain diagnoses: for example, neurosis for middle-class women and psychosis for poor women and private treatment for the middle class and public for the poor. The much-cited work of Broverman *et al.*,[33] in which the same set of socially desirable adult traits is attributed to mentally healthy men and to mentally healthy adults, is certainly relevant to any discussion of homeless women and mental illness. Women are deemed mentally ill if they reject their prescribed role, whereas both men and women are judged mentally ill if they act out the female role.[34] One cannot evaluate the association between mental illness and homeless women outside the context of the structural ambivalence surrounding the character and position of women in industrial society.[35] The social construction of mental illness, femininity, and the function of mental illness, which Oakley suggests is "an acceptably feminine escape route," implies that depression and oppression are linked.[35] That more homeless women than homeless men may carry the designation "mentally ill" or wear it like a passport, as Golden[36] proposes, is not surprising when we consider which groups in society (women, minorities, the poor and the working classes) are more likely to be processed through the mental health system. The focus on mental illness makes homelessness again an individual problem, a woman's failure rather than an economic and housing problem.

General Health

In an ethnographic study of homeless women, Strasser[37] noted their great resourcefulness regarding personal hygiene and their strenuous daily routines. All the women she observed, however, had at least one health problem. Other reports support this finding, especially these women's susceptibility to malnutrition, poor circulation, hypothermia, pneumonia, frostbite, parasitic worms, and respiratory illness. Baxter and Hopper reported that it is commonplace to see men and women with urgent medical problems, ulcerated legs, lacerated heads, and grime-filled wounds on the street.[5] Strasser, however, noted that most attempt to treat their illnesses. Apparently some homeless women have had contact with the health system[10]; often they are seen with slings, bandages, crutches, and prescription medications. Homeless women, however, may find it difficult to follow a physician's orders or to take medication. A physician or a nurse may give instructions with the assumption that the patient has regular access to water, to the correct time, and to the medications.

The empirical studies of homeless persons' health status suggest that homeless

women have more health problems than homeless men. Robertson and Cousineau found that almost one-half of the women in a 1984 Los Angeles study perceived their health status to be fair or poor, compared to one-third of the total sample.[31] Women were more likely then men to report both an acute illness (55% vs. 36% for men) and chronic health problems (63% vs. 32% for men).

Victimization

As mentioned earlier, the danger faced by homeless women is a major concern. They are prone to "jack-rollers," who prey on the homeless and are especially active when entitlement checks are received. The few, highly improbable cases of rich bag ladies, as reported in the media, add fuel to this fire. Women also are targets for rapists and for others who commit random acts of violence.[1] They are robbed, mugged, and beaten by men who regard them as whores. Shelters often are located in high-crime areas; the crime rate may be equally high inside the shelter. As one homeless women noted, "The pimps wait around because they think the first thing a woman will do when she is destitute is become a hooker."[3] The public is generally unaware that the danger to homeless women, in the form of brutalization and sexual assault, is worse in the summer than in January.[38] Ironically, this may be even more of a problem for women who try to maintain their personal appearance. Even if a man, homeless or otherwise, befriends a woman, she is still extremely vulnerable, as in the case documented by Baxter and Hopper. One woman, who had been sleeping in a cardboard box alongside several men, was threatened by a man who usually was friendly but who threatened to kill her at the urging of another man.[5]

Observers are uncertain how to classify victims of domestic violence. Battered women are not considered homeless by some; in most studies, shelters for victims of domestic violence are excluded from the sampling frame. Yet these two populations overlap (see Chapter 21). Women may be referred from battered women's shelters to more traditional homeless shelters if they cannot gain entrance or continue their stay. Some homeless women also report histories of violence that precipitated or contributed to their current episode of homelessness.

The Impact of Homelessness

Homeless women also are described as internalizing their victimization and as suffering profound disillusionment. As Rousseau notes, they have not forgotten the values of mainstream American life.

> They [homeless women] feel drastically out of place, demoralized by the inability to establish homes, find work, and belong. The cruel realities of their own lives conflicted with their desires to fulfill the stereotype of wife, mother, and daughter. . . . To have no place in the world made them question their right to be.[3]

Merves reported that homeless women reported pervasive feelings of self-blame and punishment, not feeling like a human being, disappointment with life and questioning its meaning, and resentment toward other social groups whom some agencies considered more worthy of services.[13] A prevalent theme was exemplified in such statements as that made by a 55-year-old former secretary:

> It was work and home, work and home, work and home, and that was my life for so many years. It was no wonder I came up with nothing later. Just nothing. What else was there? I didn't have the job and I didn't have the family.[39]

The disappointment with societal institutions such as family and work structures stemmed from unanticipated alienation, pain, and suffering. It was painful to learn

that there are no guarantees for a good life, no matter how hard one works or how good a parent one is.

Once a woman is homeless, she and her talents are ignored. She is often blamed for her situation and is subject to labeling or categorizing so she can be processed by a service system. She becomes a case and is identified by a number. Usually that is all that is known about her, as in the case of Rebecca Smith, who received national media attention when she died in a box in New York City, after being visited by numerous professionals. The following statement by a homeless woman is illustrative:

> Because I have the body of a woman, there is nothing I can do but be insulted. . . . I have the right to live with integrity; to be treated like a decent human being. I am so insulted, so degraded, so humiliated.[3]

Barriers to Service

Homeless women can be victimized in other ways, such as by the lack of services available to them. Most shelters and related services began by serving men; today, homeless women still face discrimination when seeking shelter, food, and employment, including spot labor jobs. Stoner hypothesizes that services for homeless women have been more limited because of these women's invisibility and because they are less feared and less threatening than men.[8] Equating homeless women with derelict eccentrics who allegedly choose their lifestyle has made them the worst social undesirables of all marginal people, according to Stoner, and has contributed to a belief that they are "less needy."[26]

The municipal shelters in New York City have been unable to meet the growing demands of the homeless female population. From 1971 to 1977 the number of applications for admission rose from 872 to 3,355.[1] The Women's Shelter in New York is one of the few public shelters for women in the country, but it is cited most often for its restrictive admission requirements (three-fourths of its applicants have been refused admission since 1975), its bleak and militaristic atmosphere, and its lack of services in comparison to what is provided for homeless men.[5]

Another important barrier to service is the attitude displayed toward homeless women by some mental health technicians, nurses, receptionists, physicians, nurses, social workers, church volunteers, and others. The kind, compassionate attitudes of some personnel are counteracted by the rude, mean-spirited attitudes displayed by others. Strasser noted that homeless women expressed fear, hatred, and distrust of health providers, social workers, and sometimes police and security guards.[37] Homeless women often felt that these personnel are not only unhelpful but contribute directly to making the situation worse. In contrast, they responded favorably to some saleswomen or waitresses who listened to them and gave them things or offered friendly advice.

Certainly the structure and the philosophy of many social welfare services foster such judgmental, unaccepting attitudes. Interaction with agencies often reaffirms the negative status imposed upon and felt by homeless women. The social welfare response to homelessness has been characterized as a return to the traditional American model of charity, wherein the key element is the reaffirmation of the status of the giver and of the receiver.[40] The women with whom Merves spent time were always aware that they were at the mercy of others.

> You are a poor person, dependent upon these people who have more. . . . You are incumbent upon their good will. And they are looking you over. . . . I don't like being on display from a disadvantaged place. . . . It makes you feel like a lesser person. . . . You are made well aware that if somebody does give, you're going to have. If they

> don't, you're not going to have it. You are at their mercy that way. Your stomach is at someone else's mercy, as well as everything about you.[41]
>
> When you leave most places, I won't say all, but most places you leave, you feel like you've just gotten up off of your knees. They've totally brought you down until you're nonexistent. You're not a person. You're just something there begging. . . . Have you ever been down to the sandwich line? You're a doggie. It's your doggie bag for the day. You're not even looked at.[41]

We must regard the residual character of social welfare services as a real and significant barrier.

STRATEGIES FOR CHANGE

There is no shortage of critiques and suggested strategies for change in housing, employment, the economy, and social welfare and mental health policies. The reader is referred to other chapters in this book for a discussion of these strategies and of the necessity to address both short-term and long-term needs of homeless persons. More fundamental, however, is the necessity of connecting our inalienable rights of life, liberty, and the pursuit of happiness with the prerequisite rights to sustenance, housing, work, and social services.[42–43] There is a growing body of literature on alternatives to what Miller and Tomaskovic-Devey call the "corporate distortion of national policy."[44] A more solid, yet flexible theoretical and conceptual framework on which to base national priorities has emerged from the recent body of research on homeless persons. Although the framework is still developing, the rudiments are presented here.

As Watson suggests, housing embodies the dominant ideology of a society. Because the dominant social relations are both patriarchal and capitalist, housing policies reflect assumptions about women's role in the labor process and in the family.[2] Defining homelessness is a sociopolitical process that may neglect certain groups of people. Because female homelessness is more likely to be concealed than institutionalized (e.g., seen in shelters), perhaps a conceptual continuum of homelessness or "housing need" is in order, along which individuals are located according to specific factors that warrant investigation.[2] In Watson's British study, this continuum embodied the following:

> Sleeping rough; emergency hostel or refuge accommodation; restricted-access hostel; and finally a conglomerate of noninstitutionalized and hidden unsatisfactory and insecure forms of accommodation. This included staying with friends or relatives in overcrowded conditions, or private rental accommodation where the woman is forced to leave or is under pressure to leave, or where the conditions were very poor and accommodation in which the woman was forced to leave due to domestic dispute or violence.[2]

The structure and the plan for housing (including architecture, ownership, and financing) must take into account that women are likely to be located at different points on a home-to-homeless continuum than are men. Furthermore, the variety of female households (including those living alone at all ages, those with children, and those sharing households collectively in cooperative arrangements) demands that the norm of the patriarchal nuclear family model be abandoned. In addition, housing should not be separated from the accessibility and quality of neighborhood services, which will determine the extent to which women can meet their needs. It is encouraging to see some new endeavors focusing on gender-related needs and on the planning and implementation of responsive housing projects and programs.[15]

Finally, as mentioned earlier, homelessness should be viewed not as an end point for everyone, but rather, as Hopper and colleagues suggest, as a subsistence strategy used by increasing numbers of people.[23] Although those authors focused only on males, it is clear that their analysis and the implications also may apply to women. For example, Rubin's research on working-class families revealed that it is usually the woman's responsibility to manage, stretch, or make do with the household income to cover monthly expenses or to juggle creditors.[45] When the household income plunges because of a work layoff or illness, the humiliating trip to the food pantry or the welfare or food stamp office is the reserve of the wife. Female households with and without children routinely exist on combinations of various resources, including shelters. The time, energy, and skill involved in coordinating such strategies are not well understood or appreciated by those outside the poor and the working classes. The theoretical conception of homelessness must incorporate these empirical social realities if we are to confront these injustices.

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19

Homeless Families
Four Patterns of Poverty

KAY YOUNG MCCHESNEY

INTRODUCTION

The rapid increase in homelessness among families during the 1980s is the result of an increase in the number of low-income families and a decrease in the amount of low-income housing in the United States.[1] By 1983, there were 25% more families living below the poverty line than in 1979,[2] whereas at the same time fewer low-cost housing units were available.[3] In conjunction with these structural changes, service providers began to report that they were seeing homeless families in significant numbers for the first time since the Great Depression and that their numbers seemed to be growing.[4–5] By 1985, there were about 11.6 million low-income renter households competing for 4.7 million low-rent units, for a shortage of 7 million units.[3] With such a shortage of affordable housing, families that cannot get into low-cost rental units either pay more, double up with family or friends, or become homeless. As a result, homelessness among families continues to be a pervasive problem in the United States.[6]

The purpose of this chapter is to describe how and why families become homeless. Over the course of 16 months, from April 1985 through July 1986, the Homeless Families Project staff interviewed mothers with minor children in five family shelters in Los Angeles County. Shelters were chosen to represent all major areas of the county; within each shelter, however, mothers were selected for interview on a convenience basis. The data used in this chapter are drawn from 80 mothers who were accompanied by at least one child under age 18 in the shelter. Mothers, and sometimes their male partners, were interviewed in the shelter. The interviews were structured loosely and lasted up to 3 hours; families were followed for as long as

KAY YOUNG MCCHESNEY • Department of Sociology, University of Missouri–St. Louis, St. Louis, Missouri 63121.

possible after the initial interview. Project staff members also lived in three of the five shelters as participant observers. Interviews were recorded and transcribed for qualitative analysis; quantitative data also were collected.

The most important finding in this study was basic. These families were homeless because they were poor—too poor to be able to pay the going rate for housing. Most of the families in the sample had been poor long before they became homeless; often they had barely been making it for some time. Before they became homeless, their lives seemed to be measured from crisis to crisis rather than from week to week or month to month; almost always the crises were connected with lack of money. Attempts to make do, to manage, or to cope were shaped by the structure of the family and by the resourcefulness of mothers and their partners (where present). Yet these efforts never seemed sufficient to overcome the basic lack of money. "Solutions" were transitory, and "successes" were temporary; the crises did not stop, and eventually the family became homeless.

FAMILY TYPES

A second finding is equally basic. Just as "the homeless" are not a homogeneous group, but rather include several different groups of people with substantially different characteristics, so, too, homeless families are not all alike. Four different types of families emerged from analysis of the mothers' histories of their lives before homelessness: (1) unemployed couples, (2) mothers leaving relationships, (3) AFDC (Aid to Families with Dependent Children) mothers, and (4) mothers who had been homeless teenagers. This typology is based on the source of income before homelessness and on the characteristics of the primary earner of that income. Not every family in the study fit one of these four types, although most did so. Consequently these descriptions of patterns of family economic support before homelessness are intended as core types rather than as exhaustive categories.

Unemployed Couples

Marginal men—sometimes employed, sometimes not—were the wage earners in unemployed couples. Their ability to support their families depended on the economic business cycle.[7–8] In good times they worked. In bad times, without enough skills to find permanent jobs and without enough luck to be able to keep their jobs, they depended on occasional work and unemployment benefits to support their families. When no work could be found and unemployment benefits ran out, unemployed couples in some states, including California, could turn to the AFDC-Unemployed Parent (AFDC-UP) program. Unemployed couples in the 25 states that did not have AFDC-UP prior to 1989 had no support.

A typical unemployed couple in this category was a married couple in their 30s with two or more children, at least one of whom was of school age. The husband previously had worked full time at a job that had enabled him to support the family. Usually he had held a blue-collar job, such as construction worker, welder, or machinist. Unemployed couples included both those who had become unemployed locally and those who had migrated to Los Angeles to look for work.

These were traditional families. Both partners felt that it was the husband's job to support the family, whereas it was the wife's job to tend to the children. This

division of labor was maintained even in the shelter, where men went out to look for work while women stayed behind to care for children. Either the unemployed couples were legally married or the women considered their partners to be common-law husbands. In these families the husband seemed to function as the traditional "head of household" of census terminology.

"Gypsy" and "Richard" are an example of the unemployed couples. Gypsy was a short, overweight woman with an air of authority and a lively twinkle in her eyes. Most of her front teeth were missing; the few remaining were badly decayed. Her long black hair streaked with gray made her look as though she were in her 50s, although she was only 39. During the interview, Gypsy told me that she was full-blooded Cherokee. She was in a shelter for homeless families with her common-law husband, Richard, and two children from a previous marriage—a 10-year-old daughter and an 8-year-old son.

Gypsy and Richard had been together for 5 years. When I interviewed her, Richard was out of the shelter to apply for a job, but Gypsy had little hope that he would be successful.

> He's a marine machinist. He worked in the Southwest Marina that used to be Bethlehem Steel . . . off and on for 10 years, and now he just can't get a job in his field.

Richard's last job had ended more than a year ago.

> You know the newspaper. . . . He was working for them and he was putting out the new racks and repairing them. For three months he worked almost night and day. . . . Once he got all the machines caught up and fixed, they phased out that job.

Gypsy said that she had narcolepsy and was unable to work, although she was a registered nurse.

After Richard was laid off from the newspaper, he and Gypsy "just happened to look into managing the motel [where they] were staying" and were offered the job. For 9 months they managed the motel, which paid them a small monthly salary and gave them a place to live. After 9 months the owner closed the motel for remodeling, promising them their job when it reopened. Originally the remodeling was expected to take about 6 weeks.

When the motel closed, the family moved into a rented three-bedroom house with Richard's mother and her boyfriend. It was crowded.

> She had my sister-in-law and her six kids there. . . . It was eight kids [counting Gypsy's two], my husband, myself, my sister-in-law, my mother-in-law, and her boyfriend.

Nevertheless, with three families sharing the house, they managed to get by.

> My sister-in-law had her AFDC; my mother-in-law had her job. She made a hundred and ten a week and so did her boyfriend. We were splitting everything three ways 'til they raised the rent. Her rent was six [hundred]-fifty and they raised it to eight [hundred]-fifty with the two extra families.

Even with the pooled resources of three families, they could not afford the rent, so they had to leave. At about this time Richard discovered that the motel owner had reopened the motel without telling them and had hired a new manager. Next, they moved into a friend's two-bedroom apartment.

> He needed someone to help him because he'd just gotten out of the hospital [after] a motorcycle accident [and he] almost lost his life. He had a two-bedroom apartment. While we stayed there with him. . . . I was taking care of the house.

At Christmas Richard was arrested for traffic tickets that had gone to warrant. Because he did not have money to pay, he had to go to jail for 20 days. At that point, with Richard in jail, Gypsy applied for AFDC and started to receive monthly checks of $587 for herself and the two children.

After Richard was released from jail in January, the family moved in with another friend who had a two-bedroom apartment. After 4 months the landlady evicted them in order to remodel the apartment for her granddaughter.

When the family moved out, they paid gas and electric bills and rented storage space for their furniture. From what was left of Gypsy's AFDC grant, they had enough money to move to a motel. On July 10 their car "blew a rod" and because they had no money for repairs, they abandoned it. By the end of a week in the motel, they had run out of money. They could not receive Gypsy's midmonth AFDC check because they had no address. Eventually they ended up living in a riverbed for several nights, after which they were able to move into a family shelter.

Richard was typical of the men in the unemployed couples group in that he had skills that had enabled him to support his family in the past. There was no question of his desire to work; the problem seemed to be the mismatch between employment opportunities and Richard's skills and experience. The shipyards in the harbor where he had worked earlier in his life were dormant. As Gypsy explained, "My husband has only a tenth-grade education. When we first got together he could be classified as almost illiterate." With Gypsy's help, Richard's basic skills had improved to the point where he could fill out applications. In the new employment market, however, Richard's skills and willingness to work were not enough. The family had only AFDC and odd jobs to fall back on. No matter what strategies they tried, they were unable to find affordable permanent housing, and they became homeless.

Mothers Leaving Relationships

By the time mothers leaving relationships arrived in the shelter, they were functioning as single mothers, whether or not they were married. Previously they had lived with male partners who had been supporting them. When they left (or were forced to leave) the relationship, however, they had no means of supporting themselves and their children. By leaving their partners, they were setting up their own new female-headed families. At the same time, lacking income of their own, they became newly poor. Thus the pattern of poverty was quite different for this type of family than for the others. Whereas unemployed couples, AFDC mothers, and mothers who had been homeless teens had been poor for some time before becoming homeless, mothers leaving relationships often had not been poor. They entered this state suddenly and simultaneously with the separation from their male partners.

The typical mother leaving a relationship was a woman in her late 20s with one or more children under the age of 6, who had been living in a stable housing arrangement with a man who was supporting the family. Usually she had a high school education and had worked before the birth of her first child, although she had not worked outside the home for the several years before she became homeless. She had no access to child care. When the relationship broke up, she suddenly found herself with no means of support and applied for AFDC on an emergency basis.

Thus the proximate cause of poverty for mothers leaving relationships was their breakup with an economically successful partner. Once the breakup occurred, however, and the women became single mothers, their main obstacle to economic oppor-

tunity was lack of work. In turn, the obstacle to returning to work was lack of child care. Typically, mothers leaving relationships had more education, skills, and work experience than AFDC mothers and mothers who had been homeless teens; this fact suggests that their prospects for finding work were better. Like the other single mothers in the study, however, they lacked child care.

"Frances" is an example of a woman leaving a relationship. A wiry woman of medium height with dark roots showing through dyed blonde hair, she usually dressed in jeans and a T-shirt. Her mother was Hispanic and Frances spoke Spanish, although English was her preferred language. She was in the shelter with 9-year-old Ellen, her older daughter.

For 2 years Frances had been living with her boyfriend, Doug, the father of her 5-year-old daughter. Doug was working for his stepfather; together they lived in an apartment owned by the stepfather. The stepfather did not like Frances; he told her, "Either I went, or my old man didn't have a job with him no more, plus my five-year-old would lose an inheritance [he] was leaving for her if I stayed."

So Frances left. After a series of frantic phone calls, finally a friend connected her with an elderly man who said that she and Ellen could stay with him. She paid him $105 for 3 weeks, but "after I paid him the last thirty dollars he threw me out that night." Frances then went to her sister's house and spent the day calling "all over the county," with no luck.

> All I could think [of was], "What am I gonna do? I'm broke, my clothes are in Pomona, I've got [only] the clothes on my back, my child's got [only] the clothes on her back. I've got no money, no place to go, no transportation."

Finally Frances discovered that a family shelter had two beds available, but she would have to go downtown, 20 miles away, to be interviewed before admittance. By the time she arrived by bus, it would be dark. If she were not accepted into the shelter, she would have to spend the night on the street in downtown Los Angeles with her daughter, an even more dangerous prospect than spending the night on the street in the San Gabriel Valley. The shelter worker finally agreed by phone to admit her. Frances borrowed the bus fare, and she and her daughter traveled to the shelter.

AFDC Mothers

AFDC mothers included all families whose primary and customary source of income for a year or more before their current homeless episode had been Aid to Families with Dependent Children (AFDC). Most of these were single-mother families, but the group also included a few couples in which the male partner had not been working and had relied on his female partner's AFDC check for support.

In contrast to the unemployed couples discussed above, the AFDC mothers clearly seemed to be the heads of their households. Their male companions, usually termed "boyfriends" by the mothers, had never supported the family and seemed peripheral to the central mother-and-children unit.

Typical mothers in this group had two or more children. They had less than a high school education and little or no work experience. Although their lives, like those of other families in the shelter, could be measured from crisis to crisis, this pattern was not new and sudden, as with some of the mothers leaving relationships; nor was it broken by an occasional odd job, as it was for unemployed couples. These families had been long-term recipients of AFDC. Because they lacked education, job skills, and work experience, they had little hope of finding work that would pull

them out of poverty. In the housing market of the 1980s, the proximate cause of their homelessness was an AFDC check that was insufficient to cover the cost of both housing and other necessities such as food and diapers.

"Dee" is an example of an AFDC mother. Dee was a tall, slender black woman; her distinguishing characteristic was her voice, which was so deep that it sounded like a man's. (She was a heavy smoker.) Dee was 28 and was still legally married to the father of her 9-year-old son and 7-year-old daughter, although she hadn't lived with him for 5 years. She also had a 3-year-old by a boyfriend, but she was on her own when interviewed. During most of her 9 years as a mother, Dee's primary means of support had been AFDC.

Dee had been living on AFDC in a Housing Authority complex in Compton (south central Los Angeles). She paid only $112 a month for her two-bedroom unit, hundreds of dollars less than she would have had to pay for a unit not managed by the Housing Authority. Yet there were problems:

> I had to move because of the environment. We had drug dealers in every apartment. We had gangs that would terrorize . . . and mess with you, try to take your money . . . try to take control. I was living by myself with my three kids and I got scared. I called the Housing Authority and told them, "Could they find me another place 'cause it was too rough." They said they couldn't help me—to leave the people alone. So I had to move.

Dee moved in with her sister-in-law just outside Los Angeles County. Although the place was safe, her sister-in-law had four children of her own; altogether seven children and two adults were living in a two-bedroom apartment.

Dee and her children then moved back to live with her sister in Los Angeles. At her sister's two-bedroom apartment, the sister and her boyfriend slept in one bedroom, the sister's three children slept in the other bedroom, and Dee and her three children slept in the living room. Again, however, there were problems. The boyfriend who lived with her sister

> dealt with drugs . . . cocaine. My sister and I also got involved in [drugs] . . . I was giving him the money to pay the rent. I found out a few months later that we were getting evicted. They wasn't paying the rent.

Both families were evicted. Dee's sister referred her to a woman who let Dee and the children stay with her. Despite all her difficulties, Dee had been managing gradually to save $400 from her AFDC checks, but this was not enough to pay the first and the last month's rent on a place of her own.

All of Dee's careful saving was fruitless, however. She was robbed of all her money in the middle of the night.

> [I was] asleep. All I know is somebody woke me up and told me "Give me the money." I said, "What money?" When I said that she hit me in the head with an iron, took my money, and wouldn't let me call the paramedics or the police. (She) threatened my life, threatened my kids' life, and made me sit there . . . blood dripping.

After all the threats to her life, Dee was too frightened to let anyone call the police. By the time she saw a doctor and had received stitches for the injury, it was early morning. She had no food, no money, and nowhere to go. A staff member at the doctor's office called Infoline, the Los Angeles County hotline, to find an available shelter. The doctor gave her money for the bus fare, and she and her children were admitted to a shelter.

The pattern of Dee's poverty was similar to that of other women classified as AFDC mothers. Typically, the fathers of their children either were not working or

had a "little hustle on the side" (i.e., illegal underground work). Although Dee wanted very much to stabilize her housing situation, she expected to remain on AFDC indefinitely. Even if she had been able to find a job, she had no one to look after her children. Her oldest son had a serious case of sickle cell anemia, and he had to be watched carefully because frequently he went into crisis.

Mothers Who Had Been Homeless Teenagers

Mothers who had been homeless teenagers had quite a different history from mothers in the other three groups. They tended to be younger, in their early 20s, and to have only one child, often an infant. Although some had received AFDC intermittently after the birth of their baby, their history of such aid was spotty compared to mothers classified in the "AFDC mothers" group, for whom AFDC had been a steady and regular means of support. Also, mothers who had been homeless teens were the only ones who had used the proceeds from illegal underground economy work as a major source of support at some time in their lives.

Mothers who had been homeless teenagers shared a history of severe abuse in their families of origin, which typically resulted in their being placed in foster homes. They then ran away from foster placement, sometimes after being sexually abused. As homeless teenagers, these young women had been unable to participate in the legal market economy. Living on the street, they learned subsistence prostitution, which became their major source of support. When they gave birth to their first child, they became eligible for a legal source of income—AFDC—for the first time.

"Vangie" is an example of a woman in this group. When I interviewed Vangie in the shelter, she was 20. A slender, long-limbed young black woman with a sad expression, she was in the shelter with her only child, her 2½-year-old daughter Randy. Vangie had never been married.

Vangie was born in rural Mississippi. She never knew her father, although she thought his last name was "Johnson." When Vangie was 8, her mother moved to Los Angeles with Vangie and her younger brother. She remembers that her mother "wasn't working" and that "she couldn't afford to send me back but she felt in her heart she couldn't afford to keep me." Eventually Vangie's mother "got to the point where she started abusing us," and Vangie came to the attention of school authorities.

> I couldn't even go to school. . . . I would go to an arcade, or I would go to a park, just watching people. Sometimes I would cry because I hurt all over. I was ashamed to come to school with bruises on my body. One day I just went to school—I was sitting in the classroom. My body was hurting so bad that I just broke out crying, you know. The teacher said, "What's wrong with you?" I lifted my shirt, and I had extension cord marks on me. They called the police and my mother explained to the police, "Yes, I spanked my child 'cause she's mine, and I will spank her again."

The police did not intervene further, however, and the beatings continued. Finally her mother said, "Can't take it no more—get out." At the age of 14, Vangie left home.

First Vangie lived in a local park for a week, sleeping in a scoreboard—"It was made like a little house"—until she was arrested for being out past curfew. When the police picked her up, they took pictures of the extension cord scars. She was sent to MacLaren Hall (the primary detention facility in Los Angeles County for status offenders) and then to her first foster home. In this home, said Vangie, "the man

would come to molest me. I would tell people and no one believed me. 'You're a liar,' he said . . . 'You're gonna be punished for this!' "

Vangie ran away from that placement and lived on the streets for 3 weeks, until the police picked her up again and placed her in another foster home. From that time on she was "in and out" of foster homes and girls' homes and on the street. She had been sexually abused in several of the placements.

Eventually Vangie became pregnant while living on the street and was sent to a residential home for pregnant teenagers. When she declined to give up her baby for adoption, she was discharged to the streets with her baby. She was 17.

After some time, Vangie found a place to live in Compton "behind an old man's house" for $125 a month, which she paid out of the AFDC benefits she was receiving.

> This wasn't really an apartment. It was a back house. It had roaches, rats, . . . [and] a ceiling that leaked. And when it rained, it rained . . . right in my bed. Puddles of water.

Although Vangie didn't know why, her AFDC checks stopped arriving.

> I couldn't pay the rent, and he told me I had to leave. So, I left. But I would keep coming back to sneak in there and sleep because I had nowhere else to sleep.

When the former landlord finally called the police, Vangie and Randy went back to living on the streets. Eventually they were admitted to a family shelter.

Vangie was typical of this group of mothers in that she had a history of physical abuse by her natural parents, sexual abuse in foster placement, and extensive periods of street living during her teens, where she had learned subsistence prostitution. She also had made intermittent use of AFDC after the birth of her child. Like most of these women, Vangie had little education and no work experience except for turning tricks and shoplifting. She was functionally illiterate, was totally estranged from her family, and cited her child as her only reason for living. Of all the mothers in the shelters, these mothers, who been homeless teenagers, seemed to have the least hope. They were alone in the world—totally bereft of anyone to care about them or help them. Further, their babies were literally second-generation homeless.

COMPARISON OF FAMILY TYPES

The four types of homeless families—unemployed couples, mothers leaving relationships, AFDC mothers, and mothers who had been homeless teenagers—differed in the length of time they had been poor and in the source of their poverty. In general, mothers leaving relationships had been poor for the shortest period of time, followed by unemployed couples, whose poverty was intermittent. The length of poverty among AFDC mothers and mothers who had been homeless teenagers was related to age. AFDC mothers often entered poverty with the birth of their first child, although many came from poor families themselves. Mothers who had been homeless teenagers typically entered poverty when they began to live on the streets as teenagers. Thus in both groups, in general, the older the woman the longer she had been poor.

All four types of families shared a pattern of residential instability during their poverty. An analysis of accounts of living circumstances during the year or two before becoming homeless (coinciding roughly with the years 1984 through 1986) showed that being poor in a high-cost residential housing market meant insufficient

money to pay for permanent housing. These families doubled up with relatives, friends, and strangers; they rented rooms; they lived in motels and welfare hotels. They moved constantly from one temporary housing arrangement to another; each move was provoked by a new crisis in their lives. This pattern of residential instability as a correlate of poverty *before* homelessness was typical of all family types in the study except "mothers leaving relationships," who often became poor at the same time they became homeless.

POLICY RECOMMENDATIONS

The provision of emergency shelter for homeless families is essential. Los Angeles County, for example, has no public shelter system for homeless families. The five shelters studied were run by private nonprofit organizations, often without even Federal Emergency Management Administration (FEMA) money or other governmental assistance. The number of beds was simply inadequate in comparison to the number of homeless families. We interviewed mothers with infants as young as 2 weeks old who had to sleep on the street because no beds were available in the shelters. Four of the five shelters in the study turned away eligible homeless families daily for lack of space. (The fifth admitted all comers, but everyone slept on the floor or on pews.)

Yet if the larger problem is seen as family poverty in the context of a shortage of low-income housing, the provision of emergency shelter, though essential, will serve only as a stopgap measure. In order to reach the root problem, policies to increase the availability of affordable housing or to decrease the number of poor families must be implemented. Both strategies—reducing poverty and increasing the number of affordable housing units—are important. Because strategies to improve the supply of low-cost housing are discussed in Chapter 3 of this volume, I will limit this discussion to strategies to decrease family poverty.

Strategies to Decrease Family Poverty

Families are poor because the adult(s) in them are unable to earn enough money in the market economy to put the family above the poverty line. However, the root of that inability differs by family type. In order to be effective, strategies to decrease family poverty must be tailored to the needs of the different types of homeless families.

Unemployed Couples

Men heading families classified as unemployed couples wanted work. Statistically, the income of white men with marginal education and skills is very sensitive to changes in overall economic growth. When the economy enters a recession, their income falls, and their unemployment rate rises. When the economy expands, their real wages, hours of work, and labor force participation increase.[9] Thus for these families, the primary approach to reducing poverty lies in economic policies that reduce the frequency and security of recessions and promote the steady increase of U.S. productivity and the gross national product (GNP).

In the absence of work, two policy changes would improve the safety net for unemployed couples. Extending the coverage and eligibility period for unemploy-

ment benefits and raising the benefit levels, an approach that has been used during times of high unemployment, would improve these families' relative economic situation, although it would still leave most of them below the poverty line. In addition, as the United States completes the shift from a manufacturing economy to a service economy, the skills of many of these men are becoming increasingly outmoded. To compete in the job market of the 1990s, they will need new skills and further education.[10] Adding an education and training component to unemployment insurance benefits would enable men (and women) with outdated skills to train for new careers and to find stable employment.

Finally, a number of two-parent families in the study came to California because that state provided AFDC to two-parent families (AFDC-UP), whereas their states of origin did not do so. The Family Support Act of 1988 now requires all states to provide AFDC-UP. This is definitely a step in the right direction. However, it would be better if states were required to provide AFDC-UP for as long as it is needed, rather than for only 6 months out of a 12-month period.[11]

Mothers Leaving Relationships

Mothers leaving relationships were potentially more employable than single mothers in the other two groups. They had higher levels of education and more skills; many had worked full-time before becoming mothers. Their entry into poverty was clearly "event-driven"[12]; they seemed most likely to be entering a short-term spell of poverty and therefore only a short term of AFDC dependency. Yet unlike the men in unemployed couples, single women who head their own households and have children under 18 will not be able to go to work even in an expanding economy unless they have affordable child care.[13] Some mothers in this group also might benefit from employment and training programs, although historically the better educated and more highly skilled mothers in employment and training programs have gained less from such programs.[8,14] Hence the provision of child care probably would be most helpful in enabling mothers in this group to return to work and to become self-supporting.

AFDC Mothers

AFDC mothers tended to have less education and less work experience than mothers leaving relationships. Consequently, child care alone would probably be insufficient to enable many of these mothers to enter the labor market. Evaluations of employment and training programs show consistently that the largest postprogram gains occur among "the most disadvantaged [women] with the least amount of previous labor market experience"[8]—the typical "AFDC mother" in this study. Thus, in addition to providing child care and income support, AFDC should become a program in which recipients who need it receive education and training leading to placement in real jobs. Such a program has the potential of enabling dependent single mothers to become self-supporting above the poverty line.

Another important step would be to replace part of the AFDC program (regarded as welfare and thus highly stigmatizing) with a child support program that would function much like Social Security. Such a program should be similar to Wisconsin's Child Support Assurance Program, in which mandatory child support is deducted from the absent father's pay at fixed percentages (17% for one child, 25%

for two, etc.) and is sent to custodial mothers as a regular monthly check. In this program, when the absent parent's income is insufficient to provide a minimum child support benefit, the state makes up the difference. The receipt of child support would become a woman's right, and child support plus a part-time job would enable many AFDC mothers to leave welfare rolls and to become self-supporting.[15,16,17]

Meanwhile, as long as AFDC remains in its present form, the benefit levels need to be increased. Although Social Security benefit levels were indexed for inflation during part of the 1970s, AFDC was not indexed. In a 1985 study, the Congressional Budget Office[18] found that the real value (constant dollars) of the median states' maximum monthly AFDC benefit for a four-person family fell from $599 in 1970 to $379 in 1985, a 37% decrease.

In addition, AFDC benefits fluctuate widely from state to state. In January 1985, for example, the maximum monthly benefit for a family of four ranged from $120 in Mississippi to $800 in Alaska.[18] (California, at $660, ranked third in the nation.)[18] In order to bring the low states up to par, states should be required to support families at or above a federally set minimum.

Finally, although AFDC was better than no income at all, in California the benefit levels were not high enough to enable mothers to pay for permanent housing on the open market. Either the benefits should be raised enough to cover market housing costs, or affordable housing should be made available to AFDC recipients.

Mothers Who Had Been Homeless Teenagers

Mothers in this group were most likely to need "support and rehabilitative services attached to specialized housing alternatives"[19] in order to stabilize their lives, to avoid recurrent homelessness, and to prevent their children from becoming wards of the court. Like mothers leaving relationships, these mothers needed child care. Like AFDC mothers, they would benefit from employment and training programs and likely would need income support, probably for extended periods. In addition, they would benefit from voluntary programs providing transitional housing in a supportive environment where they could learn parenting, social, and work skills.

SUMMARY

Homeless families are not all alike. Although all four types of families in this study were homeless ultimately because they could not afford rental housing in Los Angeles, the origins of their poverty differed. A broad class of policy options designed to increase labor market participation of family heads or to increase the amount of transfer income available to families would be of assistance to all of these families. Programs that are targeted to the needs of specific types of homeless families, however, are more likely to be effective in reducing poverty, and thus in reducing homelessness, than programs that treat all homeless families alike.

Finally, it is essential to remember the importance of affordable housing. If safe, well-managed, low-cost housing had been available to every family living below the poverty line (as it is in many European countries), most of the families in this study would have been poor, but they would *not* have been homeless.

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Women and Children without Shelter

The Characteristics of Homeless Families

ELLEN L. BASSUK

INTRODUCTION

Families are estimated to constitute approximately one-third of the homeless population in the United States and are the fastest-growing subgroup of homeless persons nationwide.[1] This subgroup consists predominantly of female-headed households with children; the majority of family members are preschoolers. A network of emergency facilities has begun to emerge only recently despite the urgent needs of these families.

What accounts for the presence of families on the streets? External factors such as the severity of the low-income housing shortage, inadequate welfare benefits, family breakdown in association with poverty, and cutbacks in federal social programs have been cited repeatedly as causes of family homelessness.[2–4] These factors, however, do not explain fully why some female-headed families living below the poverty level lose their homes while others do not. Descriptions of some families suggest that psychosocial factors combined with external factors may contribute to the origins of first-time homelessness and its seeming intractability.[5–6] As the housing crisis worsens, however, more and more families are losing their homes solely for economic reasons.

Despite the tragic consequences of family homelessness, data describing the characteristics of mothers and children[5–11] or exploring why some families become

ELLEN L. BASSUK • Department of Psychiatry, Harvard Medical School, Boston, Massachusetts 02115, and the Better Homes Foundation, 181 Wells Avenue, Newton, Massachusetts 02159.

homeless and others do not are surprisingly sparse. To begin to define the needs of homeless families, we designed a comprehensive clinical study of families sheltered in Massachusetts.[3,11] This chapter describes data from a study of 80 homeless families with 151 children sampled from two-thirds of the family shelters statewide. Overall, the sample seemed to be reasonably representative of families living in Massachusetts shelters.[3] Because the overflow of families generally is referred to welfare motels and hotels, we also interviewed 36 families with 54 children sampled from 10 motels outside Boston. Some families described in the case examples were living in these motels.

CHARACTERISTICS OF THE MOTHERS

Pat's story illustrates the problems of some homeless mothers. Pat is a 21-year-old single woman with a 2-year-old daughter. Pat never knew her father; she was raised by her mother, who worked full time as a home health care aide. Pat claims that their relationship was "crazy." Her mother beat her with chains, burned her with cigarettes, and locked her in the closet. When Pat was 14 years old, she started to run away to escape these severe punishments, but eventually she always returned to her mother.

Finally, the state placed Pat in a residential school. A year later she ran away again and became involved with a man who beat her; to escape his abuse, she returned to her mother. Since then, she has had many relationships with abusive men, interrupted only by chaotic interludes with her mother. In the 5 years before becoming homeless, she had moved about 20 times and had stayed in three different shelters. Her daughter has never known a stable home.

Pat has had eight abortions. Currently she is 2 months pregnant and feels very ambivalent about whether she will carry the pregnancy to full term. A care and protection petition was signed recently because of Pat's probable neglect of her daughter.

Feeling increasingly despondent, Pat has been living in a family shelter for 3 months. Without job skills or work experience, without a housing subsidy, and with inadequate supports, she faces a bleak future. Her benefits from Aid to Families with Dependent Children (AFDC) are more than 30% below the poverty level. Although she has been on a waiting list for public housing for 5 years, her immediate prospects for finding decent affordable housing are abysmal.

Are there many homeless families similar to Pat and her daughter? Although the homeless mothers we interviewed were a heterogeneous group with unique life histories, they had certain characteristics in common.[3] Ninety-four percent of the families were female-headed. On the average, homeless mothers in the present study were 27 years old, were single or divorced, and had two or three children. They had received AFDC for 2 years or more. Although they had completed high school, they had never worked or had only minimal job experience. Most families had moved many times before coming to the shelter or the welfare motel: They had made an average of 3.6 moves (range of 1 to 11) in the year before their current shelter stay. During the previous 5 years they had moved an average of 6.6 times (range of 2 to 24). In addition, 85% had doubled or tripled up in overcrowded living quarters with friends or relatives; more than 50% had been in other emergency shelter facilities. The average number of moves for children under age 6 was four,

with a range of 1 to 14. For many mothers and their children, homelessness had become a way of life.

Although most mothers had grown up in the geographical area where they were sheltered, the majority had minimal or no social supports. In response to the question, "Who are the three people most important to you that you could depend on during difficult times?", 26% could not think of anyone, 18% could name only one person, and 20% could name only two people. One-fourth named a child as their only support.

Relationships with men were characterized by instability, conflict, and violence. Approximately one-third of the women had moved from their parental home into relationships with men who battered them severely. More than 40% of the women reported that their most recent boyfriend or spouse was a substance abuser; two-thirds reported that battering episodes were most commonly alcohol-related. When the male's alcoholism spiraled out of control, the relationship often collapsed. Although 40% of the mothers reported that they had been in an abusive relationship at some time in the past, domestic violence only infrequently precipitated the current homelessness episode.

Historically, family relationships had been unstable. More than two-thirds of the mothers had experienced a major disruption in their family of origin, caused by factors such as mental illness (12%), death (20%), divorce (49%) of a parent or parents. Of the 27 who had lost both parents, 12 were placed with a relative, 8 became runaways, 4 were placed in foster care, and 3 were hospitalized for psychiatric reasons. The young age of the child at the time of the disruption probably compounded the effect: In 41% of cases it occurred when the woman was under age 6, and in 22% when she was between ages 6 and 11.

One-third of the mothers reported that they were abused physically, generally by their mothers. Some of these women now perpetuate a cycle of abuse; 23% of the mothers currently were being investigated by the Department of Social Services for probable child abuse or neglect.

On the basis of complete diagnostic assessments, with a focus on developmental and current histories as well as on symptoms and behaviors, one-fourth of the mothers were assigned DSM-III, Axis I diagnosis, indicating the presence of major clinical syndromes. These syndromes, however, did not cluster into a single diagnostic category. Whereas many adult individual homeless women and men suffer from psychoses (e.g., schizophrenia), these diagnoses were not overrepresented among homeless mothers. In contrast, 71% received diagnoses of personality disorders.

> Based on large-scale random sampling, estimates of the prevalence of serious personality disorders in the adult population range from 5 to 15 percent. However, personality disorder is a diagnosis of social dysfunction and does not take into account the influence of environmental factors extrinsic to the personality such as poverty, racism, and gender-bias. Criteria for these disorders are no more than descriptions of behavioral disturbances that are long-term and predate the homelessness episode. The resultant diagnostic labeling may exaggerate the degree of psychopathology within this subgroup of homeless women. Thus, the labels should primarily be used to indicate severe functional impairment and the need for help rather than implying strict causality.[3]

The story of Susan W. illustrates further some of the characteristics of homeless mothers. Susan appears to be functioning well and is one of seven homeless mothers who were working during their shelter stay. She is a high school graduate who has worked full time as a bank teller, currently is employed as a part-time secretary, and

has word processing skills. She has received AFDC only intermittently. Yet despite Susan's many strengths, she has few relationships and has had considerable difficulty in setting limits with her adolescent sons—a problem that has interfered with her capacity to maintain a home.

Although Susan described a hostile-dependent relationship with her mother, her family was intact while she was growing up. At the age of 19 she married and gave birth to twin boys. During her pregnancy, her husband became increasingly involved with drugs, began to beat her, and had difficulty in maintaining a job. When he became abusive to the twins, Susan moved into an already overcrowded apartment with her parents. Several years later, when Susan was 24, her parents divorced, her mother moved to another city, and Susan remarried. That relationship ended after 6 months. After moving several times more, Susan found an apartment where she lived for the next 7 years. Her life centered around her children. She rarely saw her family and had few friendships with women or with men.

As her sons reached adolescence, Susan's problems escalated. One son was hospitalized in a rehabilitation facility for 1 year because of severe learning disabilities. After his discharge, both boys became increasingly involved in antisocial activities in their neighborhood. They were accused repeatedly of destroying neighbors' property and of stealing. After several heated tenants' meetings, the family was evicted. Despite this outcome, Susan remained fiercely protective of her children, denying their behavior and refusing to seek help for the family.

After the eviction, they were referred to a welfare hotel, but left after 1 month when Susan got into an argument with the school authorities. As she put it, "they threatened her" because the children were not going to school. The family moved into another hotel but stayed only a few months, until shelter space became available. Susan then was evicted from the shelter because one of her sons was accused of stealing money. She said, "The shelter has no supervision, no protection; it's a perfect place for stealing." From there the family moved into another welfare hotel but again was asked to leave because the boys were destroying property. When confronted with their behavior, Susan denied significant problems and externalized their difficulties onto the school system, the hotels, and the shelters.

CHARACTERISTICS OF THE CHILDREN

The children we interviewed manifested a wide range of serious emotional, social, and cognitive problems.[3] Many of these problems were long-standing but were exacerbated severely by the stresses of losing one's home and shelter life.

As part of the evaluation of the preschoolers, we administered the Denver Developmental Screening Test, a standardized instrument used by pediatricians to measure developmental milestones in four areas: language, gross motor skills (e.g., 90% of normal children walk by 14 months), fine motor coordination (e.g., 90% of children can build a tower of four cubes by 22 months), and personal and social development (e.g., 90% of children can drink from a cup by 14 months). Forty-seven percent of the preschoolers we tested had a developmental delay in one major area; 33% had lags in two or more areas. Previous studies have shown that children growing up in severe poverty often manifest delays in language development, but multiple deficits are unusual.

Thirteen-month-old William illustrates some of the problems manifested by homeless preschoolers.[12] His parents had abused drugs before his birth. When his

father was arrested and incarcerated in a federal penitentiary about 8 months before William's stay in the shelter, his 22-year-old mother could no longer cope. Unable to tolerate being alone, she quit work, became severely depressed, and turned increasingly to alcohol for solace. Finally she was evicted for nonpayment of rent.

When we first met William, he smiled vacantly and sat immobile, exactly in the spot where his mother had placed him. When the interviewer enticed him with a colorful rattle, he purred appreciatively but made no discernible sounds, such as "ba-ba" and "ma-ma." He crawled on one knee, using his other foot to push him along, but he was unable to stand or to walk. His mother corroborated our findings and offered various explanations to account for William's delays. She believed that he could not say "mama" because they lived alone, and he never heard anyone refer to her as "mama." Overall, William had significant lags in all areas of the Denver test.

The school-age children also suffered from serious emotional problems. On the Children's Depression Inventory and the Children's Manifest Anxiety Scale, about half scored high enough to warrant further psychiatric evaluation. Almost all the children tested stated that they had thought of suicide but would not translate these thoughts into action. The need for psychiatric referral was supported by scores on the Child Behavior Checklist, a standardized instrument that parents filled out describing their child's behavior. The children's depression and anxiety seemed to have interfered with their capacity to learn. Most of the older children were doing poorly in school; 43% had repeated a grade, and 25% were in special classes.

Michael and Tommy R., both teenage boys, had been living with their 33-year-old mother in one room in a welfare motel for the previous year and a half. Because of faulty plumbing, the carpet was wet and mildewed; the manager claimed that he had tried to repair the leak. Cooking was not allowed, so the family went out for dinner every night at fast-food restaurants.

The mother had grown up in an adjacent community and had close relationships with two sisters, who both lived in overcrowded quarters with their many children. The R. family had become homeless after the mother was divorced from her alcoholic husband and the apartment house in which they were living was sold to a developer. The mother currently was working part time as a bus driver for the handicapped, but without a housing subsidy she would never earn enough to leave the motel. So far she had been unsuccessful in obtaining one.

Both boys were deeply ashamed of their homelessness. They kept it a secret from teachers and other children, avoided after school contacts, and invented telephone numbers and addresses. Previously they had been average students, but since the divorce their grades had fallen, and they were frequently truant; in the past year both had been held back. As a reflection of their distress, both boys scored above the mean on the anxiety and depression inventories, indicating the need for further psychiatric evaluation. Neither boy was receiving help, however.

SERVICE UTILIZATION

Despite their diverse and urgent needs, these homeless families either were not connected to a service agency or found the agency "not at all helpful."[3] Of the mothers we interviewed, only 43% had contact with a housing and/or social welfare agency while they were staying in the shelter. Even more surprising was the small proportion of preschoolers (14%) involved in day care or Head Start programs.

For some homeless families, service agency interventions fail because of the system's inability to respond flexibly and creatively to the complex problems of these families. The story of Diane, a 23-year-old single mother of a 6-year-old daughter, illustrates how the services offered did not fit with the mother's or the child's needs, a situation leading to disastrous outcomes for both.

Diane had been staying in a Boston shelter for 2 months with her daughter, Martha. From the age of 7, Diane was raped repeatedly by her godfather but was too frightened to tell anyone. When she reached age 10 her mother, who had abused her physically, died of alcoholic cirrhosis. The father kept the nine children together by working day and night but eventually moved the family south to be closer to his relatives. Diane felt uprooted and lost. At the age of 15 she was raped by a boy at school and got pregnant. After her daughter Martha was born, she began to abuse drugs and then married a man who beat her severely. At the age of 19, after becoming seriously depressed and cutting her wrists, she left him and came to stay with a sister in Boston. One year later, shortly after she and Martha moved in with Ray, her new boyfriend, he began to beat her. Fearful of leaving him, she tolerated the abuse for 2 more years.

The previous fall, Diane had noticed that her daughter had a vaginal discharge and brought her to a health clinic. The doctor filed a care and protection petition when he discovered that she had been raped by Ray and was suffering from gonorrhea. Diane said the social worker at the clinic "made me feel bad, like running away. She told me that if I didn't get her into therapy and school and didn't stop seeing Ray, she would put Martha in foster care." Diane insisted, however, that it was unsafe to leave the shelter because Ray lived down the street and stalked her. On one occasion he found her and cut her hair. She said that the police were involved, but "they were of no help." Diane also said that the social worker did not return her calls for 5 days at a time and that she had no safe way of going out. As a result, Martha had visited the clinic only three times in the last 6 months and Diane was not in treatment.

The social worker and her supervisor said that they had repeatedly offered Diane transportation vouchers to the various treatment facilities. At first she was compliant, but soon she dropped out, claiming that she was safe only in the shelter. Sometimes when Diane did not show up, the social worker phoned and warned her about the consequences of her behavior, but no other actions were taken. Martha had little rapport with her worker and remained essentially untreated throughout her shelter stay.

We also evaluated Martha. She was preoccupied with her body, cried for lengthy periods with little provocation, was clingy and demanding, and had almost no frustration tolerance. She told the interviewer, "I used to know my ABCs, but I can't remember them anymore." The evaluator, an experienced child psychologist, concluded that Martha was in an emotional crisis that required immediate intervention, perhaps even hospitalization. Concern about this situation prompted the research team to arrange an immediate evaluation at the hospital clinic where they worked. The mother agreed to this course of action.

Before it could be implemented, however, the situation exploded. The social worker found that Martha was being picked up after school by the rapist/boyfriend and that she was left in the shelter for hours with other mothers while Diane went out with Ray. Somewhat precipitously—although 7 months had passed since the original petition was filed—the social worker came to the shelter when Diane wasn't there, packed the child's belongings, and took her away. Although Diane had been

warned repeatedly that this might happen if she did not comply, she felt unaided, unprepared, and violated. Five days later she went to court and was informed that the child was in foster care but that she might be returned if Diane enrolled in a therapeutic shelter program. She applied but was rejected. Several days later, Ray beat her so badly that she required hospitalization.

The next time we saw Diane, she was lying immobile in front of the television set at the shelter. Because she had given Ray the address of the shelter, the staff asked her to leave. She now has no place to go, no job, and no prospects for proving that she could become an adequate mother. One can only guess what this abrupt separation means to Diane and to Martha, an already vulnerable and traumatized 6-year-old.

DISCUSSION

For two-thirds of the families we interviewed, the immediate precipitant of the current homelessness episode was housing-related. The housing and support system data, however, suggest that homelessness for many is not an acute situation with a ready solution. The long histories of residential instability, the lack of supportive family, friends, and caretakers, the frequency and severity of early family disruptions, and the patterns of family violence suggest that psychosocial factors are important contributors to homelessness in some families. Like the "multiproblem" families described in the 1960s, these families are often the hardest to reach.[13] The emergency shelter system now faces the formidable challenge of responding to other urgent and complex needs.

The data show that the average 2-to-3-month stay in the family shelters is far too short. The finding that at least half of the families had lived previously in other emergency facilities suggests that many are not reintegrated successfully into the community after their shelter or hotel stay. Furthermore, it is likely that even if they find permanent housing, the lack of other social supports might undermine their tenure in the community. Despite the dedication and the vigorous efforts of the staff, they are working against tremendous odds. The shelters and welfare hotels are a stopgap, band-aid response to a tragic problem. What is needed is a wide range of transitional and permanent housing alternatives that are interconnected with social welfare services. Special programs also must be created for the children.

Our findings of severe developmental delays in the preschoolers, and of anxiety, depression, and learning difficulties in the school-age children show that their problems cannot wait. We must make an immediate commitment to alleviating the problems of homeless families. Primary prevention should be a major goal. We should aim to identify families at risk and to rescue families who are currently homeless from a lifetime of deprivation and violence. Only then can we hope to interfere with this cycle of intergenerational homelessness.

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Domestic Violence Survivors

AMY SOMERS

INTRODUCTION

In 1984 a report on homeless populations by the U.S. Department of Housing and Urban Development (HUD)[1] identified chronic disabilities, personal crises, and economic conditions as the primary causes of homelessness. Declines in public assistance and in the supply of low-cost housing were noted as additional causes in a later report by the General Accounting Office (GAO).[2]

The Federal Crime Commission[3] estimated that one-quarter to one-third of all married American women experience domestic violence at the hands of their spouses. Other research suggests that more than half of married women in this country may experience domestic violence.[4–6] Research also suggests that the feminization of poverty and the high rate of domestic violence are related directly to the growing number of homeless women.[7–8]

This "personal crisis" of domestic violence, compounded by sexist wage discrimination in the labor force and by declines in public assistance and affordable housing, have created a population of battered women and their children who must either remain housed in a potentially life-threatening situation or become homeless.

There are no accurate statistics delineating the proportion of the homeless population whose primary cause of homelessness is domestic violence or of the proportion of battered women who are homeless. A national study of 163 battered women's programs demonstrated that

> 46,838 battered women were served by these programs . . . approximately four times as many clients were served on a nonresidential basis as were housed. During the same period, 14,473 children were sheltered in (domestic violence) program facilities. Unfortunately, the average capacity of a shelter program was 15 persons, including women and children, and program directors report that they often have to turn women away because of lack of space.[9]

AMY SOMERS • AIDS Foundation San Diego, 4080 Centre Street, San Diego, California 92103.

Historically, most studies of the homeless population have focused on men. More recent studies examining differences between homeless men and homeless women fail to ask women whether domestic violence was a cause of their homelessness.[10] Current studies of homelessness gather data from homeless shelters and feeding services but fail to include shelters for battered women in their surveys.[1]

National estimates of the number of homeless persons in the United States vary from 250,000 to 3 million. According to the HUD report,[1] Los Angeles County leads the country in the number of homeless.

Two studies of homeless populations in Los Angeles County suggest the disparity in findings that results from data biases. A study of 87 mothers of children under age 18 in five shelters for homeless families in Los Angeles County determined that

> one third of the mothers in the sample became homeless because of relationship troubles. The majority of these women became homeless when they left abusive male partners, while some had been thrown out or locked out by husbands or boyfriends.[11]

The United Way study[12] of Los Angeles County's shelter system, which did not include its 18 domestic violence shelters, determined that for .7% of its downtown and 2.8% of its suburban shelter clients, domestic violence was the primary cause of need for shelter.

According to the Los Angeles County Department of Community and Senior Citizens Services, the primary founder of most Los Angeles County shelters for battered women, 15 domestic violence shelters provided emergency housing for 1,746 battered women between January 1984 and March 1985. Several thousand others were turned away for lack of space. Domestic violence shelters provided 15,625 unduplicated services for battered women and their children who were shelter residents as well as for others who could not be sheltered.

Data based on general populations of homeless shelters are likely to include women who originally became homeless because of domestic violence but who no longer report domestic violence as their primary cause of homelessness because they are no longer in immediate physical danger from their abusers. In addition, in order to be admitted into many homeless shelters, women often cannot report that they are at risk of violence.

Data based on populations of domestic violence shelters, on the other hand, are biased because of the selection process of shelters, many of which accept only women with children or women with no resources whatever. Furthermore, many domestic violence shelters do not serve non-English-speaking women.

CAUSES OF DOMESTIC VIOLENCE

Domestic violence is an act carried out with the intention of physically and/or psychologically injuring one's spouse or one with whom one is in a relationship.

Domestic violence is a result of economic, social, and ideological systems that encourage and perpetuate sexual inequality and patriarchal domination. This system is generated by the need of the U.S. economy to maintain unpaid labor in the home and to generate classes of low-paid workers. Sexism, the ideological development of social discrimination against women, helps to support the necessary economic discrimination.[13] The result of this discrimination and inequality is that

> the position of women and men as wives and husbands has been historically structured as a hierarchy in which men possessed and controlled women. There were

> numerous legal, political, economic, and ideological supports for a husband's authority over his wife which included the approval of his use of physical force against her. The legal right of a man to beat his wife is no longer explicitly recognized in most western countries but the legacy of the patriarchy continues to generate the use of force against his wife.[14]

Many battered women and their children are forced to remain in these abusive situations because of economic discrimination and the resultant feminization of poverty.

> In the 1970's, single women, especially those with young children, became the most predictably impoverished stratum of the American working class. Today, a single woman with children and without professional or managerial skills is virtually condemned to poverty or near poverty. In 1977, 42% of single mothers had incomes below the Federal poverty line, a rate of poverty more than six and a half times that of husband–wife families.[15]

By 1980, the median income for female-headed households was 54.9% of the median income for married-couple households in which the wife was not working and 38.7% of the median income of all married-couple households in which both spouses worked. The median income for all women workers was 60.5% of the amount earned by men. By 1981, 35% of all female-headed households (with and without children) were below poverty level.[16–17] This economic reality leaves many battered women with the alternatives of remaining in a violent home or becoming poor and homeless.

CHARACTERISTICS OF THE POPULATION OF DOMESTIC VIOLENCE SURVIVORS

Contrary to earlier theories, domestic violence does not occur only among poor communities or in particular ethnic groups. Many of these assumptions were based on faulty data because most information came from police or shelter records. Police records grossly distort the picture of domestic violence victims because such violence, like rape, is a highly underreported crime. Statistics on domestic violence shelters also overrepresent poor people and women because the poorest women are likely to go to shelters, whereas women with more resources often deal with the issue privately.

According to research and testimony presented to the U.S. Commission on Civil Rights,[5] domestic violence occurs among all classes and races, and males are most often the perpetrators. Once domestic violence occurs, it is likely to increase in intensity and frequency. Domestic violence is often intergenerational: An estimated 75% of battered women as well as abusers were raised in households where the mother was abused by the father and/or where they themselves were abused as children.[18] Both abusers and victims typically have very low self-esteem and often poor verbal skills.

Male abusers tend to exhibit poor anger control, insecurity, and morbid jealousy. Substance abuse has been associated with batterers,[6] although the relationship remains unclear. Although alcohol abuse by the perpetrator has been used often by researchers to "explain" violent incidents, both alcohol and physical abuse are usually symptoms of an underlying common problem rather than cause and effect. Men often use drinking as an excuse for battering to turn attention away from their mistreatment of women. Some men drink heavily *after* abusing their spouses as a way of forgetting the crime that they have committed. Therefore treatment programs

that focus on substance abuse rather than on its root cause may result in a decline in alcohol abuse but in a concomitant increase in wife abuse.[19]

Female victims of domestic violence tend to have very low self-esteem, often are powerless, and were raised in traditional households. Many battered women are prevented by their abusers from working in the wage labor force and from learning how to use a checkbook, drive a car, or practice other skills that would afford them independence.[14] In addition, however, there is a population of battered women who are the primary and sometimes the sole family earners. Often they are made to feel guilt and responsibility for their abusive spouses as well as for maintaining an intact family, no matter what the cost to their own well-being. Most battered women are isolated by their abusers from developing social support systems such as friends and extended family.

Many female victims of domestic violence present symptoms such as anxiety, depression, gastrointestinal complaints, back pain, headaches, and somatic concerns.[20] Although the cause of these symptoms is often the battering itself or the realistic fear of additional abuse, many battered women are diagnosed as having psychosomatic illness. Rather than trying to determine and treat the battering as the cause of such complaints, practitioners often prescribe tranquilizers, which in turn make the battered woman an easier target.

The correlation between wife abuse and child abuse has not been tested systematically. Women who call domestic violence hotlines and receive services from battered women's programs often report that one reason why they remained in an abusive situation for so long was that they did not want to deprive their children of a good father. Ironically, the event that precipitates a woman's decision to leave home may be the onset of abuse of one or all of her children. Although a woman may tolerate abuse of her own person, often she will not tolerate the same abuse of her children.

The combination of psychological abuse, which leaves the woman feeling incapable and economically dependent on the batterer, and the limited wage labor opportunities for women generally make the decision to leave home a difficult one.

Although statistics on the proportion of battered women who become homeless do not exist, a recent study of battered women living in a homeless shelter suggests that when many of the women made the decision to end an abusive relationship,

> they sometimes became homeless when these relationships were disrupted. Although for many the disruption was not the immediate precipitant of the current homeless episode, attempts to extricate themselves from the battering relationships left these women without their homes, beginning a cycle of doubling up with relatives and friends in overcrowded conditions that often lead to homelessness.[6]

Many must seek refuge in homeless shelters or in programs designed specifically for survivors of domestic violence and their children. For many battered women, long-term isolation from friends and family reduces other options. Furthermore, if friends or family members also have been threatened by the abuser, the option to live with them even temporarily may be sabotaged.

NEEDS OF HOMELESS DOMESTIC VIOLENCE SURVIVORS AND THEIR CHILDREN

Regardless of the initial cause of homelessness, some of the basic needs for emergency food, shelter, and clothing are characteristic of all homeless populations. Beyond these common needs, however, domestic violence survivors and their chil-

dren also have specific needs that cannot be met by general shelters or programs for general homeless populations.

In the short term, domestic violence survivors require physical safety. Most battered women's shelters assure this safety by keeping their location secret and by working closely with local law enforcement agencies to develop security plans. Many domestic violence survivors need to flee to a shelter that is not located in their hometown because persistent abusers sometimes can track them locally. All battered women's shelters participate in shelter networks, working cooperatively with shelters located in other areas to transfer residents when safety requires such movement.

Many domestic violence survivors initially require settings that house only women and children. Their battering experience makes them feel particularly vulnerable to men, and the adjustment to shelter living itself is facilitated by the support of other women.

> Simply getting used to the shelter is an overwhelming task. . . . Women who come to the shelter are very scared. They don't want to leave their community or come to a new place. They may have language problems. They don't drive. They may never have paid bills or done a budget. . . . They're not used to living collectively.[21]

Other immediate needs of women and children in domestic violence shelters include medical attention, particularly if a recent incident of abuse was the cause of a woman's decision to leave home. Many battered women first contact their shelter intake worker in the hospital emergency room. Short-term legal assistance, including temporary restraining orders, often are required to ensure the woman's immediate safety and the custody of her children. Battered women who leave home require immediate advocacy with social service agencies, such as county departments of child protective services, to report child abuse, and public social services, when applicable, to initiate or transfer their Aid for Families of Dependent Children (AFDC).

Most important, battered women who leave home for domestic violence shelters require immediate counseling and emotional support if they are to remain out of the abusive home. The first 48 hours of a woman's stay in a domestic violence shelter are usually the most crucial. Without individual, group, and children's counseling, as well as peer support groups developed specifically to build a woman's self-esteem and to support her budding belief that abuse is not necessary, often she will leave the shelter and return to the battering situation. Counseling for the children of domestic violence survivors is particularly important if the cycle of abuse is not to be repeated by future generations.

While women are housed in a domestic violence shelter, where the average maximum stay is 30 days, they are involved in activities designed to meet their immediate needs. When the end of their shelter stay is impending, a set of long-term needs must be addressed.

> During a shelter stay, women often pass through several stages. At first they are frightened and nervous, both about the decisions they have made and about their new environment of fifteen or more strangers. For the first several days or weeks, women are constantly busy with court proceedings, welfare applications or job hunts, medical appointments, and the search for affordable housing so that the next endangered woman can take her place at the shelter. After the initial flurry of activities, women wait for apartments and court proceedings, and at this point may feel intense doubts, fear and pain.[21]

Many survivors of domestic violence, faced with leaving an emergency shelter where they received the emotional and financial support necessary to remain independent of their abusers, will not be able to make it on their own. The development of

transitional or "second-stage" housing is planned currently by many battered women's shelters in recognition of domestic violence survivors' need for transitional low-cost housing among other battered women, where counseling, support groups, and child care are available. Second-stage housing is conceived as a bridge to self-sufficiency and permanent housing.

Because few second-stage housing programs exist, however, many homeless battered women move from emergency shelter to emergency shelter or return to the abusive situation. Others live in their cars or in settings that may endanger themselves and their children, as well as keeping them from obtaining employment and benefits. As a result, their children may be placed in foster homes or institutions.

By living in a safe, comfortable, affordable, and supportive environment for 3 to 12 months, women can save money for long-term housing, learn fiscal management, improve their education and job skills, and develop a stronger and more positive sense of self. Children of domestic violence survivors can receive additional counseling and can learn nonviolent means of expression.

Once the homeless survivors of domestic violence leave an emergency shelter or second-stage housing, their long-range needs include low-cost housing, employment, legal assistance, and counseling. In view of the low median income of female-headed households, full-time employment and affordable housing are necessary if a woman is to remain on her own. Because many homeless battered women have young children, a situation that makes it more difficult for them to find affordable housing, reasonably priced child care is needed to enable women to work full time. Legal assistance in the form of help with divorce and custody proceedings, as well as support in the pursuit of criminal remedies, often are required when a battered woman makes the final decision to remain on her own. Long-term counseling, both individual and in a group, will enable a woman to develop the skills and the self-image necessary to keep her from entering another battering relationship.

SERVICES FOR HOMELESS DOMESTIC VIOLENCE SURVIVORS

The domestic violence movement began more recently than the development of services for homeless people. The first services designed specifically for homeless battered women were developed in England in the early 1970s, largely through the work of Erin Pizzey. Under the influence of the British programs, and as a result of the women's movement and antirape movements in this country, multipurpose women's centers were opened in many U.S. cities. The centers provided general peer counseling, information, and referral; some offered crisis hotlines. It became apparent to those providing counseling and crisis intervention services that a large population of battered women existed who required programs designed specifically for them. As a result, the first domestic violence shelters opened in the United States in 1975.

After 1976, hundreds of battered women's shelters, safe home programs, and counseling and hotline services opened throughout the nation.

> By 1982, estimates placed the number of shelters and safe home projects somewhere between 300 and 700. There is enormous variation from state to state in the number of shelters; in 1980, for example, Arkansas had four shelters and California sixty-eight.[21]

Most domestic violence shelters provide emergency food, shelter, and clothing, a 24-hour crisis intervention and referral hot line, counseling, advocacy, and legal as-

sistance. Some programs also provide drop-in and counseling services to battered women who have not left their abusive homes.

These programs cannot meet the needs of all battered women. As the issue is discussed more openly and as programs advertise their services, more women are willing to reveal that they are victims of domestic violence and to request services. Estimates of the unserved domestic violence population are similar in various parts of the country: Domestic violence programs in Minnesota reported turning away 70% of women requesting shelter in 1979 because of lack of space, whereas programs in Massachusetts turned away 70% of the battered women requesting shelter from July 1983 to June 1984.[6] Many of these unserved women must seek legal and public entitlement assistance on their own; lacking access to supportive services, most remain in their violent homes.

CONCLUSIONS

Research suggests that there is a substantial population of women and children who must choose between subjecting themselves to abuse or becoming homeless. In order to alter their current living arrangements, these women and children require a variety of services and settings that are specific to survivors of domestic violence. The domestic violence movement has attempted to respond to these needs by developing shelter services for battered women and their children. Because the development of general shelter programs for homeless people did not acknowledge the existence or the needs of homeless battered women, domestic violence programs were created independently and more recently. These programs are estimated to meet the immediate shelter needs of only one-third of the population requesting services. Long-term needs for low-cost housing, employment, and legal and counseling assistance also remain unmet.

Estimates of the population of homeless persons in the United States generally do not include homeless battered women and their children; surveys of homeless shelters typically do not include domestic violence shelters. Funding for homeless shelters is not always made available to domestic violence shelters.

More accurate research on homelessness in America is needed, including analyses of homeless survivors of domestic violence. More emergency shelters and crisis intervention services are needed specifically for homeless battered women, as are second-stage housing and permanent employment and affordable housing. Additional funds must be made available to programs that serve specific segments of the homeless population. Researchers and policymakers acknowledge the high levels of frequency and severity of domestic violence in this country; now we must recognize and serve the many women and children who become homeless as a result of domestic violence.

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VII

Homeless Children and Adolescents

22

To Be Young and Homeless
Implications of Homelessness for Children

ANDREA L. SOLARZ

INTRODUCTION

If asked to describe a "typical" homeless person, few people would think of a child living with a parent in a shelter for the homeless. Yet perhaps the most alarming change in the homeless population during the 1980s has been the dramatic rise in the number of homeless families with children.

There is broad consensus that the number of homeless families is growing and that children may be the fastest growing group of homeless. In their 1986 survey of 25 cities, the U.S. Conference of Mayors[1] reported that the most significant change in the homeless population over the year had been the growing number of families with children; 80% of the surveyed cities reported an increase. The conference's 1987 survey reported that these numbers were continuing to increase.[2] On average, the number of such families had grown by one-third during the previous year; one city (Charleston) reported an increase of 144%.

This chapter examines the problems of children who are homeless with their families. First, some of the events leading to homelessness for children and to separation of families will be discussed briefly. The status of homeless children then will be described, and their service needs will be discussed. This discussion will be followed by a brief description of local and federal services available for these children; the chapter will conclude with a discussion of policy implications. The chapter will not address the needs of homeless and runaway youths living on their own, who may number as many as 500,000 over the course of a year.[3]

Causes of homelessness are addressed comprehensively by other authors in this volume, but various events can precipitate this condition for families. Social and

ANDREA L. SOLARZ • American Psychological Association, 1200 Seventeenth Street, N.W., Washington, DC 20036.

economic developments leading to homelessness include inflation and unemployment, coupled with reductions in funding of social and human service programs.[4] Furthermore, gentrification of inner cities has contributed greatly to decreases in the available stock of low-income housing.[5] On a personal level, the specific precipitating incidents may include eviction from housing, estrangement from family members, criminal victimization, illness, loss of employment, and disaster (such as a fire).

Families with children may find it very difficult to remain intact once they become homeless. Family shelters may not be available in some communities; thus families are forced to separate in order to receive shelter. In some shelters, rules and restrictions can result in children becoming separated from their families. For example, adolescent males may not be allowed entrance with their mothers.[6] Among the shelter operators surveyed by the U.S. General Accounting Office (GAO),[3] one-third reported age restrictions on boys; 12% had age restrictions on girls. The average upper age limit for both boys and girls was only 11 years. Some children, particularly those who are older, take to the streets and try to survive on their own.

In other cases, a parent may choose to place children temporarily in foster care, believing that they will be provided for better while the parent attempts to recover financially and find housing. Guidelines developed recently by the National Association of Public Child Welfare Administrators discourage child welfare intervention in the absence of other apparent abuse or neglect, when parents are unable to support their children adequately despite the use of all available resources, such as in the case of homelessness.[7] California, Texas, and Maryland all prohibit child welfare intervention on the basis of homelessness alone. Nonetheless, children sometimes are removed from families because inability to provide a home may be perceived as evidence of neglect. In New Jersey in 1986, 18% of the children in foster care were in foster homes because their families couldn't find a place to live.[8] Homelessness was the primary or secondary reason for foster care placement for 40% of these children.

Removal of children from their parents' custody may result in the loss of eligibility for Aid to Families with Dependent Children (AFDC) benefits for the family, which reduces further their ability to secure housing. Conversely, custody of the children may not be allowed until parents demonstrate that they have adequate housing. Thus it may be extremely difficult to regain custody once the parent wishes to remove the child from foster care, even in cases where there was no prior evidence of parental abuse or neglect. Visitation also becomes difficult for parents who are moving from shelter to shelter, and family relationships are eroded further.[7]

NEEDS OF HOMELESS CHILDREN

It has been estimated that there are more than 500,000 children who experience homelessness with their families.[9] In New York City alone, 12,000 homeless children were sheltered in 1987.[10] Cities surveyed by the U.S. Conference of Mayors in 1987 reported that an average of one-third of their homeless were families with children.[2] In some cities (e.g., New York City) nearly two-thirds of the homeless were reported to be part of homeless families with children. In more than 70% of the cities surveyed, homeless families were reported to be the largest group for whom emergency shelter and other needed services were lacking most seriously.

A 1989 report by the U.S. General Accounting Office estimated that on any given night, there are 68,000 children and youths ages 16 and younger who are members of homeless families.[3] In addition, 186,000 additional children may be

doubled up in housing shared with relatives or friends. The GAO estimated further that more than 300,000 children homeless with their families are served yearly by shelter providers. A national survey of users of meal and shelter services for the homeless in large cities estimated that 35,000 children use these services each week.[11]

Available literature, which is based exclusively on studies of sheltered families, suggests that homeless families typically consist of women on their own (usually single) with their young children, usually under the age of 5. For example, the GAO study reported that 52% of homeless children in their survey were age 5 or younger[3]; nearly two-thirds of the children age 16 or younger seen by the national Health Care for the Homeless Projects were ages 1 to 5.[12] The relatively high percentage of young children observed in shelters probably depends on a number of factors, including shelter regulations that restrict the sheltering of older children.

Homeless families are reported to have an average of about two children.[3,15,19] Demographic information about these children is not always available, but there are data describing homeless families with children. Most homeless families surveyed in shelters belong to ethnic minorities.[13–14] Researchers generally report that these families receive Aid to Families with Dependent Children (AFDC),[11,16–17] although fewer may be receiving AFDC than similar housed families[17] and more may be receiving welfare than homeless adults by themselves.[11] Evidence suggests that homeless adults with children, when compared to homeless adults by themselves, are much more likely to be women, to belong to ethnic minorities, to be currently married, and to have lived in a house or an apartment before becoming homeless.[11] They also tend to have been homeless for a shorter period of time than adults on their own. The mothers may be more likely than similarly housed mothers to have experienced psychiatric problems, to be substance abusers, and to have fewer social supports.[17–18] Although heads of homeless families are less likely than other homeless adults to have histories of mental hospitalization, treatment for substance abuse, or criminal justice involvement, they report similarly high levels of depression and demoralization while homeless, reflecting the high degree of stress that these families suffer.[11]

The continuing rise in the numbers of homeless families with children has contributed to an increase in both popular and legislative attention to the plight of the homeless. Nonetheless, little research has been conducted to examine the effects of homelessness on these children. Most of what is known about homeless children in families has come from surveys of families in shelters. Virtually nothing is known about homeless families who survive by living in vacant buildings, in their cars, or temporarily doubled up with friends or relatives. The limited research that has been conducted on homeless children in families shows that these children experience a broad range of difficulties, including physical and mental health problems and school problems.

Mental Health

The condition of homelessness and of life in shelters places children under great stress. Researchers report that homeless children often experience a number of mental health problems, such as developmental delays and emotional problems. Little information, however, is available to determine the extent to which problems can be attributed to being homeless or to the stresses and strains associated with living in extreme poverty.

There is evidence that sheltered homeless children manifest significant developmental delays, although varying percentages have been reported for children assessed as having such problems. In studies of the children of homeless families in Boston, approximately half of the preschoolers tested were found to have at least one major developmental lag as assessed by the Denver Developmental Screening Test (DDST), compared to 16% of poor children living in public or private subsidized housing.[17] Another study, however, using a clinical sample of homeless children seen by the Boston Health Care for the Homeless Project, found that 95% made normal test scores on the DDST.[16] These scores were similar to reported scores for a sample of indigent children. Finally, 9% of a Los Angeles sample of homeless children failed two or more sections of the DDST, 50% more than expected on the basis of general population norms.[18] Fifteen percent, who failed one section of the DDST, were rated as questionable.

Children living in shelters also have been found to experience behavior problems. In comparing homeless with housed poor children, Wood *et al.*[18] reported more behavior problems among homeless children, particularly aggressive behaviors. Bassuk and her colleagues reported that school-age children assessed on the Children's Depression Inventory and on the Children's Manifest Anxiety Scale manifested high degrees of distress.[13,15,17,20] Homeless children (primarily aged 2½ to 5) observed in New York day care centers exhibited a range of problem behaviors, including short attention spans, weak impulse control, withdrawal, aggression, speech delays, and regressive behaviors.[21] In addition, these children tended to exhibit inappropriate behaviors with adults, such as lack of inhibitions with strangers and detached interactions with their mothers. Although they often showed strong bonding with siblings, their interactions with peers frequently were immature. Molnar *et al.*[21] suggest, however, that within the context of homelessness, some of these behaviors actually may be adaptive. For example, inappropriate anger directed toward peers may be the only way a child knows to make contact; hyperactive behavior may be a way to cope with a cramped, restrictive environment.

Although these studies of homeless children's mental health status have some methodological limitations (e.g., they assess only sheltered homeless children), they substantiate the generally high levels of distress that children living in shelters can experience. Much of the stress found in the children may be related to the condition of homelessness and to the concomitant stress of living in a shelter setting. Many of the difficulties experienced by these children, however, predated the current episode of homelessness, a sign that their lives may have been disrupted for some time.[20]

Despite the apparent need for special early intervention services for homeless preschoolers, few are enrolled in Head Start. In New York City, only about 15% of homeless children age 5 or younger who live in welfare hotels are enrolled in an early childhood program.[21] Similarly, Bassuk *et al.*[15] reported that only 17% of the children age 5 or younger surveyed in Boston shelters were in day care or in therapy/or counseling, despite evidence of substantial developmental delays and emotional difficulties. Even when slots are available for services, there is evidence that many homeless families never gain access to them. Reasons for underutilization include lack of motivation or awareness of services, fear of exposing children to dangerous local environments, lack of clean clothing, fatigue, and illness.[21]

The experience of homelessness places great stress on families as a whole, and children in homeless families may be at greater risk of abuse and neglect than similar domiciled children.[22] In one Boston court, homeless youths account for one-third of the abuse or neglect cases.[23]

Physical Health

Children who are homeless are at greater risk for virtually all medical disorders experienced by children in general.[5,14,22,24–25] Studies have found that homeless children experience chronic health problems at about twice the rates reported in the National Ambulatory Medical Care Survey.[5] They are particularly vulnerable to ailments that result from environmental exposure and unsanitary living conditions, such as upper respiratory and ear infections, gastrointestinal problems, and lice infestations.[5,12,14] Homeless children have been found to experience higher blood concentrations of lead then similar children living at home,[22] which may contribute to behavioral and learning problems. Substantial delays in immunizations also have been reported,[14,22] as have high rates of dental problems. It is difficult to determine whether these higher morbidities are directly attributable to being homeless or to the greater risks associated with living in poverty. For example, a Los Angeles study comparing sheltered homeless families with stably housed poor families found that both groups demonstrated high levels of morbidity and ill health in comparison to rates reported for the general child population.[18]

Homeless children have been found to experience nutritional deficits, such as iron deficiencies.[25] Such deficiencies were found among 2% of the children seen by the National Health Care for the Homeless projects; these disorders were virtually nonexistent among youths assessed during the National Ambulatory Care Survey.[12] Although both housed and homeless families reported poor diets in a study by Wood *et al.*,[18] homeless families experienced more periods of hunger and food deprivation, and children were more likely to have gone hungry over the past month because the family ran out of food. Wood *et al.* also reported abnormal youth measurements; homeless children were obese more frequently than expected.

Shelters and other emergency food assistance facilities report that they are often unable to provide nutritionally balanced meals to residents and that they regard the lack of food and/or poor nutrition as a serious problem for homeless families.[2,26] A national survey of meal and shelter providers for the homeless concluded that on the average, meals provided to the homeless provided substantial variety and adequate nutrition. They also concluded, however, that homeless heads of families had an inadequate diet when compared to the average American because they report lower satisfaction with their diet, eat fewer meals each day, and are more likely to go whole days without food.[11] Although the dietary intake of homeless children in families was not assessed as part of this study, it is quite likely that their diets suffer many of the same deficiencies as those of their homeless parents.

Shelters are poor environments for promoting children's health. Inadequate facilities for daily hygiene increase risk of disease and make it nearly impossible to follow prescribed medical regimens. Living in close quarters, particularly in communal shelters, can increase the risk of disease transmission.[27] Caretakers may find it particularly difficult to provide adequate food to infants because of the lack of a refrigerator in which to keep milk or formula.[22]

Homeless children frequently lack adequate health insurance coverage. A Washington State study found that 35% of a sample of sheltered homeless children had no insurance coverage; another 40% were covered by Medicaid.[14] One-third did not have a usual site for health care (e.g., public clinic, hospital clinic, or emergency room); more than half did not have a usual health provider (e.g., doctor, nurse, or nurse practitioner). Similar results were reported for a San Diego sample[28]; 56% of parents reported no source of health care, and almost half reported no form of health

insurance. A Boston study reported much greater numbers as having a regular pediatric provider, possibly because respondents may have regarded the Health Care for the Homeless staff conducting the assessment to be their regular provider.[16]

Lack of money or insurance coverage frequently prevents families from seeking medical and dental care for children when needed. Rates of emergency room use by homeless children have been reported to be much higher than for children in general, either because care is not sought until problems become acute or because their families have no regular health provider.[13] In one study,[28] more than three-quarters of a sample of homeless parents named the need for a nonemergency medical clinic as one of the services most crucial for their children's health and welfare. Finally, continuity of care becomes particularly difficult for children who move from one temporary residence to another.

Education

The Department of Education[30] reports that there are 220,000 school-age homeless children throughout the United States. Estimates were made through a variety of methods, including actual 1-day counts, data based on estimation, and partial data where information was not available for all parts of a state; two states did not provide data. Because of these methodological concerns, caution is advised in interpreting the data. About one-third (31.1%) of homeless school-age children and youths are believed to be in grades 10 through 12, 23.8% in grades 7 through 9, and 45.1% in kindergarten through grade 6.

Estimates of the percentages of homeless school-age children who attend school regularly vary widely, ranging from a low of less than 60%[29] to highs of more than 85%.[3] In the GAO survey,[3] 85% of homeless children staying in shelters were reported to attend school regularly; another 5% were planning to attend, once they had enrolled. In their recent report to Congress on school-age homeless children and youths, the U.S. Department of Education[30] estimated that 69.2% of homeless children and youths are attending school; 30.8% are not attending. New York City data reveal that 75% of elementary school-age homeless youths attend school (versus 89% citywide) and that 64% of junior high school-age homeless youths attend school (versus 85% citywide).[19] According to the National Coalition for the Homeless,[29] an estimated 43% of homeless school-age children do not attend school; this estimate is based on the results of a survey of families requesting help from Travelers Aid in eight cities across the country.

Homeless children missed school much more frequently than a sample of housed poor children, according to a study by Wood *et al.*[18] Homeless children were more likely to miss school because their families were in transition; housed children because of ill health. New York City homeless children reported that they missed an average of 5 days each time they made a school transition.[19]

Homeless children have been reported to perform more poorly than their housed peers and to have had previous trouble in school. Rafferty[19] found that fewer than half (43%) of homeless children were reading at or above grade level, compared with two-thirds of students citywide. Just over one-quarter (compared to 57% citywide) scored at or above grade level in mathematics. These levels also were substantially lower than those of other students living in the school districts where the shelters were located. In a Boston study,[15,20] 43% of homeless school-age children were found to have repeated a grade by the time they were surveyed in the shelter. Fifteen percent of children living in shelters in New York City had repeated a grade, a rate higher than that for children citywide.[19] In another study,[18] almost one-third

of a sample of homeless children had repeated a grade, versus 18% of a sample of housed poor children.

Homeless children face a number of barriers to continuing their schooling. Because shelters rarely have day care facilities, older children often stay out of school to care for younger children while parents are out looking for jobs or housing.[31] Similarly, school-age parents may be prevented from attending school.[30] Even if children had attended school regularly before entering the shelter, frequently they are unable to continue to attend this school because the shelter is rarely in the same area. A New York City survey found that more than 70% of homeless children were sheltered in a different borough from their most recent permanent home.[19] Until federal laws were changed recently with the Stuart B. McKinney Act (P.L. 100-77), homeless children often were refused enrollment in schools because they lacked a permanent address[9]; even with the change in law, resistance by school personnel continues in some areas.[32]

Lack of appropriate documents, such as birth certificates and immunization records, also may make it difficult for homeless families to register children for school.[26,30] Families moving from place to place may find it particularly difficult to keep important personal records securely. Two-thirds of the homeless families in a New York City survey had been sheltered in two or more facilities during their current episode of homelessness; three-quarters had experienced at least one school transfer since the loss of their permanent home.[19] Without transportation, parents find it extremely difficult to file requests personally for copies of birth certificates; by the time the copies have come through mail requests, families may have relocated. Significant delays also can occur when records are transferred from schools where children were enrolled previously.[30] If children are living separately from their parents (e.g., with friends or relatives), the unavailability of a legal guardian can prevent school registration.[29]

Even when enrolled, homeless children face additional barriers to school attendance. Attendance at a child's "old" school may require long daily trips on public transportation, and money is not always available to pay for transportation.[29] Many homeless children find that they must face ridicule from their classmates when it is discovered that they are homeless.[9,32] In addition, shelters lack the privacy and quiet needed to complete homework.[29] Educators who work with homeless children say that often special effort is needed to keep homeless children in school; some educators even knock on shelter doors every day to ensure attendance.[32] One response to this problem has been to create special schools for homeless children where they will not be ostracized and where educators understand their needs.[9] To date, such schools have been created in Tacoma, Washington, Santa Clara, California, and Salt Lake City, Utah.

OPTIONS FOR ADDRESSING THE CRISIS: THE POLICY RESPONSE

Primary responsibility for addressing the needs of the homeless has been held traditionally by various private charities, religious groups, and nonprofit agencies. Through missions, private shelters, clothing closets, and the like, the private sector has responded to meet the most basic needs of society's poorest individuals. Although few people deny that the federal government must make some response, controversy exists as to whether the government should take a primary role. Some

people believe that alleviating the homelessness crisis requires systematic solutions that can be addressed only at a national level. Others believe that discretion for programming should be retained at the state or community level, with private and civic groups working together to solve what are essentially local problems.

The primary mechanism for providing direct services to homeless families and children is through temporary shelters. Although shelters serve increasingly as sites for the provision of services beyond simple shelter (e.g., mental health services, health care services, day care), generally they do not address the many needs of sheltered families and children.

Shelters housing homeless families with children are often squalid and dangerous. Before it was finally closed and demolished, police visited the largest family shelter in Washington, DC three times a day,[33] most frequently for family violence and disputes over drugs. At the same shelter, six children died during an 18-month period, one in a fire.[34] Privacy may be totally lacking; families may be housed barracks style with dozens of other families.[31,36] Welfare hotels, where families are housed together in one room, sometimes for a year or longer, frequently are in the worst parts of the cities, expose children to the dangers of substance abuse and crime, and may contain such environmental risks as lead paint and exposed wiring. Shelters and hotels rarely have a place where children may play, either indoors or out. Cooking and refrigeration facilities often are lacking. Families may resort to prohibited hot plates for cooking; infant formula and other perishable items may be kept in coolers or toilet tanks.[31,36]

Federal Responses

A number of existing federal programs have addressed the emergency needs of poor people, including the homeless. Until budgets were cut severely during the Reagan administration, the government took an active role in developing a national stock of low-income housing. Traditional welfare programs such as AFDC (Aid to Families with Dependent Children) have provided some security for needy children and their parents. Medical care has been available for low-income persons through the Medicaid program and federally funded community health centers. Nutritional assistance is available through enrollment in food stamps and participation in the Women, Infants, and Children (WIC) nutrition program. There is evidence, however, that many homeless families eligible for these programs are not enrolled.[11,16,19]

As the need for emergency housing has become acute, many jurisdictions have taken advantage of the Emergency Assistance (EA) and special needs funds available under AFDC. These programs, in which states may participate voluntarily, allow for the limited use of federal matching funds to secure temporary shelter and other emergency assistance for needy families with children who are at risk of becoming homeless. Ironically, these funds, which were designed to provide critical aid to at-risk families, are now being used in some areas to shelter families for extended periods of time in "welfare hotels." Because of federal restrictions on the use of the funds, they may not be used for permanent housing even when such housing would be far less costly. The program is currently under review, both by legislators and by the Department of Health and Human Services.

Emergency Aid to the Homeless

Congress has a relatively short history of dealing directly with the problem of homelessness. Initially, because homelessness was thought to be a temporary crisis,

legislative efforts were of a short-term or emergency nature.[37] In 1983, Congress appropriated $100 million for the Emergency Food and Shelter Program, to be funded through the Federal Emergency Management Agency (FEMA). This arrangement allowed locally created boards consisting of representatives of charitable organizations and community leaders to distribute funds to local groups that provided emergency services. The legislation also appropriated $125 million for the Temporary Emergency Food Assistance Program (TEFAP), which provided for the distribution of surplus food commodities to the needy through the Agriculture Department. Additional legislation during the 98th Congress made it easier for homeless persons to qualify for Social Security, food stamps, AFDC, and Medicaid benefits by increasing outreach and removing rules requiring a permanent address.

Homelessness was elevated to high priority on the legislative agenda during the 100th Congress, when leaders took an active role in pushing the issue to the forefront. After passing a supplemental appropriations act providing $50 million in emergency relief funds for the homeless (P.L. 100-6), Congress began work on a comprehensive aid package.

The Stewart B. McKinney Homeless Assistance Act (P.L. 100-77) was signed into law in July 1987. Companion legislation (P.L. 100-71) provided $355 million in fiscal year 1987 appropriations; $358 million was appropriated for fiscal year 1988. The legislation contained a number of housing provisions, including authorizing funding for emergency shelter and supportive housing demonstration projects (such as projects serving homeless families with children), and authorizing unused government buildings to be converted into shelter for the homeless. Several programs under the Agriculture Department also were authorized, including outreach programs to inform homeless persons about food stamps, expedited service for homeless persons applying for food stamps, and extended funding for the TEFAP program.

In an effort to address the special needs of homeless children, the McKinney Act provided for grants for each state to establish an Office of Coordinator for Education of Homeless Children and Youth, in order to ensure access to public education for homeless children. All states, plus the District of Columbia and Puerto Rico, received Fiscal Year 1987 funds under the program.[30] Offices of Coordinators for Education are charged with gathering data on the extent of children's and youth's homelessness in each state, determining the problems of homeless children and youths in gaining access to public schools, identifying special educational needs of homeless children and youths, and developing state plans for providing educational services to all homeless children and youths in the state. The McKinney Act also provided grants for programs that address "successfully" the needs of homeless elementary and secondary students.

During the second session of the 100th Congress, the McKinney Act was reauthorized and expanded (P.L. 100-628). New provisions included requiring the Department of Health and Human Services to recommend policy changes to eliminate the need for welfare hotels and funding of demonstration projects designed to reduce the number of homeless families in welfare hotels. A total of $285 million was appropriated for FEMA and HUD programs (P.L. 100-404); $78 million was provided through the Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriations Act (P.L. 100-436).

With the addition of new McKinney funds, in December 1988, the National Institute of Mental Health (NIMH) issued a program announcement for research and research demonstrations on homeless severely mentally ill adults and on homeless families with children who are at risk of severe emotional disturbance.[38] Projects have now been funded on social and mental health characteristics of women and

children experiencing varying levels of residential stability, from housed to homeless; emotional development and cognition in homeless children; and the dynamics of homelessness and mental illness in families. In January 1991, NIMH, in conjunction with the National Institute on Alcohol Abuse and Alcoholism, convened leading researchers in the area of homelessness and family and mental health for a conference to establish an agenda for research with homeless families and children.

The McKinney Act was reauthorized again during the 101st Congress (P.L. 101-645). At that time, authorization levels were modestly increased and some services were expanded.[39] In particular, provisions were included to provide comprehensive services to families who have previously been homeless or who are at risk of becoming homeless. These centers would also provide preventive services to children of families who are homeless or are at risk of becoming homeless. No funds, however, were appropriated for these new programs in Fiscal Year 1991.

CONCLUSIONS

Homelessness has profound long-term consequences for children. Homeless children experience an array of problems that cut across traditional service boundaries (e.g., education, mental health, physical health, day care, social welfare). The disruptions to their education caused by homelessness may be irreversible, and the developmental delays associated with homelessness and social instability may never be overcome. Many of these children will weather the experience of homelessness and will overcome the associated setbacks, but for others the damage will be permanent.

Homeless children have immediate needs for accessible, developmentally appropriate mental health, physical health, and educational services, but the potential benefit of these important services diminishes when they are provided to children who do not have stable homes. For this group of homeless children—children who are homeless with their families—preventing homelessness means preventing the homelessness of families. Without question, the decreasing availability of safe, affordable, accessible low-income housing in this country is the most significant factor contributing to the increase in the number of homeless families; this lack of housing must be addressed.

The needs of the homeless in general, and of homeless children and families in particular, have been recognized by the Congress during the last several years, although appropriations for the McKinney Act have been far below authorized levels.[40] To date, however, legislative approaches to the homelessness crisis have been fragmented; they have focused on immediate temporary needs rather than on long-term preventive solutions, such as relieving the national shortage of low-income housing. It is virtually certain that legislation will not alleviate this problem substantially unless it includes a long-term comprehensive plan that involves a national commitment from both the private and the public sectors.

The country suffers greatly from this crisis, which may be laying the foundation for a new generation of homeless adults. President Bush has pledged to fund the McKinney Act fully (although administration budget proposals to date have not requested full funding for all McKinney programs[39]) and to address the needs of the homeless assertively. Jack Kemp, Secretary of Housing and Urban Development, who voted against the McKinney Act when he was a congressman, also has given assurances that he will fight for additional funding for the McKinney Act and will treat homelessness as "the highest priority."[41,42] Solving the problem of home-

lessness demands a comprehensive, multifaceted response. It remains to be seen whether these new commitments will result in the kind of social action that is needed to relieve the crisis and to prevent new generations of children from becoming homeless.

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23

Homeless and Runaway Youths
A Review of the Literature

JULIA M. ROBERTSON

INTRODUCTION

The prevalence of homelessness in the United States has increased dramatically in recent years. Policymakers and the lay public are gradually realizing that homeless persons are no longer primarily single, older, male skid row alcoholics or mentally ill people who "want to live on the streets and refuse our help."[1–2] Homelessness is determined in multiple ways and involves different age groups, including young adults, adolescents, and children.

Empirical literature on homeless adolescents is limited. Systematic studies on homeless adolescents are few compared to those for adults, and most adult studies do not mention the existence of homeless adolescents. The earlier literature on runaway adolescents did not describe accurately the current population of young people who have left home[3–4]; recent studies are limited in that they are based on interviews with adolescents in institutions or shelters[5–6] or with providers of legal, housing, and social services.[3,6]

The problems of homeless and runaway youths are complicated and in some ways are distinctive from those of homeless adults. Adolescence is a developmental stage in which a major task is to separate from the family and to establish independent existence. Many of the young people who are homeless have not completed this process successfully. Legally they are minors, for whom responsibility rests with the state. Yet many of them are living on the streets with no external source of emotional or financial support.

Society has been ambivalent about adolescents who run away, and contempo-

JULIA M. ROBERTSON • Seven Counties Services, Inc., 137 West Muhammad Ali Boulevard, Louisville, Kentucky 40202, and Department of Psychiatry and Behavioral Sciences, University of Louisville School of Medicine, Louisville, Kentucky 40202.

rary runaways have been considered juvenile delinquents. Although the laws have become less punitive since the passage of the Runaway and Homeless Youth Act of 1974, only a few publications have acknowledged that some of these children are not runaways at all. They are "throwaways" or "castaways"; that is, children who have been rejected, forced out, or abandoned by their parents.[7–8] Furthermore, researchers are also discovering that although many of these adolescents leave home "voluntarily," sometimes they do so to escape life-endangering situations involving physical and sexual abuse or parents engaged in illegal activities.[5] The popular media[9–10] have led the way in acknowledging the darker side of "running away."

National statistics on runaway and homeless youths vary from 250,000 to more than 1 million annually[3–5]; most return home within a few days. These young people use a number of coping strategies to survive on the streets, including hiding in abandoned cars or buildings, drug dealing, panhandling, scavenging from garbage cans, and exchanging sexual favors for money, food, or shelter.[6,11]

This chapter reviews the current and historic literature on homeless and runaway adolescents. Mental and physical health problems, legal status, and the availability and use of services are discussed.

DEFINITIONS OF RUNAWAY AND HOMELESS YOUTH

The designation of an adolescent as runaway or homeless is the subject of controversy. For example, in 1983 the U.S. Department of Health and Human Services[3] defined *runaways, homeless,* and *street kids* as follows:

> *Runaways* (are) youth away from home at least overnight without parent or caretaker permission; *homeless* (are) those with no parental, foster or institutional home, including pushouts (urged to leave) and throwaways (left home with parental knowledge or approval without an alternative place to stay); *street kids* (are) youth who believe they belong on the street and have become accustomed to fending for themselves.

The second edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-II)[18] defined the runaway reaction as follows:

> Individuals with this disorder characteristically escape from threatening situations by running away from home for a day or more without permission. Typically they are immature and timid and feel rejected at home, inadequate, and friendless. They often steal furtively.

In contrast, there is no specific reference to runaway or homeless youths in DSM-III.[19] It is not clear whether the omission of this diagnosis reflects an intention to cease pathologizing these youths or a loss of interest in the problem. Researchers report, however, that these types of classifications do not necessarily fit the psychological reality of the youths they studied.[5,8,20]

For the sake of discussion, the term *homeless* is used as a generic term to refer to minors who are outside a family or an institutional home and who are unaccompanied by a parent or a legal guardian.

THE LITERATURE ON RUNAWAYS

Methodological Limitations of the Research

Homeless youths are not an easy population to study. These young people may be wary of adults wielding pens, papers, and tape recorders. They may be afraid of losing their anonymity and being remanded to the authorities or returned to their

families. Some shelter staff members restrict researchers' access to their clients to protect them; major efforts are required to design and implement studies that interview the adolescents "on the streets."

Serious efforts have been undertaken to describe adolescents who leave home, but the research has major methodological limitations.[3,5–6] Most of the available literature comes from four principal sources: direct interviews with the adolescents; retrospective chart reviews; surveys of shelter, legal, and social service providers; or clinical reports of these youths in child psychiatry clinics, youth shelters, and the judicial system. Sample sizes are usually small, and subjects are recruited from single, nonrepresentative sites such as a juvenile detention facility or a single runaway house. Studies have not included control groups in their designs.[28] Interviews may not be standardized; reliability or validity of survey instruments usually are not assessed. Typologies are created before interviewing the adolescents on the basis of the researchers' intuitive classification system; rarely do researchers replicate findings to test their validity.[21–27]

Most studies published during or before the 1970s may be outdated because the homeless youth population and its options appear to be changing. Service providers report that their clients seem to be younger, more abused and more emotionally disturbed, and more from dysfunctional families than in prior generations.[3] Furthermore, a group in New York City found that during the late 1960s and early 1970s most runaways could be reunited with their families. By 1977, however, 58% of the parents of youths placed in the New York State Division for Youth Facilities were reported to be "unwilling or unable to care for their children"; 64% of the youths needed out-of-home placement because "there was no real home or because the household was 'too dangerous' to the youth's physical or emotional well being" (p. 6).[4]

Causes of Homelessness

Earlier literature on runaways, published in the late 1930s and early 1940s, was sympathetic to children, assigning responsibility for their behavior to grossly inadequate environments.[29–30] In 1963, however, Leventhal described a transition that occurred in the 1950s and 1960s, whereby accountability was transferred from the family to the child:

> In older personality and psychopathology conceptualizations, there was a tendency to explain behavior in terms of actual external conditions. Thus, in perhaps the only systematic study of runaways done during the 1930s, one of the major explanations was that of "unwholesome homes". . . . A trend in more recent theorizing has been to focus on drives and needs, and to de-emphasize reactions to external events, or else to recast responses to the environment in the form of projections from internalized processes (pp. 127–128).[25]

Many of the reports published in the 1950s and 1960s assumed that runaways were psychologically deviant, with little supporting evidence other than the runaway behavior itself. "Inner Control Deficiencies in Runaway Children"[26] is such a report, in which clinical psychiatric interviews, not administered for research, were rated by psychologists in regard to "control" and "uncontrol." Evidence of "uncontrol" included indexes such as "boy crazy" or "overeating." Examples of "control" included "rarely gets angry" or "not interested in the opposite sex." The runaway group was compared to a nonrunaway group in the general child guidance population, and the following conclusions were drawn:

> On a gradient of generalized control to uncontrol they [the runaways] place close to the uncontrol end and, as has been theorized, would also be highly sensitized to control as

> an issue, be reactive, and anticipate "complete" losses of control. The danger for them is of ego loss and it has been speculated that when such a threat becomes imminent, reactions of a gross, intense, and desperate nature may appear—e.g., running away (p. 175).[26]

To extrapolate from being "boy crazy" to fears of complete loss of control appears unwarranted. Some might even speculate that the adolescents demonstrating "control" by their lack of interest in the opposite sex manifested as much psychopathology, if not more, than those demonstrating "uncontrol."

Some authors equated running away directly with juvenile delinquency.[31–32] Jenkins and Boyer include running away as one of the target behaviors in their article titled "Types of Delinquent Behaviors and Background Factors."[33]

Multiple Causes

The literature of the early to mid-1970s began to describe multiple causes for runaway behavior: Some causal factors resided within the child, some within the family, and some involved both. Jones[34] described five types of runaways. First the "lonely schizoid runaways," described earlier by Stierlin,[21] were likely to be psychiatrically impaired. A second group, the "alternative values" runaways,[28] were products of the 1960s who had rejected the materialistic establishment and sought an alternative lifestyle. The "adventurous, well-adjusted youth"[23–34] were out for adventure; like the second type, they had no serious psychological problems. The "casual behavior-disordered" runaway, on the other hand, lacked a sufficiently nurturing parental relationship, developed shallow, exploitative relationships with others,[21] and demonstrated serious psychopathology. This fourth category demonstrates most clearly the evolution in literature toward explaining runaway behavior on the basis of the child's problems within the family. A final category is the "negatively peer-influenced" youth,[23–34] who was under the influence of his or her peers and wanted very much to please them. This adolescent often had run away to fit in rather than to escape an unpleasant environment.

Gullotta[8] was one of the first researchers to document the inappropriateness of the term *runaway.* In 1978 he reviewed a random sample of 308 charts for residents of a housing project for runaways in Washington, DC. He examined each record for the nature of the referral, the action precipitating the referral, and the source of the referral. Only 30% of the subjects met National Center for Health Statistics criteria for running away. Another 25% of the children were castaways (i.e., youths who were placed out of the home by their parents and then were reported as runaways). The remainder (46%) were termed "agency-assist" youths (i.e., adolescents who were housed in the runaway center to assist another agency that was having difficulty in placing them). Gullotta noted further that public and private social service agencies had failed to place some youngsters successfully after as many as 35 attempts. He also commented on the lack of adequate aftercare facilities for young patients leaving mental hospitals.

Other projects also have documented the inadequacy of the term *runaway.* In a survey of service providers for homeless youths in Los Angeles County, Rothman[3] reported that almost half (46%) of the clients seen by the agencies were categorized appropriately as *pushouts* or *throwaways.* Miller *et al.*[6] interviewed 125 "seen" (involved with social service agencies) and 91 "unseen" (no agency involvement, recruited off the street) runaway and homeless youths in Los Angeles and San Francisco. They devised two general categories for explaining the runaway episode based

on the degree of control over the separation reported by the youth. The "parent locus" group included youths who were fleeing for their lives from serious physical abuse (20%), who had been abandoned, neglected, or driven out of the home (9%), or who were engaged in intense parent–child conflicts severe enough to precipitate running away (15%). The "child locus" group included youths who were escaping some form of punishment or humiliation that was not of the magnitude of serious neglect or abuse (9%), those who were runaways from foster homes or institutions (20%), and those who had chosen freedom and who viewed their running away as the assumption of autonomy (27%).

Although these categories show some similarities to previous descriptions of the runaway population, half of these youths had difficulties that previously were unacknowledged in the literature. They had been seriously abused physically, had been actively rejected, or were "agency youths" who depended on public institutions for food and shelter. For these adolescents there was no safe home to which they could return.

Family Dynamics

Numerous articles have related the phenomenon of running away directly to family problems. Several reports have taken a psychodynamic approach to explain family influences on runaway behavior. Stierlin[21] examined the relationship between the adolescent's developmental need to achieve psychological separation from the family and the parent's simultaneous need to master his or her own midlife crisis. He divided the parental methods of negotiating these conflicting motivations into binding, delegating, and expelling modes. Stierlin concluded that runaway behavior has different meanings to the parent and to the child in each of these interactional styles.

Robey *et al.*[27] related runaway behavior in girls to their fear of acting out an incestuous (Oedipal) wish toward the father, which the mother is covertly encouraging. An underlying problem, according to this conceptualization, is the inadequacy of the relationship between mother and daughter, in which the mother does not show sufficient warmth and affection toward her child.

Johnson and Peck,[37] who studied the relationship between family composition and running away, found that many runaways came from larger than average families or from families where there was either a very young sibling, or where all siblings were of the opposite sex.

Service providers in Los Angeles County also estimated that half of their clients had experienced abuse, including physical, sexual, and verbal abuse, neglect, and parental alcoholism.[3] Twelve percent of the girls reported sexual abuse by their father or stepfather.

Schaffer and Caton studied residents of New York City youth shelters.[5,20] They reported a variety of reasons for the youths' homelessness, including violence in the home and interpersonal problems. In addition, more than one-third left their last living arrangement because it was temporary. Regarding the option of returning home, about half of the sample said that they could not go home; many felt that they had no permanent home; several stated that their home was a youth shelter.[20] A majority also stated that they did not want to live at home.

When asked to define themselves as a runaway or as homeless, 44% of the youths labeled themselves *runaways*, 34% called themselves *homeless*, and 22% felt that they fit both classifications.[20] In general, the older subjects were more likely to categorize themselves as homeless. Shaffer and Caton noted that half of the young

people they evaluated had lived previously in a setting provided by the Child Welfare System, which was either a foster home, a group home, or another child care placement. This sample represented a picture of considerable residential instability and also disclosed serious behavioral problems.

In a study of runaway and homeless youths in California, Miller *et al.*[6] found that two-thirds of the youths had come from homes broken by separation, divorce, or death before they reached the age of 12, three-quarters had lost one or both parents at least 5 years before running away, and five-sixths reported an average of four residential changes before they were 12 years old.

School Problems

Schaffer and Caton found that 71% of the boys and 44% of the girls in their shelter samples had been expelled from school at some time. In addition, 55% of the boys and 47% of the girls had repeated a grade. Their mean score on the Reading Accuracy Test of the Wide Range Achievement Test was 89.76, compared to a mean of 100 for the general population.

Miller *et al.*[6] also found that in comparison to a high school population including some former runaways, many more current runaways reported school expulsions, rated themselves as troublesome at school, and rated their reading ability below average. Adams and Munro[28] contend that most of the literature supports the hypothesis that school problems precede and sometimes precipitate runaway behavior.

In a survey of Los Angeles County service providers,[3] suicidal or self-destructive behavior was found to be the most commonly identified mental health problem, followed by alcohol and other drug use problems.

Mental Health Status

Adolescent Development

Mental health status of homeless adolescents should be considered in the context of normal adolescent development. Such development involves physiologic, cognitive, and emotional changes. Physical maturation begins with enlargement of the testicles in boys and development of breast buds in girls. Complex endocrinologic and anatomic alterations ensue. In addition, Piaget[12] has demonstrated that abstract thinking (formal operations), the highest level of cognition, begins during adolescence. Both these physiologic changes and the newly established cognitive processes lead youths to reevaluate their body image and self-concept.

For years, psychoanalytic writers espoused the position that adolescence had to be emotionally turbulent in order to accomplish its developmental goals.[13–14] Although recent literature [15] challenges this assumption, adolescents do experience a deepening of their emotions, higher levels of anxiety and depression, and more marked mood swings.[16]

Erik Erikson[17] wrote that the psychosocial task of adolescence is establishment of a stable identity. This process is tied inextricably to separating from one's parents and ultimately establishing mature, intimate extrafamilial relationships.

Peer relationships become a powerful influence during these years; adolescents turn to their friends for an alternative set of values while sorting out their own. It is common to experiment with different haircuts, clothing, and music, to initiate sexual activity, and to experiment with alcohol and other drugs. Yet the margin between

healthy exploration and life-threatening behavior may be slim, especially in view of the availability of highly addictive drugs such as crack, the AIDS epidemic, and violent gangs.

Many authors identify problems with self-esteem as a difficulty of runaway youths. In a review of the literature, Jenkins and Stahle[35] concluded that runaways were described most commonly as insecure, unhappy (depressed), and impulsive, traits that the authors attributed to a poor self-image, feelings of inadequacy, and a lack of self-confidence. Similarly, Levinson and Mezei[24] reported that runaway adolescent males in an emergency shelter in New York City lacked self-acceptance.

Wolk and Brandon[36] administered the Cornell Parent Behavior Checklist to 47 adolescents staying at a runaway shelter. Runaways had a significantly poorer self-concept than nonhomeless age peers, as reflected in greater defensiveness, poorer personal adjustment, and greater readiness for counseling.

Schaffer and Caton[5,20] identified psychological difficulties among the shelter clients. On the Achenbach Child Behavior Checklist, 82% of the sample scored at a level of disturbance that was likely to indicate significant psychiatric disability and was similar to a child psychiatry clinic population. Girls were more likely to demonstrate depressive and suicidal symptoms, whereas boys were more likely to engage in antisocial behavior. Of particular concern was the high rate of previous suicide attempts (33% for girls and 15% for boys). One-third of the boys and one-half of the girls wanted help for symptoms of anxiety or depression. In addition, a high rate of substance abuse was reported; 70% of the youths admitted drug use, most commonly marijuana, hashish, and cocaine. In addition, 37% of the boys and 19% of the girls had been charged previously with an offense, most commonly assault or robbery. (Robins and O'Neal,[31] in a study conducted in the late 1950s, also found a high rate of juvenile court and juvenile correctional institution experience among runaways.) Schaffer and Caton believed that this high rate could not be explained on the basis of arrests for runaway behavior because when these youths were compared with other children seen at a child guidance clinic, their arrest rates were higher for other juvenile offenses as well. It is impossible, however, to know what proportion of antisocial behavior in homeless youths is related to basic survival needs, as in stealing food to avoid hunger.

Physical Health Status

Much less information is available regarding the physical health of these youths. Rothman[3] characterized these adolescents' health as generally poor; it included sexually transmitted diseases, malnourishment, infections, gynecological disorders, poor hygiene, lice, scabies, hepatitis, AIDS, ARC, and broken bones. Pregnancy was also a frequent finding.

Schaffer and Caton[5] noted that although about three-quarters of their New York City shelter sample had had sexual intercourse, few used contraceptives. One-third of the girls had been pregnant, although only half of this group had given birth. One-quarter of the girls reported having been raped.

SERVICES

Many authors[3–5,20,28,34,42,44] have commented on the inadequacy of existing services for this population and have suggested methods for providing better care.

Miller and colleagues[6] noted that 55% of runaways surveyed found no agency to be helpful. The authors speculated that the youths are afraid that if they ask for help, the agency response will be to remand them to the authorities. In the same study, social agencies surveyed also reported that they were able to assist very few of the runaway population. Most staff members felt that lack of funds and insufficient numbers of well-trained staff persons were the main barriers to service provision. Others[42] suggested that the current system of care for runaway adolescents is focused on reuniting children with their families and therefore does not provide long-term care for those who cannot return home.

In an article discussing model programs for the chronically mentally ill, Bachrach[43] listed eight qualities which ensure that a facility meets the needs of the individuals it serves. Although Bachrach did not intend to equate homeless adolescents with mentally ill adults, her principles are applicable to these youths. The criteria, modified for this adolescent population, are as follows:

- Give top priority to the care of those most in need.
- Establish realistic links with other resources in the community.
- Attempt, in concert with a resource network, to provide the full range of necessary services.
- Tailor the program to the needs of each individual.
- Conform to the cultural and ethnic realities of the community.
- Provide trained staff members with knowledge of the unique problems of the population.
- Create liaisons with facilities that can provide treatment for emotional and physical problems.
- Engage in ongoing research to evaluate the efficiency of the interventions being used.

The service interventions necessary to provide quality care for this population are numerous. They include the following:

- Arrange for sufficient shelter beds and allow greater flexibility regarding length of stay.
- Create a continuum of living accommodations for youths having no viable homes to which to return. These accommodations would include shelter beds, long-term residential housing, and, for those who are close to full independence, transitional living services that will prepare them to take care of themselves.
- Use trained staff members and case managers capable of assessing the needs of each youth and rendering sophisticated decisions about issues such as the implementation of family therapy with possible reunification, referral for psychiatric evaluation, and linkage with other specialized service providers for those with special needs (such as non-English-speaking, physically handicapped, or teenage mothers).
- Provide a range of family, group, and individual treatment modalities including crisis intervention, short-term family and individual therapy, parenthood training, and treatment for substance abuse disorders.
- Facilitate full interagency cooperation in order to offer the broadest range of services and avoid duplication.
- Create outreach services in the shelters to treat the youths' physical and mental health needs and link these services with physicians and hospitals.

- Offer academic tutoring and vocational counseling.
- Make legal and advocacy services accessible.
- Develop ongoing research and assessment of the programs and population.

In addition, the legal status of these adolescents needs to be clarified at national and state levels. An adolescent's ambiguous legal status may contribute to underutilization of health and other social services. For example, many states require parental consent to administer medical care that is not an emergency. Therefore a discussion of forensic issues is in order.

In ancient Rome the father had absolute authority over his children to the extent of leasing, selling, or even killing them.[3,6,40] In colonial America, a similar law was passed in 1646 in the Massachusetts Bay Colony; this law granted the father the right to put to death any male child over the age of 16 who was stubborn or rebellious.[3,6]

Gradually a movement developed in the United States to treat problematic children with more lenience and to attempt to rehabilitate them. The first reform school was started in Massachusetts in 1847; in 1899, the first juvenile court was established in Chicago.[3] The early juvenile courts were assumed to be functioning in the interests of the child and therefore were granted broad powers to detain youths for long periods regardless of the severity of their transgressions.

This philosophy was challenged in the 1950s and 1960s as it became clear that the courts did not always act in the child's best interest. Boisvert and Wells quote a Supreme Court decision in *Kent v. United States* (1966):

> There may be grounds for concern that the child receives the worst of both worlds; that he gets neither the protection accorded adults nor the solicitous care and regenerative treatment postulated for children (p. 230).[41]

The 1960s were a period of societal unrest, including the civil rights and antiwar movements. In addition, the size of the adolescent population increased because of the maturing of the baby boom generation. During this era many runaway adolescents availed themselves of counterculture crash pads, which provided food, shelter, and medical attention, as well as drugs and sex. Soon thereafter, numerous nontraditional religious sects emerged and performed similar functions. These organizations provided housing, food, and clothing in return for religious devotion, sometimes referred to as brainwashing.[6] At a national policy level, the civil rights movement precipitated a reevaluation of the public and private treatment of children, as evidenced by statements on the basic rights of children issued by the United Nations and the National Commission for the Mental Health of Children.[3]

This series of events was followed by the federal Juvenile Justice and Delinquency Prevention Act of 1974.[3] This bill was designed to decriminalize runaway and homeless adolescents and to divert them from the juvenile justice system into the social service network, where their needs could be met more effectively. It limits the placement of runaway youths in lock-up facilities, disapproves of mixing runaways and truants with juvenile criminals, and encourages the use of community-based resources.[3] As in the case of deinstitutionalization of mentally ill adults, however, funding for the provision of these services has been inadequate. In addition, this act has been enforced inconsistently across different states. As a result, runaway adolescents have no way of knowing whether they will be sent to the authorities or back to their families if they use the scanty resources available.

For this reason, Miller and colleagues called runaway and homeless youths "illegal aliens in their own land." Depending on the state in which they live, many of these children may not be able to claim "emancipated minor" status, even if they

have set up an independent existence for themselves and have no home to which they can return. They may not be able to go to school in the area in which they (not their parents) live, and they may not have access to medical care without parental consent except in an emergency.[42]

These young people must be able to use the available services freely without fear that they will be returned automatically to their families against their will. Moreover, when the situation warrants such a step, these adolescents need to have the basic legal rights necessary to establish an independent existence.

CONCLUSIONS

Although limited, the literature on runaway and homeless youth has evolved from early descriptive articles to more methodologically sound empirical studies. The early literature impugned first the family and later the child in a unidimensional approach to explaining runaway behavior. Recent reports have documented that running away is multidetermined. More significantly, some of these youths are not "runaways" at all but abused or abandoned children, aptly termed *throwaways* or *pushouts*.

Although the laws regarding these youths have become progressively more lenient, provision of services remains seriously deficient. Inconsistent enforcement of the Runaway and Homeless Youth Act of 1974 leaves adolescents wary of identifying themselves to social service agencies. In addition, society has been slow to provide adequate housing and the resources required to treat the significant mental, physical, and developmental needs of these youths.

Further research is needed to expand our knowledge of this troubled population and to help policymakers carry out the nation's obligation to provide sufficient funds, staff, and resources to salvage these youths and to prevent further human disasters.

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24

Stepping Stone
A Haven for Displaced Youths

SARA PETRY AND HIDA AVENT

INTRODUCTION

Homeless youths are those who have no functioning parent, parental substitute, or institutional home. They have no support mechanisms to ensure the basic necessities for survival, including food, clothing, and shelter. These youths are known either as "runaways," in the event that they take the final initiative to leave home, or "throwaways," "forceaways," or "pushouts," when the family and social dynamics conspire actively to thrust them out. Although there are numerous reasons why youths leave home, one of the most clearly defined is the breakdown of family ties, at the core of which is deterioration of communication between the youth and the adults in his or her life. In some instances, a specific loss through relocation or death of a responsible other plays a leading role. Sometimes school failure is a serious precipitant.

These dislocated youths need food, clothing, shelter, and referral to medical care, to legal counsel, and to social agencies for a place to begin sorting out their futures. They need a place of safety, security, and protection, and a chance to solve problems under guidance; such havens are relatively rare.

National estimates of the number of homeless youths are as high as 1.5 million. In Los Angeles County the number of youths away from home and living on the streets is estimated to range from 2,000 to 20,000. These youths tend to be a hidden subculture, not readily accounted for by conventional statistics of unemployment or welfare recipiency because they often hide from police and social agencies. They often fear that contact with social services may result in their detention or in the

SARA PETRY • Olympic Mental Health, 4526 Federal Avenue, Everett, Washington 98203. HIDA AVENT • Stepping Stone, 1833 18th Street, Santa Monica, California 90404.

return to their original homes, where they suffered physical, mental, or sexual abuse.

Survival options that may be open to homeless adults are often closed to adolescents because of age factors and negative attitudes of society. Frequently, obstacles are placed in the path of youths' independence by the very institutions chartered to oversee their well-being. Bureaucratic impediments such as work permits, identification requirements, birth certificates, and parental consent often exclude youths from needed services. Because few alternatives are available, the homeless youths must develop survival strategies that may either lead them to be exploited and victimized or force them to become criminals and victimizers themselves.

STEPPING STONE

In all of Los Angeles County, there are only about 100 beds for rehabilitation of a growing army of lost youths. The work being done by these agencies is inspiring, particularly because they struggle constantly with inadequate resources. We have much to learn from these pioneering facilities as they grapple daily with the challenge of rehabilitating homeless youths. One of these facilities is Stepping Stone, a true pioneer in the field.

Stepping Stone is a licensed crisis shelter for youths aged 7 to 17, who may stay up to 14 days. The program services include crisis intervention; individual, group, and family counseling; social services; medical, legal, and educational advocacy; information and referral; and follow-up. Stepping Stone also provides extensive community education through its peer staff program.

Over the past 7½ years, Stepping Stone has provided shelter services to more than 1,250 youths from diverse ethnic, economic, and demographic backgrounds. Historically, the majority of residents have been Caucasian (64%), with significant numbers of black (21%) and Hispanic (12%) youths. Although most came from Los Angeles County (63%) or from other parts of California (9%), a significant number came from out of state (27%) or out of the country (1%). Most Stepping Stone residents are between 15 and 17 years old (74%).

Although income data are not collected by the program, residents appear to come from all economic strata. Many come with only the clothes they are wearing, but others have arrived in chauffeured cars.

Approximately 44% of residents report family violence as the main problem bringing them to the program; 43% indicate abuse as the problem before they enter Stepping Stone; an additional 20% disclose abuse after entering the program. More than 50% have dropped out of school, have been expelled, or have been suspended. Approximately 90% of the residents can be described as bright; many have been assessed as intellectually gifted.

Homeless youths are referred to Stepping Stone by other private agencies (27%); by family, friends, or self (20%); by the County Department of Children's Services (15%); by other youth crisis shelters (15%); by police, probation, and courts (11%); by hot lines (11%); or by schools (7%). (Percentages total more than 100% because of rounding.)

The principle of empowerment forms the philosophic basis for the Stepping Stone program. Homeless adolescents often feel helpless to alter the course of their lives. They come to believe that they have neither the right nor the ability to exert control over their environment. As they become overwhelmed by the seemingly

impossible task of surviving without parental support, many of them begin to relinquish responsibility for what happens to them. The Stepping Stone program attempts to reverse this trend. Every effort is made to encourage an adolescent to take control of his or her own destiny and to assume responsibility for his or her behavior.

Many residents say that their foremost desire is to find a job and an apartment. They are given all possible relevant information and then are encouraged to pursue such objectives on their own. They search want ads, apply for jobs, participate in interviews, and attempt to locate affordable housing. The goals of the program are to tap the youths' considerable survival skills and personal resources, which they have used in surviving on their own under adverse circumstances, and to offer guidance, nurturance, and counsel through experienced staff members or peer workers. The rewards of enhanced self-esteem and emotional satisfaction are expected to lead to more satisfying and more productive adaptations.

Stepping Stone Methods and Procedures

At Stepping Stone, crisis phone calls are taken by adult and peer staff members. Staff members respond to callers' needs regardless of age, location, or type of request. They draw out the callers as to specific needs and expectations, willingness to take some initiative, and sense of responsibility. Insight and capacity for self-criticism are welcome. A caller may say, "It wasn't all my mother's fault; I did break curfew, I was the one who cut school"; or "I would like to go back and see if things can work out"; or "Both my dad and I get angry and start to yell and scream"; or "I'd like to talk with my folks and see what we can all do to make things better."

Prospective residents are informed about the mandatory requirement for parental consent. House rules exclude drug use, violence, threats of violence, and illegal activities on or off the premises during their stay. A 6:00 P.M. curfew every night is enforced. The caller must agree to abide by these rules while at Stepping Stone.

By the end of the phone call, the following alternatives have been considered: the caller is asked to come in for a face-to-face assessment, he or she is turned away and referred to services elsewhere, or an appointment is set up for counseling by Stepping Stone staff. Regardless of the outcome, at the minimum the caller has encountered one person who has listened, has not been judgmental, and has shown a willingness to respond appropriately to his or her needs.

When the prospective resident arrives at Stepping Stone, an initial assessment is made. The resident then is introduced to other residents, is shown his or her room and bed, and is given clean linen. He or she has time to settle in, cool off, eat, and rest.

Within the first 48 hours, an in-depth interview is conducted, covering family background, social history, relationship history, medical and sexual histories, runaway history, and suicide history. Staff members are aware that residents may be untruthful during this initial interview because they distrust adults. At this time, however, goals for the youth's stay are laid out. A more permanent contract is set up to spell out responsibilities of both resident and counselor, depending on whether the youth will attempt to return home or to establish an independent living situation.

Stepping Stone residents use their 14-day stay to work on their contract while participating in counseling and in the life of the house. For example, M. A., age 13, was away from home for the first time and was at Stepping Stone to work on family reunification. M. A. was assigned to dinner preparation on her third day in the program. Previously she had never cooked anything other than toaster pop-ups. She

was unable or unwilling to ask for help and proceeded to cook a hamburger. The house filled with smoke, the smoke alarms went off, and dinner for the group was delayed an hour. Finally, dinner preparation was completed by M. A. with the help of two other residents, who requested a group meeting that evening. The group focused on how difficult it was having "young kids" in the house; the meeting ended with the intense discussion of how hard it was to trust people enough to let them know when you didn't know how to do something. The group suggested ways to ask for help and considered how not to feel "dumb and stupid" in doing so.

The youth coming into the program is in a "one-down" position; that is, staff persons are the experts and are ultimately in control of policy and procedures. Therefore a conscious attempt is made to equalize the power differential between clients and staff. Counseling is available from either adult or peer staff. Counseling occurs both during formal appointments and informal encounters, such as in the kitchen while cooking or when walking together on the beach.

One of the radical departures for equalizing power is to allow the youths access to their own files. Residents may read their files at any point during their stay; on several occasions they have corrected initial untruthful statements that appeared in their records. The whole process of record keeping is demystified, and the residents are able in part to control the information in their files.

Before the resident's departure, future plans are outlined. Possible outcomes include returning home, living with relatives or friends, entering a group home or another shelter, being admitted to a hospital for drug or alcohol treatment, or returning to the streets. Follow-up services include negotiation of a return-home contract, arrangements for family or individual counseling, and making contact with local, state, or out-of-state agencies to provide ongoing assistance. Follow-up is conducted at 2, 6 and 12 months after a youth has left the program. This process reinforces the message that the door remains open and that support is available.

Since follow-up services were instituted 7 years ago, contact has been made with approximately 94.5% of the youths who were reunited with family or guardians. Follow-up at 2 and 6 months shows that 57% and 54%, respectively, of those reunited youths remained at home with both parents or with guardians; the youths reported improved relationships. At 12 months, however, fewer than 43% of those reunited youths could be reached. Of the families contacted, approximately 50% continued to report improved communication.

ODYSSEY OF A HOMELESS YOUTH

The following is a first-person account of one homeless adolescent's experience. He became a resident at Stepping Stone in 1984, at age 15.

S. W. was asked to give a chronological account of his living situation from birth.

> I lived in New York until I was about 5 months of age, then went to Panama, where I resided for about 3½ to 4 years. . . . Then we moved back to Brooklyn. . .where I lived until I was 9 years of age. Then we moved out to California, where we lived in Palo Alto, Sunnyvale, Mountain View, San Diego, Los Angeles, Sacramento, and Compton.
>
> When my mother and I started having conflicts, I left home and went to New York City, residing with my grandparents in Manhattan for about 6 months. Then I returned to California and lived once again in Compton with my mother for about a month or two. Then back to New York City to live with my aunt for about 4 months off and on, and then I went to live with my uncle off and on as well. In 1983 I came back to California, while my mother was living in San Francisco. I lived with her for about 4 months, then came to Los Angeles, where I have been ever since.

S. W. then was asked about his earliest memory of living at home. He responded immediately by referring to abuse and to leaving home:

> What comes to mind is running from home, where I experienced a lot of abuse. Without asking any questions at all, my mother would beat me, either with her hands, her fists, a belt, belt buckle, stick, frying pan, or spatula. . . She once came to school with a tree branch, took down my clothes in front of my whole class, and beat me.
>
> My mother likes to play "mind games" with people. She'll tell you that it is okay for you to do one thing, and then she'd turn around and say she never gave you permission to do that and make you feel that either you're losing your mind or she's losing it, or both. She basically put a lot of heavy guilt trips and burdens on me in terms of what a son is supposed to be as opposed to what I am.
>
> My mother grew up in a home in which, if she did something wrong, she would get beaten by one of her parents. . . . A story that I was always told is that my mother had a cousin who she never got along with. [This] cousin stole nail polish one day and said that my mother did it. My mother got stripped and tied to her bed and beaten by her father and grandfather. So when I was growing up my mother thought that that was the way a child should be raised.
>
> The physical abuse stopped when I was about 9. One day I was at the baby-sitter's and the baby-sitter said I did something which was not true, but my mother believed her. I got to the point where I said I cannot deal with it anymore. My mother was not even asking me if anything was true or not, so I just ran away. I went to a friend's house, told him I was going to spend the night. The following morning [my friend's] mother realized that something was wrong. She called my mother, and my mother and uncle came and that was it. . . . I had called the police as soon as my friend's mother had called my mother. And by the time my mother got there, I told her right in front of the police that I did not want to be hit anymore. After that time of running away, she hardly ever hit me again.
>
> When I visited my uncle, he would ask me if I would watch him masturbate. . . . I was around 7. At that time it became a regular thing. He wanted me to watch him masturbate and start actually holding his penis and doing it for him. . . . With my stepbrother . . . he wanted blow jobs. He also wanted anal intercourse. . . . The abuse also happened with my two [male] cousins.
>
> My [stepbrother] and my stepfather always warned me that if I would ever repeat this to any one, he knew my mother, and something nasty would happen to she and I.

S. W. shuttled back and forth between the east and the west coasts, attempting repeatedly to make a home either with his mother or with members of his extended family. Finally he was unable to stay with any of them; often both his mother and his aunt rejected him. He was homeless. He began to live on the streets after an encounter with another homeless teenager.

> I ended up going back to Manhattan to the Port Authority bus station, where I met someone who was a teenager who said he had a place where I could stay. It was basically someone who just took you home for sex.
>
> Materialwise, he had a very nice home; he gave me nice clothes and money, and he made me feel very good in terms of all that I lacked in my life. But he played a lot of mind games with people. He was a real nasty person. He would put steaks on the table, take a knife and slam it down, and say, "This is what I am going to do to your face if you don't do [this or that]." What he meant was he wanted me to deliver drugs to people. I didn't want to do it, but he said, "It's too late now; you have to do it."

When asked what the penalty would have been for not cooperating, S. W. responded, "According to him, get killed. Having my face cut off."

S. W.'s life became increasingly unbearable as he became more involved in illicit sexual activities and dealing in drugs.

> I realized between the drugs and sex, it was not what I wanted. . . . He had three guys come over to his apartment who were interested in having sex with another person. I said, "This is way out of line."

S. W. ran away from this man's apartment. He was now on the streets again, and this time he found alternative housing.

> [I went] back to the Port Authority and then I went to the shelter. I saw a poster about a shelter right behind the Port Authority bus station . . . and I went there and got shelter.

S. W. stayed in this shelter for 2 weeks and then returned to stay with his mother in California. His attempt to remain home with his mother culminated in a suicide attempt.

> I had been having lots of problems with my mother, with what she'd say and think. I'd wonder what it'd be like if I were dead, or how I'd go about doing that. Dead meant never having to deal with my mother, with my having to do all the baby-sitting, the cooking, the cleaning. Also having to deal with her cursing. In May of 1984, I was living in San Francisco at home. I was 15 years old and baby-sitting, getting up, getting breakfast for myself and for my sisters who were 2 and 3 years old, [and] taking care of them. My mother worked the 8 to 4 shift, had a 1½ hour drive. She wanted to just change and go to the club after a stressful day at work. She says I should not question anything because she was the parent: "I provide shelter."
>
> The attempt itself was more of a spontaneous act. I was on the bus, coming home from school. A gay male sat next to me and asked me, "Do you do it?" I looked at him. He was obviously gay. I got off the bus. I was very pissed off, crying, went home, and took some pills. I didn't think consciously of attempting suicide. It was some way to deal with the anger, all building up. That was the precipitating event.
>
> I do not remember thinking of committing suicide. I was walking around the house freaking out for 15 minutes, walking to the medicine cabinet. I took 25 pills out of one container and called the hospital to see what would happen. They said, "Don't let the person go to sleep; they could go into a coma; Get the person to an emergency room immediately." I took half a glass of gin; it burned; I hated it. That was the first and last time I drank gin. I took some punch afterwards. I went to my bedroom, closed the door, and went to sleep. I was crying all the time.
>
> I woke up 2 days later at Kaiser Hospital. My mother came home with a friend, realized that my sisters had not been picked up, found me in my room, got me to the ER. She stayed in the ER, bitching all the time, her ungrateful son of a bitch: "Look what he's putting me through."

After his hospitalization, S. W. was offered foster home placement, but

> I realized that was not what I wanted. . . . I felt I was treated shitty enough by my own family that I wasn't going to take it anymore from another family.
>
> I stayed at the Tom Bradley Terminal, Los Angeles Airport . . . for about 5 days. My thought was to try to do the same thing that I did in New York and get into a shelter, except I did not know if they existed out here. I didn't know how I was going to get in touch with them.

S. W. took up residence in a Los Angeles shelter for 2 weeks and then was referred to Stepping Stone.

S. W. was asked whether he felt that he was actually pushed out of his home or whether he saw himself as a runaway.

> Yes, I do feel pushed out by the fact that my mother did not give me an opportunity to be a kid, to do the things a kid could do, like camping, Boy Scouts, being active in sports, going out on the weekends, talking on the phone. My mother said in sports you could get hurt, camping was dangerous, going out on weekends you'd have to be supervised, using the phone raised the bill and ties up the phone. I was also pushed out by not being . . . in an environment where I could deal with my sexuality without the threat of being thrown out, or of being abused physically. One time she told me to get out of the house and never come back. If I had said I'm not sure I want to date girls, or I want to talk to you about the abuse that I experienced while I was growing up, she would have said, "I'm tired of this fucking shit; get out of here."

Admission to Stepping Stone

S. W. became a resident at Stepping Stone in 1984. Like all residents he participated in drawing up a contract outlining his plans and goals during his stay. This

contract included his agreement to (1) make contact with the Department of Public and Social Services (now known as the Department of Children and Youth Services), (2) find alternative living arrangements, (3) find a job, (4) read about birth control and venereal diseases, (5) do house chores, (6) participate in self-evaluations, and (7) participate in counseling with a focus on the need to please even if it is self-destructive, and on his anger toward his family.

S. W. refused placement in a foster home, which Children's Protective Services in San Francisco would have provided because he was a dependent of the court in that city. He wanted to remain in Los Angeles to pursue a career in acting. Stepping Stone staff then assisted him in finding alternative living arrangements locally. Because this procedure required a great deal of time and energy, S. W. remained at Stepping Stone for 4 weeks. Finally he was able to find living space for a year with the daughter of a person he had engaged to further his acting ambitions.

S. W. continued to work at Stepping Stone, initially as a peer staff member and later as a night coordinator for a new long-term independent living program located next to Stepping Stone. He also worked as relief staff at Stepping Stone and held many "survival jobs" including bus boy, food stand attendant, and stock boy; he also worked at a local shelter as a youth advocate. He has had many other living arrangements, including a guest house and several apartments with roommates. In answer to the question "In what way was the Stepping Stone experience important?" S. W. replied "They helped me to find a place to stay so I didn't have to go back to San Francisco, and I had people who weren't trying to change my mind but who were supporting me."

CONCLUSIONS

Society must ask itself several fundamental questions when dealing with the issue of homeless youths: "What value do adolescents have in our society? What is our responsibility to this population?", and finally, "Are we willing to expend the energy and physical resources necessary for effective interventions?"

Although agencies such as Stepping Stone are making limited steps toward effective intervention, there is greater need to deal with the problem at its roots and to stop the spread of dysfunctional situations that drive youths from their homes. Part of the problem is an almost complete lack of national response and a poorly coordinated, loosely connected response on the local level. Existing socioeconomic and political systems do not provide for those who are disenfranchised. There is little consciousness of the need to assist those who do not fit into conventional categories and social structures. Our tolerance for those who do not adapt to a standardized value system is limited; yet many of the factors that make adaptation impossible are endemic to society itself. Therefore we must create, implement and nurture a national policy on youth that will unite all the public sectors in a coordinated effort. It is imperative that we develop an atmosphere in which youths can grow as individuals without alienation or disenfranchisement.

VIII

Strategies for Change

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Litigation on Behalf of the Homeless

GARY BLASI AND JAMES PREIS

INTRODUCTION

The dirt and the dust are everywhere. No breeze is ever gentle. When there is wind, it brings not relief from the sun but more dust. Set out on the dirt are rows of army cots under incongruous blue and white canopies. It is cold at night, and the people on the cots wake up wet with dew. Others sleep in the limited number of tents, each 4 feet high, for which there is a long waiting list. The wind carries not only dust, but the stench from the plywood latrines. Only the sights in the distance distinguish this camp from refugee camps around the world: Fifty yards away a high steel fence surrounds the area, the closest thing here to four walls; just beyond the fence sit dirty gray industrial buildings and railroad tracks. In constant view, however, are the modern skyscrapers of downtown Los Angeles in the summer of 1987.

According to the Department of Housing and Urban Development, Los Angeles has more homeless people than any other community in America.[1] Between 1983 and 1987, largely in response to litigation against the Los Angeles County government, the number of shelter beds available to the homeless was expanded significantly in both the public and the private sectors.[2] Yet in the winter of 1987, the city government confronted the fact that thousands of people were still sleeping on the streets and that many were dying there.[3] After a spate of unfavorable publicity, the city quickly opened 1,000 shelter beds in the heart of Los Angeles. As the cold weather subsided, however, these beds were eliminated and were replaced by self-help shelters, shantytowns, and "cardboard condos" erected on city sidewalks.

GARY BLASI • Legal Aid Foundation of Los Angeles, 1550 West 8th Street, Los Angeles, California 90017. JAMES PREIS • Mental Health Advocacy Services, Inc., 650 South Spring Street, Los Angeles, California 90014.

Yielding to pressure from the business association in the area, the city moved to demolish these shantytowns. The demolitions were slowed for a time by court actions, but eventually the decision was made to use the police to solve the problems. The homeless would be arrested if they did not move from the streets.[4] Again, following an outburst of publicity and further legal action, the city created the "urban campground," known by its residents as "New Soweto," "Camp Dirt," or just "the camp."[5] Now the police could offer an alternative to the homeless: Go to jail or go to the camp. The camp filled quickly and people were turned away.[6]

Even though the policy failures evident in the camp are balanced in Los Angeles by some truly exemplary shelters and transitional housing projects, the camp serves as a reminder of the limits of advocacy and litigation on behalf of the homeless. Our purpose here is to inform a larger discussion about homelessness in America with some insights from the perspective of lawyers and advocates, gleaned by hard experience in Los Angeles and elsewhere. For whatever its limits, the legal system has occupied a peculiarly central place in public debate and decision making about homelessness. It is no accident that New York City has the dual distinction of being the first site of homelessness litigation and the city with the largest emergency shelter system in the United States. Indeed, one could argue that before the "right to shelter" was litigated in New York,[7] there was little public debate about homelessness at all. In cities across America, the homeless and their advocates have turned to the courts for redress, with varying degrees of success.

THE LAW AND SOCIAL CONTROL OF THE HOMELESS

In order to understand fully the role of the law in dealing with homelessness, one must understand the role of our laws in American society as a whole. First and foremost, the law is a mechanism of social control, a method of controlling behavior regarded as deviant. Thus the experience of many individual shelterless people with the law has come in the form of police action enforcing some local ordinance. For example, laws against "vagrancy" have existed for hundreds of years.[8] Such laws typically make destitution a penal offense.

Not until 1962 did the United States Supreme Court declare that such crimes of status could not be applied constitutionally. The Court held that the states and localities could not criminalize the status of being ill or poor.[9] In place of vague vagrancy statutes came ordinances that criminalized not the status of poverty of homelessness itself but the inevitable manifestations of poverty and homelessness. For example, although it is not a crime in Los Angeles to be homeless, it is a crime to sleep on a sidewalk or in any other public place, to have one's possessions on the street, to sleep in a car, or to sleep at a bus stop.[10]

As a result, a great deal of legal effort has been made merely to prevent the incarceration of people whose primary offense is lack of funds for housing. In Los Angeles, criminal prosecutions for sleeping in a vehicle[11] and for trespass[12] have been defended successfully with the common-law defense of necessity. This defense has roots deep in ancient common law; it codifies the commonsense notion that people sometimes may break the law in order to avoid a greater harm. Thus one who breaks into a building to put out a fire is not guilty of breaking and entering. As applied to homeless persons, the necessity defense means that it is not a crime to sleep in a vehicle or on another person's land if there are no reasonable alternatives.

In recognition of this fact, Los Angeles officials constructed the urban camp described earlier in order to continue police raids on homeless people's encampments because the camp was the legal alternative that deprived the homeless of the necessity defense.

Even where homelessness has not been criminalized, public officials have sought to treat homeless persons as less than full citizens. For example, the homeless often have been denied the right to vote. Here litigation has been successful in restoring the franchise to the homeless poor.[13–15]

THE RIGHT TO SHELTER

Much of the legal activity on behalf of homeless persons has been categorized as "right-to-shelter" litigation. Such litigation has been based on state or local laws, primarily because the United States Supreme Court held in 1974 that there was no federal right to housing and by implication no right even to emergency shelter.[16] Indeed, there is a very long tradition in American law that "rights" consist mainly of the right to be free of government interference. The notion that a person also might have a right to survive is alien to most American law, even though the United States is signatory to several international treaties and accords that recognize such rights.*

In the context of specific statutes, however, the situation may be different. In New York, homeless persons may be said to have "right to shelter" by virtue of the decree in the *Callahan* case.[7] In fact, the order in the *Callahan* case was notable not so much because of the right it created for homeless persons but because of the obligations it imposed on the City of New York. Those obligations consisted of the duty not to turn away any homeless person from the city's long-standing municipal shelters and of the duty to maintain those shelters in accord with certain minimal conditions. In contrast, homeless persons won a "right to shelter" from the West Virginia Supreme Court, which held that the adult protective service laws of that state created such a right.[17] The West Virginia Supreme Court, however, did not impose any specific enforceable obligation on any defendant to create, operate, or maintain any shelter, housing, or other programs.

Thus in a practical sense, the creation or recognition of the "right to shelter" may have little effect on the lives of the very poor and the homeless. One could argue that they already have the right to liberty, property, and the pursuit of happiness, to which the right to shelter would add little beyond abstract value. Therefore the practical question is not whether the homeless have a right to shelter, but rather whether anyone has an enforceable obligation to provide that shelter. In this context, in the often-complex "social safety net" of such legislatively created obligations, much litigation on behalf of the homeless has taken place.

*United Nations Charter 59 Stat, 1031, T.S. Ng 993, 3 Bevans 1153 (1969), entered into force October 24, 1945; Covenant on Economic, Social and Cultural Rights, General Assembly Resolution 200 (XXI), 21 U.N. GAOR, Supp. (No. 16) 49, U.N. Doc. A/6316 (1966) (signed but not ratified by Senate); International Covenant on Civil and Political Rights, General Assembly Resolution 2200 (XXI), 21 U.N. GAOR, Supp. (No. 16) 59 U.N. Doc. A/6316 (1966) (signed but not ratified by Senate); Protocol of Buenos Aires, T.I.A.S. No 6847 (1967): American Declaration of the Rights and Duties of Man, reprinted in Lawrence J. LeBlanc, *The OAS and the Promotion and Protection of Human Rights*, Appendix (The Hague: Martines Nyhoff, 1977).

THE LAW AND THE SOCIAL SAFETY NET

Apart from its function as a mechanism of social control, the law also sometimes embodies common normative values and sets out the social legislation intended to fulfill these values in great detail. Thus the shared value that children should not be subjected to neglect and abuse gave rise to child protective service laws. From the shared value that the elderly and the infirm not otherwise able to care for themselves should not merely be allowed to starve or to freeze to death came the Social Security Act and other welfare laws. General assistance, unemployment insurance, and other programs were created from the less deeply held feeling that even ablebodied unemployed persons should not be forced to starve. Long before the notion of homelessness existed in the national vocabulary, poverty lawyers were active in court, attempting to give full meaning to the statutes enacted for the protection of the poor and the disabled. General poverty litigation has continued, often entirely apart from the legal and political debates concerning homelessness. In recent years, however, much litigation concerning welfare and other programs has come in the form of litigation on behalf of homeless persons.

Although the homeless poor share the inadequacies of the welfare system and other programs with the housed poor, they suffer additionally because of their lack of housing. For example, a legal or practical requirement that one have an address may effectively exclude the homeless from using whatever resources exist.

In another sense, however, the homeless are distinguished from the housed poor by the perceptions of the homeless among the powerful in society, including judges. For example, it is one thing to argue to a judge that a housing program is inadequate because it provides substandard housing that is less satisfactory than one would like. It is entirely different to argue that the housing program is inadequate because it leaves people without any shelter at all. The underlying facts may be the same—the inadequacy of a welfare shelter allowance, for example—but the perception is significantly different. These perceptions of "the homeless" thus are potentially very powerful from an advocate's perspective. Powerful images are provided by the notion that there exists a class of persons required to live lives of desperation that have been thought unacceptable for centuries.

Such images also may be potentially very dangerous. One solution to the homelessness problem is the creation of shelters to house homeless people. Surely the creation of shelter is a worthwhile short-term goal in order to save lives and alleviate suffering. Yet, any policy whose end purpose is the creation of shelters to house the homeless must fail: The shelters will merely become housing for persons whose presence in the shelters is traced to widely disparate problems that have no relation to the shortage of emergency shelters. To be sure, there is a subset of the homeless who are chronically, consistently without shelter, and for whom basic emergency shelter is essential. Yet a far larger proportion of homeless persons consists of those who have fallen out of the housing market for a large variety of reasons. Thus the homelessness problem turns out to be primarily symptomatic of the low-income housing crisis, the transfer of capital and low-skilled jobs overseas, reductions in social support systems, the dismantling of the mental health system, a rapid increase in substance abuse, and other conditions. Homelessness is more than merely a symptom of other problems, however; it creates additional problems that also must be addressed. Primary among those problems is the obvious need for shelter.

Patching Holes in the Social Safety Net: Income Maintenance Programs

Many people find themselves on the street simply because they lack the funds to buy housing in the marketplace. This situation may be aggravated by a drastic imbalance between the supply of low-cost housing units and the number of very poor persons seeking such units. A very direct cause, however, is the lack of income, which, if remedied, will have the most direct and the longest lasting effect on a person's homelessness. For persons with no disabilities, this remedy means a job. In systematic surveys, the homeless themselves report that a job is what they need most.[18–19] In the depths of the most recent recession, many highly skilled persons found themselves homeless because of disruptions in patterns of industrial activity in this country.[20] The industrial heartland, now called "the rust belt," sent hundreds of thousands of people to the south, the southwest, and the west in search of jobs. The press became fond of stories about these, the "new" homeless.[21] Doubtless the new homeless still exist, even in the economic recovery, because the recovery was uneven and in some places nonexistent.

In Los Angeles in 1987, the largest group of individuals in the shelters consisted of young (ages 30–35), primarily minority men with high school educations but few marketable skills.[18] The jobs that once existed for such people, principally in the manufacturing sector, have been reduced sharply in recent years.[20] Only about one-third of the unemployed are covered by unemployment insurance,[22] which even in the best of situations provides only temporary assistance. For these ablebodied but unemployed workers, the social safety net is particularly lacking. In many states there is no assistance at all; in others the only program available is "general assistance," which is invariably quite limited.

For other sectors of the poor there are other programs available, most of which provide far more help than a general assistance program (see Chapter 4). The Aid to Families with Dependent Children (AFDC) program provides a monthly stipend to families, the great majority of which are one-parent families with dependent minor children. For the aged (over 62) or the disabled there is Supplemental Security Income (SSI). Veterans have a panoply of programs, including direct shelter resources, pensions, and medical care. Children can benefit from a variety of child welfare service laws, which provide for emergency shelter care. Furthermore, virtually all of the poor are eligible for food stamps. Thus, in theory at least, this web of safety net programs would seem to make homelessness an unlikely consequence of the lack of resources. Nevertheless, advocates dealing with the bureaucracies that administer these programs learn quickly that the theory and purposes of the programs are related only very loosely to actual practice. This dichotomy between theory and reality has been the focus of much activity in courts throughout the country, as exemplified by a series of lawsuits brought on behalf of homeless people in Los Angeles.

The Los Angeles Litigation Experience

Litigation challenging the failure of safety net programs to provide food and shelter to homeless persons has focused predominately on two issues: access and adequacy. A series of cases brought in Los Angeles County by the Homeless Litiga-

tion Team* demonstrates how these issues were attacked in Los Angeles's general assistance program, referred to as General Relief.

As part of the General Relief program, the County of Los Angeles provided an emergency shelter system, which ostensibly issued hotel vouchers to any homeless applicant who needed assistance. While thousands of homeless people lived on the street, hundreds of voucher hotel rooms went unoccupied. Investigation of this phenomenon pinpointed two practices by the county that had the effect of keeping homeless people out of the emergency shelter system and therefore out of the General Relief system itself.

First, in order to receive an emergency shelter voucher, an applicant was required to provide a certified birth certificate or a driver's license. Yet because of the high rate of victimization and the transient nature of homelessness, such identification often was lost or stolen. As a result, individuals in immediate need of shelter were left on the street. The identification requirements also were used to fine-tune the emergency shelter caseload. In winter, when demand for shelter was high, the identification requirements were enforced strictly; in summer, when demand slackened, lesser forms of identification were accepted.

In addition to the identification requirements, the county controlled the number of persons who received emergency shelter vouchers by establishing daily quotas for the number of persons they would assist with General Relief. If a homeless person sought assistance after the quota was reached, he or she was told to return on another day. In the first case brought by the Homeless Litigation Team, the court found both practices to be inconsistent with the county's statutory obligation to "relieve and support" the indigent and the disabled.[23]

Other bureaucratic barriers often are created to control approved caseloads and ultimately to protect the amount of funds spent by counties on general assistance programs. Perhaps the most absurd is the requirement that one have an address before he or she can qualify for assistance. Thus homeless people are denied assistance because they have no address; yet it is impossible to pay rent and to establish an address without assistance. Courts at sometimes have struck down address requirements [24–25] and at other times have upheld them as necessary to control fraud.[26] In Los Angeles County no litigation was necessary in this area because no address was required for participation in the emergency shelter program; in turn, the shelter provided an address for receiving the General Relief grant.

Litigation was pursued, however, challenging as a barrier to General Relief the extremely complex, convoluted application and intake process itself.[27] In that case the judge approved a county plan that provided for special assistance to individuals identified as mentally or developmentally disabled. The county promised to provide individual help to such disabled applicants in maneuvering through the myriad forms and the countless outside appointments required in order to obtain General Relief. The complex nature of the application process presented mentally disabled homeless persons with as insurmountable an obstacle as does a stairway to paraplegics. Because Los Angeles County received federal funds in its welfare system,

*The Homeless Litigation Team is composed of lawyers and legal workers from eight public-interest law firms: Legal Aid Foundation of Los Angeles, American Civil Liberties Union Foundation, Western Center on Law and Poverty, Inner City Law Center, Mental Health Advocacy Services, Center for Law in the Public Interest, Protection and Advocacy, Inc., and San Fernando Valley Neighborhood Legal Services.

such a barrier was in violation of Section 504 of the Federal Rehabilitation Act of 1973 and similar state laws prohibiting discrimination on the basis of handicap.

Even for individuals in Los Angeles who are able to surmount the numerous obstacles and eventually to qualify for General Relief, a final barrier to assistance has been created in the form of a "60-day penalty," which prohibits persons who have been terminated from General Relief from reapplying for assistance within 2 months of termination. This penalty is imposed on individuals for being late to their work projects, failing to turn in a form on time, or failing to document the required 20 job searches per month. Approximately 2,500 people per month are terminated and are given a 60-day penalty. This penalty was challenged by the Homeless Litigation Team on both procedural and substantive law grounds.[28] The procedural challenge resulted in new regulations requiring that violations of General Relief rules be "willful" before the county can impose sanctions. The substantive challenge, focusing on the harshness of the penalty in relation to the nature of the wrongdoing, is still in litigation.

In addition to focusing on process requirements that restrict the number of persons allowed on general assistance, it also was necessary to challenge the adequacy of the program for those receiving benefits. Inadequate benefits and uninhabitable voucher hotels are as much a deterrent to general assistance as are access barriers. Indigent individuals may prefer to remain on the street rather than giving up their privacy in a county-sponsored poorhouse.[29] For homeless individuals a shelter that does not meet minimal standards of cleanliness, warmth, space, and rudimentary conveniences is no shelter at all.[30]

In Los Angeles, clients felt that the voucher hotels were more dangerous and more unsanitary than the streets, parks, and alleyways in which they slept. Litigation challenging the conditions in these hotels has led to a requirement that heat be provided in all voucher hotels in the winter and to an agreement that specific hotels be brought into compliance with all applicable housing, building, fire, health, and safety codes.[31] Even for those willing to live in skid row hotels, the total amount of their General Relief grant would not cover an entire month's rent. Consequently, individuals who had to spend some of their grant on food would find themselves unable to pay the rent toward the end of the month. Thus many people lived on the street at least part of every month. Litigation of these issues led to a settlement increasing the General Relief housing allowance over a 2-year period.[32]

Although the Homeless Litigation Team has been successful in a series of cases, it is very clear that the county system still does not serve adequately even the most basic needs of homeless people in Los Angeles. One need look no further for proof than the city's campground and shelters, filled by more than a thousand people who remain homeless even after the litigation against the county discussed before.[33]

Services for Homeless Mentally Disabled Persons

Mentally disabled individuals make up a large but undetermined segment of this population. Like others, they require emergency food, shelter, and income maintenance, although these essentials are not enough to keep them from living on the street. Many of these individuals either are too disabled to seek general assistance in the first place or fail to make their way through the general assistance application process. Other disabled individuals, once they receive general assistance, need help in managing their money in order to ensure that food and shelter

are available throughout the entire month. Still others, who maneuver successfully through the complex application procedures for general assistance programs, often find themselves barred from even the most minimal shelter by the stigma associated with their disability and by nonacceptance of their sometimes bizarre behavior.[34]

The solution to homelessness for mentally disabled persons thus requires more than the mere provision of shelter and other necessities. This population needs continuing assistance and support in order to use those resources. Such assistance falls under the rubric of community mental health services and requires individual case management, advocacy, and treatment. The efficacy of an adequately supported community mental health program is well documented.[35] The failure to provide such programs throughout the United States also is well documented.[36] This failure is most apparent when we note the swelling numbers of abandoned mentally disabled persons on the street.

Historically, the phenomenon of homeless mentally disabled persons is due largely to the failure of local, state, and federal governments to shift to the community the tremendous fiscal saving created by drastic cutbacks in the number of state hospital beds available to mentally disabled persons. This failure is related directly to the slow development and the relative weakness of the mental health constituency in the political process.

As in the case of all the disenfranchised groups that make up the homeless population, the failure of the political process to provide essential services can be challenged effectively through litigation. Litigation specific to the special needs of mentally disabled homeless persons can be developed pursuant to several different legal theories.

Although a universal constitutional right to mental health treatment in the community has not been recognized generally by the courts, several viable theories arguably provide a mandate for the provision of mental health treatment to homeless mentally disabled persons.

The federal constitution remains a source of such a mandate. Although the circuit courts of appeals have conflicted in interpreting the U.S. Supreme Court precedents,[38] at least two courts have found a constitutional right to community-based treatment for mentally disabled individuals.[37–38] In both cases, however, this right was applied to individuals who were confined involuntarily in institutions. The right was based on the protection of individuals' fundamental liberty interests from the massive state restriction inherent in involuntary confinement. In order to extend this analysis to provide a right to community-based treatment for mentally disabled persons who are homeless rather than confined in an institution, one can argue that this right is justified to the extent that it reduces the risk of loss of liberty through involuntary treatment and incarceration of such homeless persons.[39]

In addition to the federal constitution, state constitutions also might form a separate basis of a mandate for providing community-based services to homeless mentally disabled persons.[40] Arguments also can be made that federal statutes prohibiting discrimination on the basis of disability provide an affirmative duty to provide treatment to homeless disabled persons where the lack of treatment acts as a barrier to the equal participation of these individuals in the services and programs offered for their assistance.[41]

Whereas the federal and state constitutions and federal antidiscrimination statutes provide a theoretical basis for a right to treatment for homeless mentally disabled persons, actual litigation has relied much more heavily on state statutes. These statutes generally are of two types: The first provides a specific mandate for mental

health services, and the second provides generally for the protection and assistance of indigent persons in a particular locality. Litigation pursuant to both types of statutes has yielded mixed results.[42–46] Even when successful, litigation on behalf of mentally disabled homeless persons—like other types of litigation on behalf of the homeless—has not provided comprehensive solutions.

APPROACHES TO LITIGATION

Individual Advocacy and Systemic Change

The role of lawyers is to represent clients. Sometimes that role consists of the relationship between two people: the client and the lawyer. Often the lawyer is called upon to represent a group of clients, although he or she may have contact with only with a few of the group members. Most of the publicized work of lawyers on behalf of the homeless, however, has been of the latter type: class actions and other legal efforts to cause systemic change beneficial to people who are homeless. Yet throughout the United States, individual attorneys and legal services work daily to resolve the specific problems of individual homeless clients without attempting to change the system in which those clients find themselves. In the vernacular, these are known as "service" cases. Although this work seldom is recognized in the media, it is absolutely essential for two reasons.

First, without individual advocacy, many homeless people might die while waiting for the systemic change. People interacting with the bureaucracies ostensibly established to aid the poor already have considerable rights—on paper. Yet without advocates who know the often Byzantine regulations that govern such programs and who can deal socially and politically with the bureaucrats who implement such rules, the poor in general and the homeless in particular frequently are deprived in practice of those rights granted to them on paper. Indeed, this fact makes individual advocacy essential for a second reason: Without it, the results achieved in court and on paper regarding such systems are likely to be purely theoretical and abstract. It is not what happens in court that determines whether the poor and the homeless win in litigation; it is what happens in the streets and the welfare office waiting rooms.

Approaches to Systemic Advocacy

In any careful approach to whether and how the suffering of homeless people may be alleviated through legal action, one must begin with an understanding the place of the legal system in our political structure. Whatever we are taught in civics classes, it is not some abstract notion of justice that is dispensed in our courtrooms. Conservative rhetoric to the contrary, virtually every judge in America sees himself or herself as an interpreter of rules made by the political departments of the government, not as a maker of rules. Only within the framework of those accepted juridical principles may significant differences exist between judges of different backgrounds or social perspectives.

Moreover, to the extent that what advocates seek is complex or requires intervention or supervision over time, all judges are reluctant to become involved. Judges do not want to operate the welfare system. By contrast, if the judge can achieve a significant result merely by ordering the government to cease doing something, a favorable result is much more likely. In general, then, it is not enough to demon-

strate to a judge that something is wrong; lawyers also must demonstrate that the judge can do something practical about it, something supported by the laws enacted by the political departments of government.

Some examples may illustrate these principles. The first piece of "homeless litigation," *Callahan v. Carey,* often is called a "right to shelter" suit. In fact, however, the court in *Carey* ordered the City of New York to cease turning people away from the men's shelters that had long existed in New York. A later settlement presented in great detail the conditions of the shelters and other points. It is very important to note that both by law and in practice, New York already had a shelter system of sorts; the city, however, was turning people away from the shelters, and the shelters were such miserable places that many people preferred to risk sleeping on the streets.[47] Similarly, in *Eisenheim v. Board of Supervisors,* the first "homeless litigation" in Los Angeles, the situation that was challenged was not the lack of any shelter system for homeless people but the mechanisms that kept people out of that shelter system.

In communities where a public shelter system is nonexistent, advocates face a much tougher challenge. As noted earlier, it is much easier to persuade a judge to order local officials to cease turning people away from shelter than to persuade a judge to order the creation of an entirely new system. In such a case, significant concrete results may be obtained by the way of settlement and political pressures that flow from a lawsuit. In St. Louis, for example, a suit was brought on an ancient statute requiring the county to care for the poor.[48] Such statutes exist in most American jurisdictions, although local government may observe them primarily in the breach. If such a case proceeds to trial or appeals, the most that is likely to be achieved in court in such a case is an order requiring some abstract recognition that the homeless should be sheltered by someone. As occurred in St. Louis, however, the case can serve as a framework for achieving an enforceable settlement.

In any event, obtaining recognition of the abstract right of the poor to be cared for by someone in particular may be an important first step, particularly toward creating a shelter system where one has not existed before. The nature and the scope of such a shelter system can be the focus of later advocacy activities. As noted earlier, even mandatory, sweeping orders issued from the courthouse may have no effect at all on the streets and in the alleys of the community unless the advocacy community is prepared to reach out to homeless people and to advocate for their individual rights.

THE ROLE OF THE SOCIAL SCIENTIST IN HOMELESSNESS LITIGATION

In many pieces of homelessness litigation, social scientists and other experts have played essential and varying parts. The recent litigation in Los Angeles, for example, has relied on experts in statistics, survey methodology, economics, sociology, urban planning, psychology, medicine, social welfare, and psychiatry. Experts have played an important role in helping attorneys and clients to frame a litigation strategy that will lead to legal victories that will translate effectively into improvements in the world outside the courtroom. Equally important, outside experts may help to assess whether certain legal victories will have unanticipated side effects. For example, urban planners and economists can assess the effect on the local housing market of an increase in welfare housing grants, so that advocates can plan a strategy that does not merely result in the diversion of welfare housing grants to slumlords, with no net increase in the numbers of persons being housed adequately.

Beyond choosing targets and helping to guide strategy, expert assistance may be essential in communicating a complicated set of facts to a court. Sometimes such expert evidence takes the form of survey research, analysis of survey data, or other systematic empirical study. An example is the Los Angeles case, in which it was alleged that the assistance provided to General Relief recipients was so low that it required many of them to be homeless for at least part of each month. The underlying evidence included such elements as a survey of General Relief recipients conducted by the welfare department and information about the Los Angeles housing market collected by the U.S. Census. All of this material constituted an enormous database, which would have been opaque without the assistance of an expert to illuminate and explain the salient relationships.

At other times, expert evidence many be less quantitative. In *Rensch v. Board of Supervisors*,[27] the plaintiffs challenged the discriminatory effects on the mentally disabled of the complex application process for emergency shelter and subsistence benefits under General Relief. A specialist in vocational rehabilitation was retained to accompany a homeless applicant for assistance through the system, to record the nature of the tasks demanded of him, and to assess the abilities required to complete such tasks. A social psychologist with a great deal of field experience was retained to conduct a "key informant" survey of persons interacting daily with the application process, in order to highlight the particular deficiencies of the system. Another expert was retained to review the forms that homeless applicants were required to complete, in order to assess the level of reading and skill needed to complete the forms. Without these experts, attorneys would have been left to argue from the face of the forms and from their own descriptions of the application process, a much less convincing presentation.

This is not to say that all expert testimony in homelessness litigation comes, or should come, from social scientists. Indeed, much of the most compelling testimony has come from persons who are experts by virtue of their experiences. For example, emergency room nurses and doctors have testified about the illnesses and injuries that homeless people suffer; shelter operators have testified about the lack of resources in the private sector.

Homeless persons themselves perhaps are most knowledgeable about the consequences of homelessness and the attractiveness of various legal remedies. On the streets of our country there is an amazing wealth of intelligence, insight, and common sense. No approach to ending homelessness can succeed unless it is guided and informed by the homeless themselves.

CONCLUSION

There are many approaches to litigation and advocacy on behalf of the homeless. No one experience is translated easily to another community, but attorneys and advocates hope that they have learned both from their mistakes and from their successes.

On another level, it is important to recognize the limits and dangers of litigation as well as the possibilities. One such danger is the bringing of lawsuits that are not well thought out or adequately prepared; the results are likely to be legal defeats from which it is hard to recover. Furthermore, all litigation carries the risk that energies that could be put to use more effectively in political or other settings may be diverted to a legal system that can offer no ultimate solutions. It is always important to remember that the courtroom is most often a place of last resort, the place to which

the disenfranchised turn when they have been turned away by every other institution in society.

The end to homelessness in America will not come ultimately from judges or from legal opinions. Homelessness will end only when sufficient numbers of people are organized with sufficient cohesion to demand the necessary resources. In the meantime, attorneys and other advocates can try to ameliorate the suffering of the homeless poor and they can work with many others to keep the awful truth of homelessness in America before the public and in the halls of power.

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26

Homeless but Not Helpless

Squatters Take Care of Themselves and Each Other

MARY BETH WELCH

INTRODUCTION

Wherever there are homeless people, squatting activity goes on—under freeways, on sidewalks, in parks,* and in empty houses and buildings. Some of these settlements are more permanent than others, but few are more than ad hoc claims on available space. Organized squatting could turn these ad hoc arrangements into political claims for shelter rights.

Urban squatting is the occupation of empty buildings without the owner's permission. This activity has occurred in most European countries, although the extent and the nature of the squatting vary according to the housing situation and the legal framework. Squatting has occurred most in Britain, where large numbers of publicly owned buildings have been held empty in preparation for rehabilitation or removal, and where squatting is a civil rather than a criminal offense. In the United States, thousands of people have squatted and continue to squat, but they receive little national notice. Nevertheless, where organized squatting has occurred, it has drawn

*In Los Angeles, two major homeless camps in parks and on sidewalks are Love Camp and Justiceville. The homeless also have been successful in securing temporary permits to set up large tents for shelter during the coldest rainy days of winter. Every winter since 1984–1985 the homeless coalition has coordinated the Tent City, which is placed on County Building grounds, usually over the Christmas holidays. In addition, a local chapter of the Philadelphia-based Union of the Homeless sponsored a media-covered squatting action in which veterans broke into a Veterans Administration-foreclosed house, declaring homeless veterans' right to housing. They left the premises, however, when they were informed that the house was in the process of being sold to a veteran.

MARY BETH WELCH • Urban Studies Program and Women's Studies Program, California State University, Northridge, Northridge, California 91331.

a direct response from local and in some instances federal government,[1] either in the form of Housing and Urban Development policy changes or as the direct provision of additional low-income housing. For example, Philadelphia has been the site of numerous squatting actions that convinced the city council to develop a homesteading program that serves low-income residents and effectively legalized squatting. Squatting provides shelter, an immediate need, while it calls attention to the concomitant problems of neighborhood neglect, homelessness, and the lack of decent, affordable housing. As Philadelphia ACORN chairman Grover Wright has often stated, "Some say squatting is illegal, but we say letting houses sit empty is immoral." Given the success of past squatting activity, the homeless and the organizers of the homeless might consider squatting as a direct action that brings attention to the issue of shelter rights while building political consciousness and a sense of efficacy.

While the shortage of affordable housing continues to grow, abandoned building and houses remain vacant. Ironically, the very agencies responsible for housing the homeless and developing low-income housing are stockpiling abandoned housing and removing units from the housing market, either for future rehabilitation or for demolition. For example, between 1983 and 1986 the Los Angeles Community Redevelopment Agency (CRA) brought nine hotels and has closed five of them,[2] effectively removing 290 formerly available single room occupancy (SRO) units. More than 60% of the units in New York City's *in rem* buildings are empty.[3] (*In rem* buildings are those to which the city has taken title because the prior owner failed to pay real estate taxes.) The great majority of empty units are in burned-out buildings or in structures open to the elements, although a 1985 report commissioned by the city stated that many of these units are potentially recoverable.

SQUATTING: HISTORICAL AND POLITICAL ANALYSIS

Urban squatting often has been characterized as a direct challenge to private property rights, but in actuality, its impact on the rights of private ownership has been minimal. Instead, squatting in the United States and Europe has been used to call attention to the local or federal government's failure to carry out adequately its role as a housing provider. In the case of Britain, squatting generally has occurred in government-owned council housing, which was held vacant pending rehabilitation or removal despite the hundreds of thousands of people without adequate shelter. Even at the height of squatting activity in Britain, only 3% of the 50,000 squatters were in privately held housing.[4] Kevin Kearns, an authority on squatting activity in Western Europe, has surmised that

> squatters exhibit a clear preference for government-owned rather than private residences, for several reasons. Eviction from publicly held buildings must be routed through the bureaucratic maze, taking months or years. Secondly, government authorities have a delicate public image to protect, encouraging prudent action. Conversely, private owners often use illegal, forcible means of eviction. It is also important to note that most squatters have a strong moral and psychological hesitation about invasion of private property.[4]

Although squatters may not challenge the notion of private property, they assert that shelter, like food, is a necessity, and that as such it should be considered a basic right. Squatters usually battle with the city or local government because often that government is the property owner of last resort in cases of foreclosure, abandonment, and nonpayment of taxes. Furthermore, local governments often are responsible for providing affordable shelter for their citizens.

Face to face with the failure of market-operated housing production, the homeless have a visceral understanding of the U.S. housing crisis. They have experienced the results of property speculation and incompetent housing authorities. Squatters interviewed in New York and Philadelphia recounted how their understanding of politics changed with their decision to take action to find housing for themselves and their families. These squatters were predominantly women who, because of their commitment to children, had taken the major step of challenging the fundamental tenet of society that private property was "sacred." Morally they knew that people should come before property and that the community should protect its members. Gloria, a squatter in Philadelphia, stated, "It's hard, and you know you do not have a job; you are going about trying to get something the right decent way, trying not to be illegal; but when your back is pushed against the wall and you have nothing else to do, then what else can you really do?" (p 83)[5]

Squatting is an activity that demands total commitment from its participants. Squatters need to keep a constant vigil against eviction and at the same time build community and legal support. The targeted houses usually are in derelict condition, neglected by landlords who milked the property and finally abandoned it when it was no longer profitable. Thus one of the first activities of the squatters is to clean up and repair the house or building; often it requires repairs that include mending or replacing roofs and windows and replacing walls, floors, sinks, plumbing, and electrical wiring.

Squatters who ultimately are successful learn that although they are poor and homeless, they are not helpless. They replace plumbing, plaster walls, and nail up wallboard. The children help out and feel pride at seeing their mothers take charge of their lives. Gloria was lucky; she found a small abandoned row house whose plumbing, roof, floors, and walls were still intact. There had been a small fire in the kitchen that necessitated the replacement of some wallboard. Gloria took care of this and also painted the walls and replastered the ceiling. Because of her work and perseverance, she eventually won the right to stay and to become the owner of the house. Thus after staying passively for 2 years on public housing and gift house waiting lists, she took a chance and won.

In the late 1960s in the United States, and currently in Europe, many squatters have developed alternative institutions such as food cooperatives, cooperative child care, cost–price shops, schools, and grocery stores. These alternative institutions may seem a part of a bye gone era; however, many homeless persons are looking for less than traditional living arrangements. Communal living and cooperative support institutions may better support the needs of persons who have fallen out of more usual family support systems. These collective or cooperative arrangements may even increase self-sufficiency and independence, particularly in the case of the single parent who, without social supports or services, must make complex work and child care arrangements in order to work and take care of her family's needs. Moreover, current social services that attempt to serve the homeless persons' economic needs without simultaneously creating a support system often fail the person they are intending to help. Many homeless persons reject the agency's job referral or housing voucher because they fear losing their street support system, which they'll need if the job or shelter is lost.

The Tradition of Urban Squatting in the United States

Squatting, or occupying property without the owner's permission, has existed since colonial days. Nineteenth-century homesteading acts institutionalized the

practice. Not surprisingly, twentieth-century urban squatting activity has been highest during economic downturns, represented most notably by the Hoovervilles of the Great Depression. The Hoovervilles, found in every city and town across the country, were known for their mutual aid and organization, oftentimes run like small towns with their own councils and elected leaders.

Squatting in the 1960s and 1970s

Since the late 1960s there have been numerous types of squats: those organized by activists, those co-organized by squatters and by activists, those initiated by the squatters themselves, those in city parks and vacant lots, those in city-owned property, and those in foreclosed property. The squatters themselves are equally varied; they include single parents with children, single men, older single women, two-parent families, the near homeless, and the already homeless.

In the United States in the early 1970s, most of the squatters had been displaced by urban renewal projects and institutional expansions. Thus the squatting actions attacked both private and public landholders and challenged their right to displace low-income tenants. Community groups also organized squatting actions to relocate ill-housed or unhoused families into vacant apartments and buildings. In addition to organizing the actions, community supporters orchestrated demonstrations, marches, and confrontations to draw media coverage.

For the past 20 years, New York has been the site of the most extended squatting activity in the United States.* Official and community documentation of this activity is limited and incomplete, but many activities have been recorded by film,[7–8] partially because film can be used as an organizing tool while documenting permanently the words and actions of the squatting participants. Other activities remain part of the unrecorded folklore of housing activism.

Many squats took place in New York City, including those by groups and movements such as welfare rights and women's liberation groups. One example was the 1971 squat by the National Welfare Rights Organization (NWRO) of a newly completed, not yet occupied high-rise tower in the West Side urban renewal area. This squat was organized by leaders of a local organization and was carried out by welfare families who were staying in the basement of a church and in welfare hotels. The families moved in at about 4:00 P.M. and unfurled a banner from the top windows that read, "People before Profits." Supporters left by midnight; the police moved out all the families by 4:00 A.M. The same buses that had brought the squatters to the building in the afternoon took them back to a Harlem church to sleep. Eventually all the squatters were relocated into some form of public housing, but the amount of public housing was not increased.**

Two major squats also took place in the late 1960s: the Morningside Squat and Operation Move-In. The Morningside Heights squat took place in the neighborhood of Columbia University on the Upper West Side. It was the first squat to take place in

*I am indebted to Bill Price, longtime New York housing activist and an organizer of Operation Move-In, for this account of the activities of the NWRO People Before Profits squat.

**Material on squatting in New York City in the early 1970s was provided primarily by an interview with Tom Gogan, a participant in the Morningside Squat and at the time of the interview an organizer for the City-Wide Tenant Union; interviews with Bill Price, an organizer of Operation Move-In and a title-vested tenant in one of the buildings with units squatted; 1973 slide presentation, "Architecture of Fear," developed by Bill Price in conjunction with the Upper West Side community group HOMEFRONT; and "Break and Enter," a film about Operation Move-In produced by Third World Newsreel in 1970.

privately owned (institutionally owned) buildings. The three buildings targeted had been bought by the Episcopal Diocese for the creation of middle- to high-income senior citizens' housing. Low-income, largely Hispanic elderly persons would be replaced in the units by affluent elderly tenants.

The organizers compiled a list of 300 families who could be squatters for the buildings. Because the buildings were "new law" tenements (i.e., built between 1901 and 1929), they were structurally sound and needed only limited system replacement. After publicity had been generated by street marches, daily demonstrations, community support, news coverage, and lawyers' mediation, the squatters gained a negotiation settlement to obtain equivalent housing for those displaced by the building conversions.

"Operation Move-In" was the first major squat that occurred on the Upper West Side of Manhattan; it represented an alternative to urban renewal. The 30 square blocks between 86th and 96th Streets, bordered by Central Park West and Amsterdam Avenue, had been an urban renewal target area since 1956. By 1970, 112,670 people, mostly low- to moderate-income blacks, Puerto Ricans, and whites, had been displaced from the West Side. By 1970 there was a shortage of low-income rental units all over New York City, especially on the Upper West Side. Families were doubling up while speculators held apartments vacant, waiting for the city to buy them. In turn, the city-owned buildings were kept vacant in anticipation of demolition. The community plan was to revitalize the neighborhood with higher-priced rental housing. Little thought was given then, just as little thought is given now, to the fate of the low-income tenants in the neighborhood.

Although the buildings were boarded up, plumbing and electricity remained intact, and the utilities were still turned on. In early 1970, the Mid-West Community Corporation, the umbrella group of all the antipoverty agencies on the West Side, met and voted unanimously to issue a declaration that all existing vacancies should be viewed as "community resources which should be used by members of the community." On February 1, 1970, the first squatter took the tin sheet off one of the vacant apartment doorways and moved her family in. By summer, over 200 squatter families had taken possession of the vacant apartments in the Upper West Side urban renewal area.

At first the "Operation" was not publicized. By design, many squatter families moved in to secure the building before public notice was given. The city's first response was to evict a squatter from one of the buildings; after the police left, community supporters helped her to move in again. After a number of evictions, the city began to rip out plumbing, smash toilet bowls, and seal the entrances of the remaining vacant apartments. Community support and sympathetic media coverage, however, moved the city to recognize the squatters as tenants of the city. Under pressure, the city eventually promised to build 160 units of public housing to replace a 40-unit building that they intended to demolish. This offer split the squatter community between those who considered the city's offer a victory and those who thought it better to hold onto the 40 units of which the community could be sure. The city never did build the public housing, but all units that were placed under the public housing authority at that time remained low-income housing, occupied largely by the original squatter/tenants.

One of the first visible aspects of the campaign was the creation of an alternative high school, followed by a community vegetable market, a food cooperative, a coffehouse, and a community newspaper. Many of these community institutions still exist, although their goal was to gain housing, not to make a political statement

about housing rights. The squatting, however, also brought attention to the destruction and elimination of low-income housing by city and federally financed urban renewal activity on the West Side.

Squatting in the 1980s

In the 1980s, most of the squatting activity in the United States took place in New York City, Philadelphia, and Camden, New Jersey, but it occurs in almost every major city. Where there are abandoned buildings, squatting takes place.

Homesteaders in New York

After a period of inactivity, squatting began again in the early 1980s. Since the City Council's 1976 passage of tax arrears legislation (Public Law 45), which shortened foreclosure proceedings on tax-delinquent buildings to one year, the city reluctantly had become the landlord of last resort. As of May 1980, *in rem* proceedings had brought into public ownership 12,444 residential properties containing 38,910 occupied units. The intent of the *in rem* program was to lessen the effects of private disinvestment—that is, to stem deterioration, to make feasible improvements, and to expedite return of abandoned buildings to nonpublic ownership wherever possible. If the building was not occupied, the city usually attempted to transfer it to the private sector through auction. If it was occupied, the city might manage the building itself through the Office of Property Management of the Housing Preservation and Development Department (HPD), place it in one of the alternative management programs, or sell it through auction. If tenants wanted to buy the building, they had to be accepted into the Tenant Interim Lease alternative management program, a bridging program to tenant ownership.

To qualify for the alternative management programs, the buildings had to be 50% occupied. When acquired by the city, many of the buildings still were 50% to 60% occupied. The city, however, did not always maintain or attempt to rent the vacant units, and the buildings deteriorated even further under city ownership. Other buildings were less than 50% occupied when the city took over ownership, but residents were able to show that other displaced community residents wished to move in and to participate in advancing the building toward tenant ownership. Yet when the tenants moved in additional tenants and took over maintenance to prepare the building for the cooperative program, the city often moved for eviction. When the tenants refused to leave or to move to other city-owned buildings, they were called squatters,[9] but they preferred to be called *homesteaders*. Connie is an example of a homesteader in this situation.

When Connie first learned about the vacant apartments at LaSalle Street, she was living in a three-room apartment on the Upper West Side with three teenage children and one grandchild. She was facing a rent hike from $250 to $475, which effectively forced the family out of the apartment. When she moved into the LaSalle Street building in August 1981, 24 of the 29 families living there had recently moved out after the city had removed the burner from the heater. The remaining tenants invited others to join them in petitioning for entry into the city's homesteading program. Together they cleaned the hallways, installed four water lines and some wiring, repaired the roof, and replastered ceilings and walls.

In the LaSalle Street building, the homesteaders were evicted twice, each time with the use of police SWAT teams. The court, however, issued an injunction on both

occasions, allowing the homesteaders to move back into the building. After the December 8, 1981, eviction, the judge ruled that 8 of the 19 tenants could remain legally in the building. During the winter of 1982 the residents created makeshift heating systems, usually consisting of the gas oven and burners to provide heat and a fan hanging in the doorway to push the warmth through the apartment. The "homesteaders" had hot water because the superintendent from the neighboring building contributed a water heater. To help with security, the "out tenants" (i.e., the 11 not protected by the court injunction) continued to stay in the building, living unobtrusively in apartments whose doors and windows were covered by sheet metal. "This building is filled with love," said Connie, one of the legal homesteaders. "Everyone in here knows each other's names, knows their next-door neighbor." The city, however, treated them as opportunists who had not followed the procedure to homestead their abandoned building.

Philadelphia: The Birthplace of a National Squatting Movement

In 1977 there were over 40,000 abandoned buildings in Philadelphia; many belonged to the U.S. Department of Housing and Urban Development. In North Central Philadelphia, a predominantly black, low-income area, HUD owned 5,000 vacant residences, all of which potentially qualified for the homesteading program. In addition, many houses taken for tax arrears qualified for the city's gift-house program. The city mismanaged both programs, however, and gave the houses to real-estate speculators rather than to low- or moderate-income residents. Meanwhile, low-income families remained 2 or more years on waiting lists for public housing, doubling and tripling up with relatives. Only a handful were selected for the gift-house program.

In August 1977, Milton Street and his brother John began to organize people in North Philadelphia to use his "pass key"—a pair of metal clippers—to enter and occupy abandoned houses. They started a movement that since has stretched across the United States.* Not surprisingly, public officials were hostile to the squatter campaign; the city council president said, "This is the beginning of anarchy." Patricia Harris, then secretary of HUD, declared that the "'walk-in homesteaders' were no better than shoplifters who grab a piece of merchandise off the shelf, claiming it should not be left unused."[10] HUD threatened evictions of the families and in some cases carried them out.

The general community and the press, however, showed enormous support in the face of such strong official criticisms, A *Philadelphia Daily News* editorial dated January 6, 1978, criticized Secretary Harris's denouncement of the squatters, saying:

> HUD is a slumlord. Only HUD doesn't want to be bothered with tenants. Homes lie unoccupied and gradually become useless. People need housing. That is supposed to be HUD's business, putting people into homes instead of keeping them out.[10]

Neighbors of the squatters generally were supportive of people moving into the vacant houses on their blocks because the homesteaders provided security from arson and crime and removed the blight of a rundown, unclaimed house.

In its 4 years of operation, the gift-house program had given 1,000 homes to real estate interests while a waiting list of 5,000 families remained and 30,000 houses

*Informants about squatting in Philadelphia and about the ACORN national squatting campaign were Seth Borgos, ACORN National Campaign organizer; Madeleine Adamson, ACORN national campaign organizer; and Gloria Giles, squatter in Philadelphia.

stayed vacant. Despite the pressure placed on the city council by community groups, a local television station investigation, and sympathetic news coverage, the Council was slow to alter the administration of the program. Finally, in 1978, after 18 months of city government opposition to the squatters, half of the 200 squatters received title to their new homes through the city's gift properties program, 50 received conventional or FHA mortgages to buy the homes, and 25 became tenants of HUD. Ten of the squatters were evicted, and the remaining 15 were still involved in litigation.[10] With these concessions, community groups temporarily suspended squatting activity.

In October 1980, however, when it became clear that there was no substantive change in the gift-house program, the Association of Community Organizations for Reform Now (ACORN), began a new squatting campaign: "Need a House?" the recruitment flyer asked. "CALL ACORN."

The flyer explained that ACORN did not own houses itself but that the city owned them; by organizing, ACORN could make the city operate its gift-property program for low-income people. Interested persons formed a citywide group called SQUAT—Squatters United for Action Today. After individuals selected the houses in which they wanted to squat, they went to City Hall to determine the status and the owner of each house. The ACORN squatting campaign also required potential squatters to visit or "doorknock" the surrounding block of homes. The potential squatters went to each house in the neighborhood, told the neighbors that they were thinking about moving into the abandoned house, asked for information about the house and its owner, and requested the neighbors to sign a petition giving support to the squatters' action. When the first ACORN squatter moved in, 100 people rallied outside, including two ministers who helped remove the boards. The action received generous media coverage.

The squatting action made housing a major political issue in the November 1980 city elections. Council members were elected or defeated on the basis of their support for the squatting campaign, and Rizzo's followers finally were ousted. One of the new council members was John Street, an early squatting organizer. With the new city council, ACORN and the Kensington Joint Action Council (KJAC) were able to make an agreement with the city that 200 houses a month would be transferred through the gift-house program.

Squatting Made Legal in Philadelphia

After a year of pressure by KJAC and ACORN members, the sympathetic city council passed a precedent-setting city ordinance that gave legal status to families who occupied abandoned houses. Under the terms of the statute, a person could move into any house that had been declared a public nuisance (i.e., abandoned and tax-delinquent) and then could enter an "improvement contract" with the city. The new occupant was required to make repairs to bring the building up to housing code, whereas the city agreed to try to obtain the property by confiscating the tax-delinquent house. If the city was unable to confiscate the house or if a private realtor outbid the city at the delinquent properties auction, the city agreed to pay the occupants for the repairs they had already made, including their labor time.

The problems for squatters in Philadelphia, however, did not end with the passage of this bill. One powerful council member was able to exclude his two wards from the program, wards with the highest rate of abandonment in the city. Furthermore, the statute had no budget authorization; thus nobody was available to admin-

ister or oversee its implementation. Segments of the city's bureaucracy refused to recognize the ordinance or sabotaged its administration. For instance, the licensing and inspections department, in charge of developing the improvement contracts, would not inspect occupied buildings. This lack of action effectively forced the squatters out of the buildings in which they had squatted so tenaciously before the legal recognition of their rights to remain.

Six months after the enactment of the city ordinance, the *Philadelphia Inquirer* reviewed the program and concluded that it wasn't working. Between July 1982 and January 1983 more than 3,000 people had applied for gift houses, but only 32 had succeeded in signing the "improvement contracts," which authorized the squatter to enter and make repairs. Months, rather than weeks, were required to process each application. ACORN again appealed to the city to manage its homesteading program effectively. In the summer of 1984, ACORN was ready to renew its squatting campaign when the city agreed to process right-of-entry applications in 30 to 60 days, develop a list of available houses, and provide renovation grants of $1,000 to $4,000.

In 1986, ACORN formed a nonprofit housing corporation that acquires housing and uses the Community Reinvestment Act to work with local banks to qualify low-income people for loans. ACORN has reached an agreement with the cooperating banks that stipulates how food stamps, sweat equity, and part-time income can qualify as income. ACORN also trains tenants in construction skills. Thus squatting was used as a tactic to force the city to deal with the issues of abandonment and lack of affordable housing; to some degree, squatting succeeded in changing the way in which low-income people in Philadelphia obtain houses.

The ACORN Campaign Goes National

In the early 1980s squatters in Philadelphia and in 13 other cities took their action to Washington to press for changes in the federal homesteading program. This action was part of ACORN's national squatting campaign, which, in 1982, included squatters in more than 250 abandoned homes in 15 cities: Philadelphia, Pittsburgh, Detroit, Lansing, St. Louis, Boston, Tulsa, Atlanta, Houston, Fort Worth, Dallas, Columbus (OH), Phoenix, Columbia (SC), and Jacksonville (FL). The Washington action, which included a specially called hearing of the House of Representatives Housing and Community Development Subcommittee, resulted in 1982 housing legislation that revised the federal homesteading act to serve low-income people more effectively. Congressman Bruce Ventor (D.-Minn.) stated:

> We pay more attention sometimes in this country, in terms of law, to property than we do to people. I hope we can turn that around. We are going to continue to fight. We hope in the future we will be able to provide a realistic opportunity for you to have decent sanitary and affordable housing.[1]

The ACORN campaign required potential squatters to come to the ACORN office and become members, to sign a contract saying that they understand that they are part of a national campaign (and are not taking action as individuals), that they understand that squatting is illegal, and that they may be evicted. The contract also outlines the squatter's responsibilities, which include fixing up the houses and finding materials and assistance. Members can use the ACORN name to solicit these donations, which have included such contributions as plywood from a building materials outlet and doors from a wrecking company.

The campaign has focused primarily on single-family houses, but ACORN also has sponsored other actions: a campaign in Jacksonville, Florida, to push the Public

Housing Authority to repair and rent 280 units held vacant solely because they needed minor repairs; a squat of a school building in Boston, Massachusetts, to demand that 50% of the units in the converted building be designated as low-income housing; a squat, also in Boston, of a HUD-subsidized apartment building with units being held off the market; and in Columbus, Ohio, a squat by the former owners of their foreclosed home.

A film about the Philadelphia squatting campaign and the trip to Washington focuses on the empowering aspect of the squatters' campaign.[7] The original squatters quickly become "old hands," helping the new squatters to do research, "door-knock" the neighborhood, find materials, and make repairs. Although the squatting is done by individuals, largely in single-family houses, each squatter has the help and support of the ACORN community.[6,11]

Camden, New Jersey

Camden, located across the river from Philadelphia, also has a legalized squatting or homesteading program, initiated in 1981 after a series of Concerned Citizens of North Camden (CCNC) sponsored squats in North Camden.[12] North Camden has a lower median income than the squatting communities in Philadelphia. The Camden ordinance provided for the transfer of properties to organizations that would rehabilitate the abandoned properties as an approved Community Development Block Grant (CDBG) project. Such organizations pay only $1 per house and distribute and oversee grants up to $1,338 for the structural repairs of each property.

THE IMPORTANCE OF COMMUNITY SUPPORT

The squatters' greatest defense against forced eviction and criminal charges and prosecution is the general community. If the squatters have community support, publicity of a violent eviction can prove embarrassing to an owner or an administration. In 1970 in New York City, the strong community support and the threat of an outbreak of violence led the city to enter a private owner/tenant dispute to offer city-mandated solutions. Units were renovated with low-interest loans and then were leased to the New York Housing Authority, which rented the units to the remaining tenants and squatters.[13]

In Europe, community support is won most often through the development of sorely needed community institutions, such as child care programs, community gardens, food cooperatives, and street fairs. In Philadelphia, as noted, the ACORN squatters were required to visit all the neighbors, asking them to sign a petition of support. In many squats, the organizers have found community leaders such as the clergy to support the activity. The community and the neighbors tend to support squatting because it can help to revitalize an area, to eliminate vandals and drug dealing, and to remove the threat of fire by teenagers or drifters building fires in the building. In addition to direct solicitation of support from neighbors, sympathetic news coverage has proved essential. Press releases that emphasize the basic issues and causes of homelessness and property abandonment give the media a "people-before-property" context for reporting their stories. To counteract the impression that the squatters are "lawless rabble," many organizers focus media attention on families with children and on people from the local area rather than on those who might be considered dropouts or political extremists.

LEGAL CONSIDERATIONS FOR SQUATTING

Few legal writings address squatting in the United States. Squatting, or "adverse possession," generally is considered to have little legal justification, although some lawyers have argued that squatters have some legal defense under "adverse possession" and "forced entry and detainer" law.[14–15] In San Francisco, as of 1982, police officers were told not to remove anyone from their dwelling place unless there was clear evidence that the person was trespassing. "Regardless of who's involved in the dispute, the police should avoid removing a person from a house if there's a question in their minds at all. It's a matter for the courts to decide," said a San Francisco Police Department spokesman.[16]

Evidently it is helpful to retain a lawyer to settle that question in the mind of the police officer. Squatters have used their lawyers in housing court battles to force a landlord to rent a federally subsidized unit that he was holding off the market; to press the City Council to legalize squatting through a nuisance abatement program; to file a restraining order allowing continued tenancy in the building pending the outcome in the courts; to buy time for squatters by requiring police to produce proper papers for eviction; to defend squatters arrested for criminal trespass; to monitor arrests to determine undue force or violation of rights; and to assist in legal paperwork.

Some cities or states may have obscure state codes or ordinances that support squatting. ACORN activists have claimed successfully that a relatively obscure and unenforced state code in Illinois exempts from prosecution for criminal trespassing a person who "beautifies unoccupied and abandoned residential and industrial properties located within a municipality."[17] Activists also call for new legislation that would encourage owners no longer interested in their houses to donate them to a government agency or a nonprofit group. In many cases it is less expensive to hand over the deed than to pay to have the house knocked down. Landowners also may be able to receive a tax break if they donate the property to a tax-exempt organization.

WOMEN AS SQUATTERS

Many organizers might believe the squatting is more appropriate for single men than for single women or female heads of household. Most squatters are women, however, and most of them are female heads of household. Because women, particularly women of color who are heads of household, are those least able to find affordable housing, squatting offers a housing solution not provided by shelters, the streets, or conventional public housing. Abandoned housing is available for the taking; the houses or apartments are large enough for families; mothers need not give up their children to child welfare authorities; the walls offer physical security that the streets cannot provide; and squatting provides immediate shelter while the family is building toward a future home. Moreover, women who squat are adamant that they won't be passive any longer. Many believe that as homeowners, they will end the insecurity that comes from not knowing whether the rent will be raised, and they will have the freedom to make a comfortable home. Connie, of the LaSalle squat in New York City, explained why she and other squatters wanted to own the building rather than renting from the city:

> [Then] there was no way in hell that anybody could come and say "get out," there would be no such thing as eviction or anything, it would be your apartment, my apartment, his apartment. . . . If you wanted to take and put purple ceilings, nobody could tell us nothing. If we wanted to put windows in the walls, nobody could say nothing (p. 52).[5]

In Europe, women have played a vanguard role in squatting actions. In particular, women have organized the communal aspects of the squats, such as sharing child care and cooking. In lesbian squats in Hackney (a section of London), the women took over an entire city block of council-owned housing and created an exclusively female squat, which included a women's center and child care for the surrounding community.[18] Women's squatting groups in Amsterdam have organized squats for other community organizations such as a battered women's shelter.[19]

By recognizing that female-headed households constitute the majority of squatters, organizers can address some of the specific issues that women face. One major consideration is that of dealing with the welfare system. Mothers may lose their benefits, either in part or entirely. Some caseworkers say that because the mother isn't paying rent, the benefit is reduced by that portion that goes for rent. Some caseworkers cut off the mother completely if they discover that she doesn't have a legal address. The mother may face threats to take away her children because she is engaged in an illegal activity.

Another consideration is the importance of encouraging women's empowerment and guarding against reinforcing passivity through sexist hierarchical structures. The women themselves should be the leaders and organizers. Programs in self-help construction and repair should be oriented toward the female participant; child care should be provided. If the squatters are encouraged to participate in decision making from the start, the squat is more likely to be successful. The squatting organizer would benefit substantially from studying other woman-centered organizing such as that of the National Congress of Neighborhood Women or the radical feminist organizing practices of the Battered Women's Shelter movement.[20–22]

CONCLUSION

Although squatting is homesteading without legal sanction, it also is homesteading with politics. Urban squatting is a unique direct-action tactic that fulfills basic needs for shelter while it demonstrates the need for more adequate, affordable, low-income housing. This tactic empowers the squatters by giving them an opportunity to contribute substantively to improving their material conditions. Thus people formerly dependent and seemingly deficient in basic skills demonstrate to their local governments that sweat-equity projects can work and that the low-income people have the skills, resources, and ingenuity to make the project successful. Homeless people already have demonstrated their capacity to care for themselves through makeshift encampments. Squatting can serve to make the government more responsive while making squatters' own lives more comfortable. At present, the homeless are being told to wait while the government cleans up the buildings or sets up the shelters. In squatting, the homeless can participate in creating affordable shelter while putting the local government on the hot seat until it produces better solutions.

Ultimately, squatting poses a threat to the city establishment by raising ques-

tions: Why are there so many homeless? Why are there so many empty houses? Why is low-income housing destroyed to increase the supply of less needed high-income housing? Why is the city eliminating single room occupancy housing? Why is the proportion of family income devoted to housing rising steadily?

Urban squatting in the United States has historic precedents and in some instances a legal basis. Most important, however, it exposes an unfulfilled Congressional promise to provide "a decent home and suitable living environment for every American family."* Through squatting, the homeless have been able to meet their immediate housing needs and to demonstrate their ingenuity and determination to develop an answer to the current housing and employment crisis.

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IX

Conclusion

27

Homelessness
A National Perspective

MARJORIE J. ROBERTSON AND MILTON GREENBLATT

INTRODUCTION

The 1980s and early 1990s in the United States have been characterized by multiple political and socioeconomic changes that have contributed to the "social construction of homelessness."[1] These factors include recessions, a shift in the labor market from industry to services, reduced social welfare and educational programs, and consequent increase in the size of poverty populations.[2] A marked reduction in low-cost housing and deinstitutionalization of state and county mental hospitals have also contributed significantly to the problem.[2] However, research in the past decade has focused more on the individual who is homeless rather than on public policies, social and economic factors, and service delivery systems.

This book provides a broad perspective on homelessness in the United States and tries to examine the crisis both from an individual and societal point of view.[3–29] In this chapter we provide a thematic overview with special attention to assumptions and stereotypes about homeless persons in the United States. The identified themes will be used as a foundation for strategies for social and political change.

MARJORIE J. ROBERTSON • Medical Research Institute of San Francisco, Institute of Epidemiology and Behavioral Medicine, Alcohol Research Group, 2000 Hearst Avenue, Berkeley, California 94709. MILTON GREENBLATT • Department of Psychiatry and Biobehavioral Sciences, and San Fernando Valley Program in Psychiatry, University of California, Los Angeles, Los Angeles, California 90024, and Department of Psychiatry, Olive View Medical Center, Sylmar, California 91342-1495.

RESEARCH ON HOMELESSNESS, WITH SPECIAL REFERENCE TO THE DECADE 1980–1990

Defining Homelessness

Varied definitions of homelessness have been used in this book, reflecting lack of consensus among researchers during this decade. In earlier studies a definition of homelessness was seldom specified because a person was assumed to be homeless simply because he or she was interviewed in a shelter or meal program. Whether runaway youth, those doubled up with friends or family, individuals in institutions, or in domestic violence shelters should be considered homeless has also been a subject of debate throughout the decade.

Increasingly, researchers are portraying homelessness as an experience rather than personal attribute. Further development of the concept has emphasized the longitudinal aspect of the experience of homelessness rather than status at a particular moment in time.[30] Although there is as yet no fixed definition of homelessness, it is now viewed as an aspect of extreme poverty, with all its complications, rather than an isolated or unique phenomenon based entirely on lack of shelter.*[31–32]

A History of Research Approaches to Homelessness

Most of the research on issues related to homelessness since 1980 has been on homeless individuals. It divides roughly into three types. Early in the decade, empirical work was exploratory and descriptive. Not guided by an evolving theoretical base, it tended to be ahistorical. Samples usually targeted adults in shelters or missions, and data collection was usually not systematic or based on random selection.[33–35]

However, despite serious methodological limitations, strikingly similar results were reported across diverse urban areas, including New York,[33,36–37] Los Angeles,[38] Chicago,[39] Baltimore,[40] and Phoenix.[41] The consistency of findings suggested that homelessness was a widespread national phenomenon rather than a local one. These studies distinguished homelessness in the 1980s from that in previous decades.[33] Important ongoing changes in the size and composition of urban homeless populations were documented wherein the stereotypical homeless person, described as an older white man, usually with alcohol problems, represented only a small percentage of a larger group.[33]

Early studies also documented a "new" group of homeless individuals to include surprising numbers of families with children; women alone; military veterans; and a disproportionate number of racial and ethnic minority persons, especially African Americans and Native Americans. These "new" homeless adults were also younger, better educated, more likely to be unemployed, and substantially poorer than their counterparts from the 1950s, 1960s, and 1970s.[2,17,33]

Homelessness was also defined early in the 1980s as a mental health problem.[42] Indeed, persons with mental disabilities and histories of psychiatric hospitalization

*A pragmatic solution that considers the definitional preferences of individual researchers while enhancing comparability across studies is increasingly used. Because the lack of access to and control over stable housing is the single most universal identifying characteristic of homeless persons, homelessness is conceptualized as the extreme pole on the continuum of residential marginality. Researchers are encouraged to specify precisely where their study population is located along the continuum.

were overrepresented among the homeless.[35,43–45] These findings prompted emergence of a new stereotype of the homeless person as a single psychotic adult.[1]

In the mid- to late 1980s, a second generation of studies with more rigorous and defensible methodologies was conducted. Some studies confirmed and further detailed the heterogeneity of the "new" homeless, whereas others estimated the size of homeless populations in varied geographic areas.[32,46–53] Generally, they drew on more rigorous and conventional methods of sample selection, from a greater number and array of sites, including meal programs, drop-in centers, jails, and the "streets." In addition, they used standardized instruments and other assessment techniques to assess physical and mental health status and alcohol and other drug use. Several studies used nonhomeless comparison groups.[46,54–56] Although these refinements led to increased documentation of diversity of the homeless population,[15,46–48,57] most focused principally on mental health issues.

As indicated, many reports on high rates of mental health problems among homeless persons have been forthcoming.[33,43–45,58–59] This, in turn, has evoked great concern that the deinstitutionalization movement has been a national failure.[9] It evoked also a vigorous polemical response from others who disputed the stereotype that all or most homeless persons suffered from chronic mental illness.[38,60]

Because varied methods were used and because rates of specific mental health problems in a shifting population were not consistent across studies, the specific prevalence of mental health problems among homeless persons was virtually impossible to estimate. Not to be gainsaid, however, was the fact that homeless persons consistently demonstrated higher rates of mental health-related problems compared to nonhomeless groups. This relationship held for homeless men, women, adolescents, and younger children.[35,58]

Contrary to some previous claims that persons with severe mental illness constituted up to 95% of the homeless adult population,[35] severe mental illness did not apparently characterize the *majority* of homeless persons. Even among persons with severe mental illness, their disability alone was often not sufficient to explain their homelessness. In addition, second-generation studies identified severe mental illness as only one of many conditions that contributed to a person's vulnerability to homelessness. These newer findings instigated an enlivened, politicized debate on the multiple causes of homelessness.

Popular perceptions have, nevertheless, endured.[1] As Koegel and Burnam observe, "the homeless mentally ill have captured the attention and interest of the public to such an extent that in spite of the marked diversity characteristics of today's homeless population, a single image—that of the floridly psychotic street person—has eclipsed all others and mistakenly has come to represent the population as a whole."[12]

Toward the end of the decade, a third generation of homeless research emerged that was more likely to be theoretically informed and to use rigorous techniques. These studies often focused on special populations (such as families or persons with severe mental illness) in order to explore the relationship between their unique characteristics and experiences and the course of homelessness. Often the homeless were compared with other poor populations.[56,61–62] Longitudinal studies on the course of homelessness and its impact on physical and mental health were also initiated during this time.[30,63] Subpopulation studies, such as homeless street people with serious mental illness, have become more prominent, particularly in service demonstrations.[64] And where individual homeless persons were still the object of interest, findings were more likely to be interpreted in a broader socioeconomic context.

Political Implications of Research Paradigms

Research in this area during the past decade has not been a value-free enterprise. Most studies during the early 1980s were not formally theoretical in their presentation. Nevertheless, description was often confused with explanation, and many publications and reports indulged in highly ideological interpretations of causes of homelessness based on limited empirical data. Often nonexplicit but underlying theoretical perspectives suggested either social selection or social causation as fundamental etiological mechanisms for homelessness.[65] On one hand, some researchers attributed the fundamental cause of homelessness to the individual, whose personal mental disability or alcohol or drug use allowed him or her to drift into homelessness (i.e., social selection). On the other hand, in an attempt to move away from what appeared to be a "blame the victim" posture, others placed the principal causes of homelessness at the structural level, including lack of affordable housing, insufficient welfare benefits, and a changing labor market (i.e., social causation).

Implications of these competing interpretations are important because strategies for change often draw from perceived causes of homelessness. The social selection perspective suggests that individual-level interventions such as reinstitutionalization or other clinical treatment of individuals may offer a solution to widespread homelessness. On the other hand, social causation suggests that structural factors must be targeted. More recently, a synthesis has emerged suggesting that homelessness is likely the product of a dynamic interaction between structural conditions and individual vulnerabilities.[2,31,66] Structural conditions must be changed to create a context in which individual-level interventions will have significant impact.

Morse[17] has identified etiologic forces at six levels of social organization: *cultural* (such as the forces of racism or sexism), *institutional* (such as the crisis in low-income housing, the structure of the labor market, or deinstitutionalization), *community* (such as local norms and policies), *organizational* (such as the characteristics of local public service systems), *group* (such as the disruption of family of origin or social support systems), and *individual* levels (such as mental disability or alcohol or drug abuse). The interplay of multiple factors is reflected in the profiles of homeless individuals, families, and children presented throughout this book.

STRATEGIES FOR CHANGE

Information and analysis in the preceding chapters promote a view of homelessness as a social phenomenon largely the consequences of national social and economic policies. In this connection, Morse and Calsyn[18] suggest that just as the causes of homelessness are multidimensional, so must be the interventions to prevent or reduce homelessness. Clearly, the prevention and amelioration of homelessness will require intervention at all structural levels, including reinforcement and expansion of service systems for low-income persons.

Gaps between Need and Available Resources and Services

Preceding chapters refute the perception that homelessness results from homeless persons avoiding or rejecting plentiful services and support. Homelessness is a product of inadequate housing and social programs and services. Research on assessed needs and service utilization by homeless persons reveals that programs and services are often unavailable, inaccessible, or inappropriate.[17]

Consistently, the prevalence and severity of health and mental health problems are documented to be greater among homeless persons than the general population.[3,6,11,20,25,29] But despite their apparent greater need, homeless individuals face greater barriers to medical, mental health, alcohol and drug treatment.[6,11,29,67] Access to the most basic services such as emergency shelter, social welfare, or other programs is inadequate.[4,17,29,68]

Those with serious alcohol, drug, or mental health problems face additional barriers to basic services.[4,17,29,68] Staff members of public and private programs may exercise discretionary power in determining whether a potential client may receive services.[17,69] In this case, "creaming" occurs, that is, in competition for scarce services and resources, homeless clients who are more functional or compliant or who exhibit "potential" are more likely to be served, whereas "problem" clients are more likely to be excluded. For lack of access to more appropriate service systems, those with serious mental disabilities may end up in jails rather than in stable housing or in appropriate treatment facilities.[7]

Highly Tailored Interventions

Researchers and services providers argue for the development of highly tailored interventions when providing services to homeless persons. This would include adaptation of traditional services to the unique needs of homeless individuals. Brickner and his colleagues, for example, suggest that tailoring medical services may require substituting interdisciplinary teams of nursing, medical, and social work professionals in place of the traditional physician–patient relationship.[6] Services must also be developed that focus on the unique needs of subgroups. For example, Wilhite recommends special detoxification services for homeless persons with extensive histories of alcohol abuse.[29] Institutional changes are also recommended. For the chronically mentally ill, Shore and Cohen[24] call for reorganization of urban mental health service systems under a central authority with administrative, fiscal, and clinical responsibility.

Although specific programs must be developed, there is a danger in overspecifying target populations for intervention. In the allocation of limited resources, difficult decisions must be made between targeting particular subgroups or targeting structural factors that have a broad impact across the homeless and other poverty populations.

One product of the documented heterogeneity over the decade is the identification of sympathetic or "deserving" groups[10] to receive special or accelerated interventions. These include children in families, domestic violence victims, elderly individuals, veterans, or persons with severe mental illness. Less sympathetic groups include young, single males, especially from minority groups[10]; unattached women[16]; unaccompanied youth[20]; and persons with alcohol- or drug-dependency problems.[29]

In sum, although immediate needs must be met and target populations must receive special interventions, it is also important to implement policies that have a long-term impact on housing, employment, and social services.

Linking Housing and Service Delivery

Housing is clearly the single most obvious need of homeless persons, and many related problems of the homeless would be less acute if adequate and stable housing were provided.[70] Yet, despite the importance of housing, Leavitt suggests that be-

cause of the complexity and diversity of root causes of homelessness, housing should be considered a necessary but not sufficient response.[14] However, once a person is housed, meaningful social, mental, and physical health interventions can build on the stability and safety that housing represents.

A Centralized Federal Effort

Federal intervention is clearly needed. As Morse[17] points out, because of the pervasiveness and persistence of homelessness in the United States, substantial resources, great political will, and a comprehensive plan are needed.[71] Only the federal government has the authority and resources for such an undertaking. To implement a plan of such scale, perhaps one person must be invested with the authority and responsibility to monitor, coordinate, and integrate homeless programs. Coordination and efficiency are particularly critical in these times of tight domestic budgets. A combination of federal leadership and money together with local energy, commitment, and creativity are needed.

Any comprehensive federal plan must be founded upon an adequate supply of decent and affordable housing. As Leavitt states, the nationwide crisis in affordable housing is due to gentrification, abandonment, and the federal government's failure to fill the gap between low-cost units available and units needed.[14] Until affordable housing is available, efforts to provide services for homeless persons will focus on symptoms rather than broad socioeconomic conditions. As Hartman notes, entitlement to such housing for the poor is missing, in contrast to homeowners who have the advantage of income tax deductions for mortgage interest and property tax payments.[72]

Other elements in a comprehensive plan would include universal health insurance[11]; education and job training to help workers adapt to changes in the labor market[15,32]; restoration of welfare entitlements, and an increased pool of eligible recipients.[10,32] Provision of family support services and other efforts to reduce family poverty[3,15]; and tailored support programs for individuals with mental illness and alcoholism and other drug problems must also be provided.[5,24,29,57]

A final element in a comprehensive federal program is research and development. We simply do not yet know enough about the course of homelessness; the differential experiences of women, men, and children; racial and ethnic differences; adaptation and survival strategies; or patterns of alienation from society. Nor have we adequately documented the relationship of homeless and other poor people to prevailing systems and institutions, including housing, medicine, law enforcement, welfare, education, and religion. Continuous evaluation of the efficacy of various new services and programs by critical observers and feedback to planners and implementors are essential. Also needed are further studies of the impact of homelessness on individual health and mental health, on family stability, and on the larger community. Wherever possible, researchers should work closely with service providers, policymakers, and the public to ensure that planners and decision makers working to bring about change are informed.[72]

The most important federal legislative effort to assist the homeless to date is the McKinney Act, passed as an emergency response to the growing national crisis. It is a promising first step.[71] Besides funding services and research, it establishes an Interagency Council on Homelessness to coordinate, monitor, and improve the federal response. The Department of Housing and Urban Development (HUD) is the lead agency for the 15-member council of federal agencies.[71] McKinney funds are

being used to support the national Health Care for the Homeless effort in many cities.[11]

Additional federal programs have been initiated that serve narrowly defined target populations. For example, the Department of Veterans Affairs implements a program to assist homeless veterans with chronic mental illness.[73] Promising collaborations between federal agencies have also occurred. For example, the National Institute of Mental Health and HUD have worked together to provide supportive services in housing for adults with serious mental illness.[74] Unfortunately, however, despite their promise, existing federal programs do not yet constitute a sufficient response to the crisis.

Private Efforts

One major accomplishment of the 1980s has been the development of an extensive network of emergency food, shelter, and health services for the homeless poor.[31] Much continues to be done for homeless persons by a caring public through nonprofit and religious organizations, including the Robert Wood Johnson Foundation, the Pew Memorial Trust, United Way, the Salvation Army, the Catholic Worker, and many other large and small organizations.[11,24,75–76]

Ironically, however, during a period of decreasing federal support for social programs, tax benefits for charitable contributions have also been reduced, making it more difficult for the public to donate to nonprofit agencies, and consequently limiting the work that charitable organizations can do at a time of increasing demand.

Another achievement of the decade has been increasing involvement of the homeless poor in advocacy efforts on their own behalf.[31] Multiple collective responses by homeless persons have occurred, including squatting in abandoned buildings to accomplish a political agenda[28]; organization into homeless unions or other political groups; class-action litigation[4]; and participation in client-run shelters. Again, despite their successes, private efforts are no substitute for a comprehensive, integrated federal plan.

FINAL WORD

This book has attempted to describe a complex social problem that must be addressed at the broadest social, economic, and political levels. A major issue often overlooked is that resolution of problems of homelessness will take years of planning and hard work and a massive mobilization of human and financial resources. Forces that contribute to widespread poverty and homelessness have been operative a long time[2] and countering their effects in this era of increasing federal and local deficit spending will also take a long time.

Widespread homelessness is a serious social problem in itself, but it is also symptomatic of the failure of basic domestic programs such as housing, education, and social welfare. Viewed from a national perspective, the organization of programs sufficient to resolve a crisis of the proportions of homelessness will require a great effort. The practical problems alone related to the mobilization and direction of the national will, financing and organizing such an effort, and integrating public and private efforts are staggering, to say the least.

Given the current recession, the increasing federal budget deficit, and the most

recent commitment of national resources to the Persian Gulf War and its aftermath, new domestic initiatives on behalf of the poor and the homeless appear unlikely to come from the federal government at this time. Although there is evidence that the conscience of the nation has been stirred by the enduring presence of homeless individuals and families in our communities, we must acknowledge that the nation is not yet mobilized sufficiently to eradicate this great social problem. Until there is a federal commitment to ending homelessness, we will continue trying to resolve the national problem of homelessness one person at a time.

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