Chapter One: The Literature on Homelessness

Most of the popular notions of homelessness are traceable to studies by sociologists, psychologists and psychiatrists, that have detailed the social and demographic characteristics of the homeless, with a primary focus on their *deviant* characteristics. For example, some have sought to determine whether homelessness is "primarily a mental health problem" (Bassuk, Rubin & Lauriat,1984), or a result of some other defect of individual persons, such as criminality, substance abuse, antisociability, or "disaffiliation" (Bahr, 1968). Others, including advocates for the homeless and the homeless themselves, have maintained that homelessness is better understood as a consequence of the unjust distribution of social resources and power, evidenced by the unavailability of affordable housing, the inadequacies of social insurance programs, the inaccessibility and low quality of employment opportunities and health care (Mowbray, 1985; Ropers, 1988). In order to better understand this debate, some of the literature on homelessness will here be reviewed, and its merits assessed, both as research and as public statements on the homeless problem.

For the purposes of this review, the literature on homelessness is divided into two sets of studies, "defect" studies and demographic studies. "Defect" studies are those reports that focus on the individual malfunctioning or incompetencies of homeless people. In addition to these more individualistic studies, there has been a larger number of reports commissioned by state and city governments that are more demographic in nature, and that have had the goal of establishing the size and location of target populations of homeless for social services. These two sets of studies, the defect and the demographic, are enlightening as to some of the population characteristics of the homeless and how the population has changed rather dramatically since the 1950's and

1960's. Many of these studies are also revealing of the unfortunate biases that have guided various investigations. But the basic insufficiencies of existing reports, which this research project will attempt to resolve, are that 1.) they have failed to provide us with much demonstration or information as to how homelessness is connected historically to the production of social and economic inequalities, and 2.) they shed little or no light on the more focused concerns of how becoming homeless and being homeless are experienced by homeless people, and how those experiences are mediated in the context of family, work and social relations. Both sets of studies, defect and demographic, will here be reviewed for a better understanding of who the homeless are, and what has been said about them.

The Demographic Profile of the Homeless

Some Historical Background: From 'Skid Row' to the New Homeless

Many researchers have done detailed surveys and ethnographies of "skid row" at various times and places in the history of the United States (Bogue, 1963; Bahr, 1968; Bahr & Caplow, 1973; Wallace, 1965; Spradley, 1970; and Anderson,1975). Along with journalistic ventures into the "subculture" of the indigent, these sources combine to provide a wide and interesting , but often decontextualized view of the underside of America's labor and housing markets, the fallouts or dropouts from the social and economic "safety net." One can learn from these works the social classifications of "row" members such as tramps, bums, meth-drinkers, working stiffs and mission stiffs, or the language, the habits, the drinking traditions, and the socialization experiences of urban skid rows. They paint a tragic and painful portrait of social isolation and deprivation, but one with its own networks and rudimentary social organization. Oftentimes there are portrayals of a romanticized vision of life as a tramp, bumming and conning an existence through the missions, the jails and the box-car countryside

(Spradley, 1970). And along for the ride has travelled the interested sociologist, followed more recently by the discerning psychiatrist:

> Whatever else he may be, the skid row man is not his brother's keeper. Nor his brother's opinion-leader, norm-enforcer, or action-initiator...Therein lies skid row's fascination for the sociologist. For the price of a subway ride, he can enter a country where the accepted principles of social interaction do not seem to apply (Bahr &Caplow, 1973, p. 10).

As exciting as a research setting that it might provide, by the end of the 1960's, "skid row" and its researchers were falling out of fashion as a reservoir for "hard travellin'" tales. Skid rows were on the decline, making way for urban gentrification projects, and leading some close observers to comment that they would soon disappear altogether (Bahr & Caplow, 1973).

From 1949 to 1972, the Bowery in New York City, perhaps the nation's most famous skid row, declined in population from 13,675 to 4,152, with no signs of regaining its population (Bahr & Caplow, 1973). In a survey of skid rows in forty cities across the country, Bahr and Caplow report that 24 of those cities had declining skid row populations, with 3 stable, 1 increasing, and 12 for which information could not be obtained. All of the data is not the most reliable, with some of it based on the unsystematic observations of city officials or academics, but it does reflect a growing consensus at the time that skid row areas of cities were losing their visibility and their position as a focus of social concern. Medicare, changing elder housing placement policies, a loosening of social security eligibility requirements and an increase in benefits, a declining economic function for skid row in the urban labor and housing economies, and urban redevelopment programs, have all been attributed with causing the decline in skid row neighborhoods (Bogue, 1958; Bahr & Caplow, 1973). "Skid row," as a geographic region in central cities, was being taken over by higher priced offices and

housing developments, often whole areas were subject to demolition, and the social niche they provided was replaced by a geographically dispersed network of lodging houses, elderly housing, and shelters, if they were replaced by anything at all.

It is important to note that the phenomenon we best know as "homelessness" in the 1980's is not at all synonymous with what was then known as "skid row," though that is what is commonly assumed. As will be shown in this chapter, the more recent research shows that today's homeless are both demographically and definitionally distinct from those people who inhabited skid row in the 1950's and 1960's, further evidence that the former skid rows and the functions they served, were at an earlier time on the decline. Skid row referred to a *place* where poor people, usually single adults, mostly men, and marginal immigrant groups, found cheap housing in shelters, missions, lodging houses, and cheap "flophouse" or cubicle hotels. While the term "homeless" was always equated with this group, it was usually because the people resided in an area characterized as residentially unstable, and socially isolated, though many, if not most of the "homeless," might still be *renting their own rooms.* Studies designed samples on the basis of geographic areas known as "hobohemia" or "skid row." Contrasted with past definitions, homelessness today is rarely if ever localized to a specific residential area of a city such as "skid row," and *never* refers to people who have *rented rooms* as homeless, unless they actually combine periods of temporary rental with the use of emergency shelters.

The disappearing reference to and research on urban sections known as "skid row" in the 1970's is itself evidence of the declining presence of that type of "homelessness." Skid rows were disappearing, as is notable in the decline in registered Single Room Occupancy units (SRO's) and rooming houses. Hopper and Hamberg (1987) report that from 1970 to 1982, 1,116,000 single-room units, nearly half of the total stock, disappeared nationwide. "Many cities lost more than two-thirds of their rooming units (Green, 1982; Paul, 1981; Werner & Bryson, 1982)" (p. 23). In Boston, between

1950 and 1985, the stock of registered single rooms for rent declined from over 28,000 to under 3,000 - a dramatic loss of 25,000 units (Flynn, 1985)! Most of these units were concentrated in the South End, Back Bay and Beacon Hill, now three of the most expensive residential neighborhoods in Boston. Since 1970, the housing stock of single rooms in Los Angeles has similarly been halved (Rossi,1988).

This decline of skid rows occurred not only at a time when gentrification programs besieged central city areas, but also when skid rows were themselves experiencing high vacancy rates. For example, Bogue (1963) found in Chicago that high vacancy rates in SRO's and cubicle hotels, as well as a decline in the economic functions that skid row served, such as widescale casual labor, were contributing to the declining prominence of skid row in the 1960's. As industry moved out of the central city areas, so did the relevance of skid row communities to the city's economy. This is corroborated in Boston, where the bulk of rooms in rooming houses that have been lost to demolition or conversion disappeared *before* 1970, a decade before the city's more recently documented boom in homelessness.

Hopper and Hamberg (1987) report that during the 1970's some of this rooming house population became homeless (defined as living in shelters and on the streets as opposed to rented rooms) as a result of declining marginal housing supply, and others became homeless in the 1970's through failures in community programming for the deinstitutionalized mentally ill. But if shelter capacity is taken as a rough indicator, throughout the 1970's two shelters with a combined total of 487 beds handled the housing emergencies of the city of Boston, while the 1980's saw such demand for emergency shelter that in 1987 nearly fifty shelters provided emergency overnight housing for over 2,600 people every night. Similarly in Philadelphia, until 1980 there were only 500 beds available for emergency shelter, while by 1987 that number had grown to

5,600.

Many tenants were involuntarily displaced by SRO conversions before 1970, and some undoubtedly became homeless as a result. But the later wave of homelessness in the 1980's, and the very different demographic profile that it presents, suggests that there was a significant lagtime before the effects of displacement and shrinking affordable housing options would begin to be most evident in this new form of homelessness. A hidden housing problem with overcrowding and increasing housing expenses was slowly building into the urban landscape as a result of many factors, including the disappearing skid rows, and without the marginal option of cheap housing that they provided, a new kind of homelessness was inevitable under the declining incomes and the rising housing expenses of the late 1970's and through the 1980's.

Comparing Skid Row With the Current Homeless

The evidence suggests that indeed skid rows did decline significantly by 1970, along with many of its residential institutions. However, while skid row as a *place* was starting to fade into American history, as has been said, a new wave of "homelessness" was soon to follow. And while some of the old population of "skid row" is to be found among the current "homeless," the old skid row population and the new homeless of the 1980's are *not* interchangeable. There are some very distinct and important differences between the two, which this section will attempt to detail.

Before beginning this review, it is notable that most of these demographic studies are based on samples obtained in two or more shelter sites, with one by Rossi, et al. (1986) attempting to interview all of the homeless in Chicago, both those staying in shelters and on the streets. The studies are all based on fixed alternative questionnaires, so the depth of information that they can provide is limited. However, because samples generally included several hundred, and in some cases several thousand subjects, these studies do help guide an understanding of the prominent social groups recently found among the

homeless, which is the purpose of this review. Some of the demographic studies have sample selection biases, as a result of focusing on particular shelters, and most have undersampled single women, both with and without children. The sampling biases are somewhat moderated by the large number of subjects, and the repeated observations across cities, when considering the case of single men. However, since many homeless families, who are staying in hotels and motels, are not always sampled or well-represented in shelter surveys, and since the case is often the same for single women without children, the demographic studies are not as informative about these groups. And, of course, because these are demographic studies, they do not inform us much about how homeless people became homeless in the context of work, family and social relations, nor how homelessness is connected to the historical production of social and economic inequalities. Despite these limitations, consistent findings from these surveys are suggestive of trends in the population that are important, and which will be discussed below.

First, as has already been suggested, "homelessness" today is a term restricted to people who have *no* private room or apartment whatsoever, and does not include cubicle hotel or rooming house residents. The "homeless" of today must rely on welfare subsidized hotels for families, public shelters, private charity or profit-making shelters, public buildings and waiting areas, abandoned buildings, or the streets. A minority of the old skid row's members relied on missions or religious shelters for sleeping; the vast majority stayed in cheaply rented rooms or flophouse hotels (four out of five by Bogue's exhaustive count in Chicago); few ever actually lived on the streets. In fact, Bogue in 1958 found only 110 people sleeping on the streets of Chicago, out of the 12,000 "homeless" he counted, or fewer than one percent. Blumberg, Leonard, et. al in 1960 found only 64 among Philadelphia's 2,800 members of skid row sleeping on the streets, or about 3%. In contrast, a recent study in Ohio (Roth, et. al, 1985), found

16% of the homeless sleeping on the streets. In a Phoenix study (Brown, et al.,1983), based on two samples collected in soup kitchens, one sample reveals 48% sleeping on the streets, and a second sample, after two shelters are instituted, finds 14% sleeping on the streets. Though the homeless sleeping on the streets continue to be a *minority* in the recent surveys that have been reviewed - a fact that is conditional on the availability of emergency shelter and the condition of shelters - the remaining homeless documented in most of the demographic studies are not concentrated in rented rooms or cubicle hotels as Bogue (1958) and Blumberg, et al. (1960) found, since those have come to be definitionally excluded from the label "homeless." Instead, they are staying in public and private shelters, places with large open rooms that have anywhere from 20 to 2000 beds. Hence, the definition of homelessness today is restricted to a group of people who are much more shelter-needy than the old members of skid row, sleeping primarily in congregate shelters, on the streets and in other public places, as opposed to single rooms and cubicle hotels and flophouses. None of the current studies have identified rooming house or SRO hotel residents as "homeless."

As has been said, this definitional restriction of "homeless" has accompanied declining forms of "intermediate" types of housing, that is, between shelters and standard rental apartments. It would seem to suggest that escaping "homelessness" involves a bigger leap in accommodation than existed in the varied arrangements of skid row. In the times of skid row, one might sleep on the street or in a mission until one could earn a week's rent on a room. Now, working for a week is not likely to get someone a room, both because the cheap SRO's and flophouse hotels have largely disappeared, and because rooms are most likely to be found in apartments rented monthly that cost considerably more and require large deposits in advance. The fact of a widening gap between the homeless and the "homed" is related to a second distinguishing feature of today's homeless - shorter

periods of homelessness, but with more repeated episodes.

Though it may be an artifact, or direct result, of the above mentioned deterioration of skid row areas and the accompanying definitional restrictions, the homeless today are more likely to become homeless for much shorter periods of time than the former residents of skid row. Moreover, they are also very likely to report having been homeless before. "Length of time homeless" was less of a consideration in earlier "skid row" research; however, we do know that in Bahr and Caplow's 1966 survey (1973), that *more than half* of the Bowery members were residents of skid row for *over 10 years*. This compares with recent studies that found 60% of the Phoenix homeless as "homeless" for *less than 6 months*, and only 12% of them homeless for more than two years (Brown, et al., 1983). In an Ohio sample (Roth, et al., 1985), 49% report having been homeless *less than* 60 days, 74% less than a year, while only 15% have been homeless for more than two years. Similar findings in New York and Chicago confirm that the more recent and narrow definition of homelessness, which has accompanied the decline in skid row areas, has restricted the application of the "homeless" label to relatively short-term, emergency situations - those in shelters and on the streets - though long-term homelessness certainly still exists and may yet develop among those now included among the short-term homeless. Particularly since these studies have undersampled families, and since families are often harder to place in housing than single adults, the median length of homelessness may be potentially longer, and is subject to change over time. (The fact that "length of time homeless" was not a primary concern in earlier studies of skid row is probably due to researchers' nearly universal view of residence on skid row as a stage in the development of a relatively permanent 'skid row career.' While there was evidence that some used skid row as a means of departure to other sectors of the housing and labor economies, for most, and what was the major fascination for the researchers, residence on skid row was a sign of

one's dependence on, or entrapment in, a "subculture" of homelessness.) Again, the disappearance of skid row areas partially explains the aforementioned narrowing of the definition of homelessness to more emergency situations, leading the "length of time homeless" issue less likely to reveal a career of living as "homeless." Moreover, if the the decline in skid row areas is seen as creating a wider gap between the "homeless" and the "homed," with fewer, and less affordable options for single residency in between, then one would also expect greater difficulty in obtaining a permanent exit from emergency situations and into secure, permanent housing. The finding that many people report having been homeless before - 58% in Minneapolis (Piliavin & Sosin, 1988) and 35% in Phoenix (Brown, et al., 1983) - suggests just that. Homelessness is now a status which people typically move away from, though not always permanently, and apparently the homeless exit into housing situations that may remain highly vulnerable to future episodes of homelessness.

Definitions and characteristics of peoples' homelessness are not all that mark important differences between the old skid row and the new homeless. *Who* becomes homeless is also *dramatically* different. First consider the age of the homeless. Nearly half of the Bowery population (46%) studied by Bahr and Caplow in 1966 was *over* 55 years of age, with similar proportions of older adults among the homeless reported in other cities: Sacramento 51% (Western Real Estate, 1957), Chicago 40% (Bogue, 1958), Minneapolis 59% (Caplow, et al., 1958), and Philadelphia 45% (Blumberg et al., 1959). Among the first studies to document a declining age among the homeless was the New York State Senate Democratic Task Force on the City of New York, which in its 1976 report on the "Shelter Care for Men" found that from 1969 to 1975 the median age of shelter users dropped from 43 to 38. More recently however, municipal studies of the homeless indicate that the median age has fallen even more deeply into the prime years of

adult life: in Phoenix, 58% of the homeless are below the age of 40, 30% below the age of 30 (Brown, et al., 1983); in New York City - 63% are below the age of 40, 28% below the age of 30 (Hoffman, 1982); in urban Ohio - 61% are below the age of 40, 35% below the age of 30 (Roth, et al., 1985); in Minneapolis - 63% are below the age 35, 21% below the age of 25 (Piliavin, et al., 1988); and in Chicago, 66% are below the age of 45, and 39% below the age of 35 (Rossi, et al. 1986). In general, the median age of the homeless has fallen more than 20 years, to about 32-35 years old nationwide, with one study showing homeless blacks to be younger than whites (First, Roth & Arewa, 1988).

This shift in age, toward a much younger homeless population as opposed to the elderly one that characterized the days of skid row, is a very important development, and is not given the recognition in the literature that it deserves. The following chapter will explore in detail the socioeconomic reasons for the increasing risk of homelessness among young adults, but for now, some brief things could be said about reasons for a decline in *elderly* homeless. Census data indicates that the poverty rate among elders has declined from 25% in 1968 to 13% in 1985, an increasingly well-known consequence of the efforts of the "War on Poverty." As a result of "Great Society" reforms, social security benefits were indexed for inflation by statute. In other words, while benefit programs such as Aid to Families With Dependent Children and General Relief have been allowed to deteriorate substantially against inflation since the the early 1970's, social security is adjusted for increases in inflation annually, such that benefits have risen 162% since 1968, with an expanded range of persons covered. Accompanying an increase in cash benefits to the elderly has been expanded access to housing, and to health care through the Medicare program. The successes in lowering the poverty rate for the elderly, though far from complete, has shown how effective entitlement programs can be in improving living standards, when given adequate political and financial backing. This lowering of

the proportion of elderly among the poor is one reason for the increasing proportion of poor that are young adults, and other reasons shall be considered in the next chapter.

Another shift in population between the old skid row and the new homeless is the disproportionate concentration of blacks found among the new homeless. Blacks accounted for only 14% of the homeless in Sacramento in 1957, a mere 9% in Chicago in 1958, 3% in Minneapolis the same year, and a high of only 27% in New York's Bowery (Bahr & Caplow, 1973). Today, however, race is a far more important factor in homelessness. Black Americans now constitute a majority of the homeless in Chicago (53%) (Rossi, Fisher & Willis, 1986), a majority in New York City (64%) (Hoffman, et al., 1982), a rather substantial majority in Philadelphia (85%) (Ryan, Bartelt & Goldstein, 1989), and significant minorities in Minneapolis (26.2%) (Piliavin & Sosin, 1988), and urban Ohio (34%) (Roth, et al. 1985). So, equally as striking as the decline in age, has been a sharp rise in the proportion of blacks, representing a disproportionate concentration than demographics in the respective cities would suggest, sometimes accounting for as much as 1.5 to 3 times their number in the general population.

The dimension of the homelessness problem for minorities has also been largely ignored in the literature. Reasons for increasing numbers of blacks among the homeless will be explored in the following chapter along with explanations for homelessness among young adults, but the failure of research to effectively communicate this shift in the population should be noted. It should also be pointed out that the presence of other ethnic and racial minorities among the homeless has not received much attention either. Informal reports suggest a strong regional distribution of ethnic and racial composition, with Hispanics and Native American Indians counting highly among the homeless in the southwestern states, much along the same lines as the breakdown for poverty rates in that region. Future analyses could explore the extent to which ethnic and racial breakdowns for the homeless are the same as, or differ from, regional figures on poverty.

An increasingly well known fact about today's homeless, that is only recently receiving more attention, is the extent of employed people found among the homeless. A recent front-page story in the *New York Times* , headlined "Belying Popular Stereotypes, Many of Homeless Have Jobs" (Schmalz, 1988), is indicative of the growing awareness that today's homeless are not what common images of the skid row, alcoholic bum would suggest. Not that the image of skid row members as a group who never worked was ever correct, however. Bogue (1958) and others repeatedly tell of the important role skid row members played in local labor markets, and how their labor was exploited in similar ways and by similar brokers, as it is today. Bahr and Caplow (1973) reported that between one-third and one-half of the skid row population worked, typically at "menial" jobs. The recent *Times* story notes that the United State Conference of Mayors, using information supplied by city offices across the country, reported in 1987 that 22 percent of the homeless surveyed in shelters had full- or part-time jobs, up from 19 percent the year before. The number is expected to increase again this year, as shelter providers continue to report that more and more homeless people are working and living in shelters. Many shelters now specialize in serving *only* working homeless people, and many more have subdivided shelters by employment status. Functionally, at least, some shelters are in fact dormitories for a segment of the low-waged workforce.

The demographic studies corroborate this finding about "working homeless," with all of the studies finding significant segments of the homeless working, with the substantial majority reporting having worked before. The most frequent pattern of a work history is of a sporadic attachment to the labor force, or, conversely, the job market's sporadic attachment to them. Besides some facts about how long or how frequently people have worked, there is little data about the kinds of work homeless

people have done or are doing, or the kinds of wages they receive. Nor do we know much about how they choose work options or view those options available to them. In the New York City study, 77% report working before, 27% steadily employed, 50% sporadically employed. Thirty-six percent report working steadily in the last year. In Ohio, Roth et al. (1985) found that 25% of the homeless had jobs in the last month - half of those in day labor pools, half in steady jobs. Still yet another 25% report having worked in the last year, making the total proportion of homeless that worked in the last year about 50%. When asked for reasons for unemployment, the most common answer (30%) was that they can't find work, with the second most frequent reason given being disability (13%). A small percentage didn't want to work (3%). In Phoenix (Brown, et al., 1983), 37% of the homeless usually support themselves through work or some combination of work, food stamps (21%) and the blood bank (27%). Seventy-nine percent have worked last year, 68% in the last six months, 40% in the last month. Most of the homeless from outside of Phoenix came to Phoenix seeking work. In Phoenix, a full 46% worked full-time in the last year, 30% in the last six months. A significant minority, 27%, are skilled laborers in Phoenix. However, the majority (55%), are unskilled or farm laborers.

The presence of workers among the homeless raises interesting questions about the wages and the quality of jobs which homeless people perform, as well as the fact that these are predominantly young minority workers, who have recently had very high unemployment rates, and who have historically had devalued status in the labor market, while supplying the surplus labor for that marketplace. The residential instability of this segment of the labor force serves important functions, particularly considering seasonal occupations such as migratory farm work, or the temporary placements required to meet worker absenteeism, strikes, and surplus orders. Anecdotal evidence and personal experience both suggest that a segment of the homeless spend time in

shelters during the off-season in farming, and that shelters have become *de facto* retirement and respite centers for some migrant populations. Even in northeastern cities of the US like Philadelphia, hundreds of people staying in the shelters board buses in the summer every morning bound for New Jersey, where they earn $25 a day picking peaches, apples, blueberries, cucumbers, tomatoes and other vegetables.

A well known difference between the homeless of the 1980's and the former population of skid row is the growing presence of families among the homeless. Unless one wants to refer to the times of the Great Depression or the Dustbowl, the problem of homeless "families" was virtually unheard of in the United States, and constitutes a startling and disturbing development in the 1980's. Many poor families with housing emergencies in the last couple decades have been placed in so-called "welfare hotels," but the extent of the problem grew alarmingly in the 1980's, and the "homeless" label was subsequently attached. The United States Conference of Mayors has reported that in a survey of city officials in 1987, 35% of the homeless being provided emergency shelter nationwide are families, accounting for 65% in New York City, and 60% in Boston. Families, especially those headed by solo parents, are the fastest growing group among the homeless, and if children had been represented in studies earlier reported on the declining age of the homeless population, the age would obviously be much further in the direction of youth. Because of welfare laws requiring emergency housing for families, homeless families are given more consideration in the provision of emergency accommodation - though that doesn't necessarily mean better quality - and are thus more likely to be found in hotels and motels, as well as a growing number of public and private shelters for families. Massachusetts, for example, had four state-funded shelters in 1982, while the state now supports over *100* shelters, the majority of which are for people in families (Loth, 1989). The Massachusetts state budget for emergency shelter provision is indicative of how the dimensions of the problem have grown, and how states

such as Massachusetts have become fully invested in resurrecting the Poorhouse. When Michael Dukakis became governor in 1983 the state spent $11.8 million on shelters, while in 1989 it will spend $254 million, a fact about which state officials frequently brag (see Loth, 1989). (It is worth noting that states are increasingly interested in supporting shelter development for families - they say because of their commitment to homeless people, though it is just as likely that they support shelters because shelters are usually "not-for -profit" and can operate for much less money than the daily rates charged at hotels and motels. Moreover, placing people in shelters is much easier than finding people housing.)

Municipal studies furthermore suggest that growing numbers of single women without accompanying children are also now found among the homeless, accounting for about 10-15% (Hoffman, et al., 1982; Brown, et al., 1983). Since studies have frequently undersampled single women without children, and because they have received such little attention in the literature, estimates of their rates of membership among the homeless are frequently not available or reliable. Ropers (1988) in a review of demographic studies across the country finds the lowest estimate of women at 4% in San Francisco, and the highest at 33% in Chicago, although the presence or absence of children is not indicated. This is an area deserving of much more attention in the literature, because as increasing notice is given to homeless families, most of which are headed by women, the issues and needs of single women without children should receive adequate consideration. The problem of single women who are homeless raises important concerns over the structuring of the housing and domestic environment in ways that devalue the choices of women, particularly women who don't attach to men or have children, or that structure women's choices within traditional roles upon which their housing is dependent. Furthermore, since housing is the primary center for sexual

relationships, the fragile nature of housing arrangements for single people and people who don't practice heterosexual preferences is of considerable importance in understanding the sexual dimensions of homelessness, for both men and women.

The presence of families and women among the homeless is part of the growing evidence, in addition to the growth in young adults and minorities, that some social and/or economic dislocations have occurred in the United States in the last decade, and perhaps having roots going further back than that. The demographic studies are important for this contribution, though they do not investigate what factors might be associated with these changes. Since comparable data from across cities is not available, with differing sample sizes and sampling procedures, attempts to explore any systematic relationships among variations in characteristics of homeless populations, with variations of other measures across cities, is difficult if not impossible to investigate. However, as the following chapter will show, population shifts can be used to ask questions about social and economic changes that might account for the prominence of certain social groups among the homeless.

Despite the fact that some of the demographic studies reveal sample selection biases, with an emphasis on shelters or shelter sites for men for their samples, consistent trends from across the country make a compelling case for accepting that dramatic shifts have occurred in the population, at least as compared to the days of skid row. Reiterating the important trends, remember that 1.) definitions of homelessness have restricted the term to apply to a much more shelter-needy population than skid row, to people mostly in shelters and on the streets; 2.) accompanying declining options for housing between shelters and standard apartments, the leap out of homelessness is larger; therefore, today's homeless are much more likely to report having been homeless before, or to enter vulnerable housing situations when exiting homelessness; 3.) with much more marginal, emergency housing considered "homeless" than during skid row, and considering other

changes in *who* becomes homeless, relatively few people are very likely to stay "homeless" in the shelters and on the streets for more than six months at a time, and are not as likely to establish a 'career' of homelessness; 4.) one such change in *who* becomes homeless that is likely to influence a change to shorter periods of homelessness, is that the population is much younger than during skid row, with the median age falling from around 55 years of age to 32-35 years of age; 5.) the homeless problem is increasingly a problem disproportionately afflicting minority groups, such as blacks, though the literature is not very illuminating about the dimensions of the problem for minority groups; 6.) a significant number of the homeless are working, another issue not well-covered or publicized, and much more needs to be known about the economic functions of the labor and wages of the homeless; 7.) homeless families, unheard of in the days of skid row, now account for 35% of the homeless nationwide, most of whom are solo mother households; and 8.) single women without children are also a growing group among the homeless contrasted with the days of skid row, though research in this area is very weak. In way of concluding this section on demographics, what was once a problem of elderly, white men, and known under varying names such as skid row and hobohemia, "homelessness" today is quite another problem, and has become a struggle predominantly facing young adults, workers, their families, minorities, and women. The full implications of these shifts has not received adequate attention in the literature, but they will be explored more fully as part of this study.

Defect Models: Pathologizing Homelessness

Defect or pathology models have tended to treat homelessness as a problem of individual persons whose health problems or incompetencies cause or sustain their homelessness. Such studies have investigated the prevalence of mental disorder, and the rates of alcoholism and drug addiction among the homeless. Yet, despite repeated efforts,

to seek services from the shelter system. Hence, it should be noted at the outset of this section on homelessness and mental illness that this *image* of the homeless as mentally incompetent people, living on the street, and consistently refusing efforts to help, has been applied to a majority of the homeless despite the fact that most of the homeless do not sleep in public, nor do they refuse social services, nor are they necessarily the subject of "visible" recognition as being homeless. In other words, this popular image of homelessness is highly reliant on the rather exceptional case.

The position that the homeless are predominantly mentally ill is not, however, only a consequence of media images and popular stereotypes. Perhaps guided by this popular image of homelessness, and by a recognition that an undetermined number of people became homeless as a result of "deinstitutionalization," a flurry of research efforts by psychiatrists, begun in the early 1980's, reported that many, if not the majority of the homeless in shelters were *also* mentally ill. It was, in a sense, the "discovery" of a psychiatric problem, within what was already being recognized as a severe "sheltering" crisis.

The scientific reports on the prevelance of mental illness among the homeless give *widely* varying estimates of the extent of the problem, ranging from 20% to 91% (Crystal & Goldstein, 1983; Bassuk, et al., 1984). While prevalence estimates have most consistently clustered between 25% and 35%, the tremendous variability in estimates is indicative of the methodological and diagnostic problems confronting studies of this type. For example, most of these studies have sample selection biases, as a result of sampling from a single shelter site, usually for single men. Homeless women and families, along with other residents from the diverse supply of shelter sites are not usually included in study samples. It is commonly known among both the homeless and providers of services to the homeless that homeless people are selective about what shelters they will stay in, and that administrative procedures at shelters very often

systematically exclude certain segments of the population. Consequently, any study that chooses a single shelter site for its study population is limited in the generalizability of its results, and potentially biased by the choices of homeless people and their service providers. The nature of the diagnostic process, too, introduces another potential source of bias in these studies, since the subjects are already stigmatized by their presence in a shelter; suggesting, at the least, that diagnositic criteria should be clearly specified, and reliability checks included to diminish the perception that the class biases of psychiatric professionals are entering into the judgements of lower class attitudes and behaviors.

It is worth examining more closely the two studies with the highest reported rates of mental illness among the homeless to better understand the methodological weaknesses of psychiatric research on the homeless. One of those studies, by Arce, et al. (1983), found the prevalence of mental illness to be 87% in their sample. Arce, et al. (1983) conducted their study in a shelter for *single men,* that screened 600 applicants for shelter and accepted 193 persons based on being judged "most in need" by welfare officials. The fact that this sample was biased in the direction of a greater proportion of disabled persons is also suggested by a commment by the authors that when establishing a shelter, "intensive screening to identify the *truly needy* who cannot make use of other community facilities must be part of the program structure" (p. 815, emphasis added). The authors did not determine diagnoses from interviews with homeless people, but gathered their data from admissions information that the authors themselves state was inconsistent: "the thoroughness of the records varied greatly" (p. 813). No further detail regarding measurement procedures or diagnosis is reported. Ropers (1988) comments with regard to this study, "What the findings are actually based on is anyone's guess" (p. 150).

Not only is the Arce, et al. (1983) study evidence of the methodological weakness of

these reports, but it is also a good example of the kind of high visibility that these reports have received. Ropers (1988) reviews this same article, and another by Lipton, Sabatini and Katz (1983), and notes that the *New York Times* did a story headlined "Studies Report Mental Illness in Most Homeless in 2 Cities" (Nelson, 1983), citing both of these reports as evidence of the claim. The article stated: "The vast majority of homeless people studied in two urban areas are mentally ill and many have a history of psychiatric hospitalization, medical researchers have found." The article failed to note *any* of the methodological shortcomings of the Arce, et al. (1983) study, and actually misreported that the study found a majority of the homeless as having previous psychiatric history, when in fact, the study could only document a rate of 35%. The other report by Lipton, Sabatini & Katz (1983) that was referenced in the *New York Times* article did its survey on homeless people admitted to *Bellevue Psychiatric Hospital!* An obvious case of sample selection bias, one would expect a high rate of diagnosable mental illness among homeless people going to a psychiatric hospital!

The highest rate of mental illness found among the homeless to date - and one of the most publicized - was by Bassuk, Rubin & Lauriat (1984) who claim to have found that *91%* of the homeless are mentally ill! This study was conducted in Boston under the authority of a psychiatrist from Harvard Medical School, and was published in the prestigious *American Journal of Psychiatry.* Again, this study was based on a single shelter site, and the sample was non-random. Though the authors report that the shelter population closely matched the demographic profile of the rest of Boston's homeless, the potential for a subject selection effect remains because only a single shelter site was studied. No specification of the diagnostic procedure and criteria are reported, other than to mention that standards from DSM-III were applied. Nor were any reliability tests of diagnoses done to check the potential bias introduced by the class positions of the psychiatric professionals, who were judging the character and behavior of a lower class

subject population already stigmatized by its presence in a shelter. In one respect, the study was an improvement over other studies since it included women and families. However, the prevalence rate reported by Bassuk, et al. (1983) of 91%, has never been replicated, and is nearly three times the rate that has been found in most other study populations (see Fisher & Breaky, 1986, or Ropers, 1988, for other reviews of studies on mental illness and the homeless).

An American Psychiatric Association Task Force Report on the Homeless Mentally Ill featured a chapter by Arce and Vergare (1984) reviewing the literature on the prevalence of mental illness among the homeless that has become a *widely* cited report of "expert opinion" on mental illness and the homeless. Based on their review of nine epidemiological studies, the authors conclude that "It is evident that in most universes of homeless people, between 25 percent and 50 percent have serious and chronic forms of mental illness" (1984, p.88). Ropers (1988) looks more closely at the nine studies that were reviewed and concludes the following: The first study was conducted in England in 1955, and Roper asks "What can it tell us about the homeless in the United States during the 1980's?" (p. 152). It consisted of a non-random sample of 100 males admitted to a *psychiatric unit*. The method of diagnosis is not reviewed. The second study was also done in the 1950's, and both the methods used to gather the data and the basis of diagnosis are unspecified. The third study, a 1970 study of a Bowery project for alcoholics, was based on 200 non-randomly selected admissions, and "The authors did not detail the exact procedures used to reach diagnoses" (Arce & Vergare, 1984, p. 81). A fourth study in 1971 interviewed men in hostels, and no review of methods is reported by Arce and Vergare (1984). The fifth study, a comparison of a British homeless population with one in Chicago in 1976, is not discussed by Arce and Vergare regarding "methods, sampling strategy, or operationalization and standardization of protocol" (Ropers, 1988; p. 152). The sixth study was the already mentioned report by

Lipton, et al. (1983) that had the sampling bias of diagnosing people admitted to *Bellevue Psychiatric hospital.* The seventh was a non-random, single shelter site study of Bassuk et al. (1986) that was not examined by Arce and Vergare at all for its methods. The eighth study was Arce's own flawed study reviewed earlier based on a sample of the "truly needy" as opposed to the "fake needy" (Arce, et al., 1983), and the ninth was a follow-up by Arce and Vergare of admissions to a shelter, with no discussion offered of the methodology in the review. On the basis of this "review" of the literature, it is amazing that any conclusion can be drawn regarding the prevalence of mental illness among the current homeless at all, but Arce and Vergare are comfortable suggesting that up to 50% are mentally ill, in most "universes" of homeless people.

Fisher and Breaky (1986) offer a much more thorough review of the study of mental illness among the homeless, and conclude that each study relies on a single service location, and that they "do not offer a rigorous or broad view" of the homeless population. Ropers (1988) is far more comfortable with a study by Farr, Koegel, and Burnam (1986) that found 28% of its sample to meet the criteria of severe or chronic mental illness (11.5% schizophrenic, 17.4% personality disorder, and 19.9% affective disorder, including duplications by dual-diagnosis), that had a random sampling strategy, and used the "diagnostic interview schedule," instead of the estimates of potentially biased psychiatric professionals. However, Ropers (1988) continues to question the applicability of psychiatric standards to the homeless, including the "diagnostic interview schedule," which assumes that psychiatric diagnosis can be determined through a "computerized algorithm." It would seem to be a legitimate concern that psychiatric standards for the "homed" population are being inappropriately applied to the "homeless" population, where potential judgments about disheveled appearance, anger, feelings of paranoia, and suspicion of interviewers and psychiatric

professionals may have quite another meaning than applies in more stable, less restrictive settings.

Aside from these methodological concerns, perhaps the issue of even greater importance in these studies is the interpretive one. Bassuk et al. (1984) introduce their research as attempting to resolve a controversy over "whether or not homelessness is *primarily* a mental health problem" (p. 1546, emphasis added,). In other words, the assumption is often made that if most homeless people are determined as suffering from poor mental health, that homelessness *is* primarily a mental health problem, and consequently, the *primary* solutions will be found in better mental health service delivery, or in the extreme interpretation, in institutionalizing homeless people, even if against their will. In a separate article in the *Scientific American*, Bassuk (1984) provides a clearer view of what is implied by the conjecture that homelessness is "primarily" a mental health problem. After discussing the potential influence of the recession, unemployment, the housing crisis, and government benefit cutbacks on the growing number of homeless people in the 1980's, Bassuk states that "Far more important, however, in its impact on the homeless population has been the long-term change in national policy for dealing with the mentally ill" (p. 41). Hence, though these other economic factors may play a role, they are secondary to the mental health issues. But even this sort of "systemic" analysis of the mental health problem seems to disappear as the author talks more specifically about how people become homeless. The author acknowledges that it may be too simplistic to argue that poor mental health, even when found, is always associated with a persons' homelessness. But rather than contextualizing the individual in a dynamic social and economic process, the author generalizes the identification of some deficiency in mental health with an overall failure in the life of the homeless individual:

There is usually no single, simple reason for an individual's becoming homeless;

> rather, homelessness is often the final stage in a lifelong series of crises and missed opportunities, the culmination of a gradual disengagement from supportive relationships and institutions (p. 43).

The previous review of the demographic studies has already shown that most of today's homeless are not "homeless" for extended periods of time, therefore, to suggest that their homelessness is the "final" stage of a lifelong pattern of personal failure is fatalistic, and prematurely consigns the population to the miseries of retirement in the shelters.

More importantly, the individualistic, "defective" bias of this interpretive process does not end with discussing how people might become homeless, but continues into the discussion of possible solutions. Bassuk (1984) is critical of the shelters because they aren't appropriate for the mentally disabled, many of whom "will never be able to live independently" (p. 44) - sounding like a suggestion for greater institutionalization of homeless people, though the living skills of homeless people have not been assessed in this study. Bassuk goes on to comment that "Shelters would be the *appropriate* solution if the homeless were simply the victims of unemployment, or of disasters such as floods and fires" (p. 44, emphasis added). Such a statement truly shows that the author does not fully recognize the influence of the crowded and violent shelter environment on the mental health of the homeless population, and the influence that that environment might have on findings from prevalence studies. However, it does fit within a de-contextualized view of homelessness and mental illness, as medical problems that precede arrival into the shelter system.

While better mental health services to the homeless may be desirable and necessary, this interpretation that homelessness is "primarily" a mental health problem, appears to be both overly generalized and overly simplistic. Losing one's home may be caused by

a whole range of problems, some of which might include inadequate mental health services or poor mental health, and some of which might be completely independent of the mental health system, though they may in turn have negative effects on one's mental health. Regardless of the cluster of reasons, simply identifying poor mental health among some of the homeless does not provide evidence that improved mental health services will alleviate the homeless problem or attack the root causes of either the mental health *or* the homeless problem. The flaw with this over-simplification can be illustrated with an analogy: because many homeless people will be found to have sore feet from standing in line for services all day does not mean that better shoes or even shorter lines will solve their homelessness, nor that homelessness is primarily a problem for podiatry. Why, then, has a psychiatric interpretation of the homeless problem been predominant in the United States in the 1980's?

First of all, it is not simply the biases of psychiatric experts that have led to the causal association between poor mental health and becoming homeless, though they have clearly contributed to this perception. The process of "deinstitutionalization," whereby patients from public psychiatric hospitals were discharged into the community, has led many to conclude that the mentally ill homeless are mostly products of this abrogation of responsibilties on the part of state mental health systems. Indeed, some people became homeless in the 1960's and 1970's as a result of failures in community programming for the mentally ill, though the extent of that phenomenon has never been determined. Many services were promised but never delivered to the formerly institutionalized. However, the fact that the deinstitutionalization process was complete well before the number of homeless requesting shelter dramatically increased in the 1980's, leaves a significant amount of time unaccounted for, and leads one to suspect that the recent homelessness of the mentally ill, and all other homeless, may have other sources. As was the case with the prevalence of mental illness, a significant amount of research and

speculation have been offered to determine the extent of the deinstitutionalized among the homeless, which will be briefly reviewed here.

Jones (1983), a psychiatrist writing in the journal, *Hospital and Community Psychiatry*, certainly spoken for many when he claimed that "foremost among the causes of homelessness is deinstitutionalization" (p. 808). Other more publicized accounts, such as a front-page story in *Newsweek* (Abandoned, 1986) and a report by the *New York Times* (Nelson, 1983) that the "vast majority" of the homeless are psychiatric casualties, have proclaimed to the American public that the boom in homelessness in the 1980's has been primarily a result of deinstitutionalization policies from the 1950's, 1960's and 1970's. Based on existing studies, we can ask what percentage of the homeless have previously received psychiatric treatment, though the relationship to the policy of deinstitutionalization in the 1950's, 1960's and 1970's remains much more complicated.

Existing estimates of "previous hospitalization for psychological disorder" among the homeless vary from a low of 10% (Crane, 1984) to a high of 35% (Arce, Tadlock, Vergare, & Shapiro, 1983). It should first be noted that both extremes are *well below* the extremes in estimates of mental illness among the homeless, meaning that many of those identified as mentally ill must be homeless for reasons independent of "deinstitutionalization." Moreover, both extremes studied populations for single adults in shelters, which means that families and people who avoid shelters have been excluded. In other words, a rather signficant proportion of the homeless have not even been represented in study samples. Three of the larger demographic studies report similar findings of previous hospitalization among the homeless that range from 18.5% in Minneapolis (Piliavin & Sosin, 1988) to 23% in Chicago (Rossi, Fisher, & Willis, 1986) to 30.6% in urban Ohio (Roth, Bean, Lust & Saveanu, 1985).

None of these studies found that a *majority* of the homeless were once hospitalized

in psychiatric institutions. In fact, it is worth noting that the study showing the highest rate of previous psychiatric hospitalization among the homeless, 35%, was the study by Arce, et al. (1983) reviewed earlier. The sample was biased to a single shelter site of the "truly needy," as judged by welfare officials, and estimates were based on records that the authors state were inconsistent. Bassuk (1984), who emphasizes the primacy of national mental health policies in creating homelessness over other economic factors, only found one-third of the sample in the Bassuk et al. study (1984) as previously hospitalized for mental illness, though the authors determined that nearly everyone in the shelter was "mentally ill." And as was the case with prevalence studies of mental illness, in each of these studies on deinstitutionalization, among those who did have psychiatric hospitalization, with the given level of data, there is no way of establishing a causal relationship to homelessness, nor determining whether the period of hospitalization was terminated as a result of the deinsitutionalization policies from the decades prior. With the exception of the Arce et al. (1983) study that interviewed *no one*, these studies report "prior hospitalization for mental illness" based on answers to fixed alternative questionnaires administered to homeless people, where the survey respondents simply answer "yes" or "no" to a question regarding having had prior psychiatric hospitalization. None of the studies reviewed here had any questions providing a *context* for understanding that hospitalization, and its real or imagined link to deinstitutionalization policies or homelessness. In fact, on the basis of the given level of data, it is just as valid to interpret the findings as showing that people became hospitalized for psychological distress associated with becoming and being homeless, as it is valid to claim that they became homeless as a result of circumstances following hospitalization.

In spite of the methodological limitations of many of these studies, claims by Jones

(1983), by Bassuk (1984) and by popular reports such as that which appeared as a cover story in *Newsweek* ("Abandoned," 1986), that homelessness in the 1980's is primarily caused by deinstitutionalization policies carried out in the 1950's, 1960's and 1970's appear to be inaccurate. At *most*, one-third of the *single adult* population has been previously treated for psychological distress, with an accurate rate that is probably much lower. Even then, it is not known whether such hospitalization preceded or followed homelessness, or more importantly, what events connect hospitalization and homelessness. To conclude from the finding that a segment of the homeless have been in psychiatric hospitals that therefore psychiatric hospitalization played the primary role in inducing their homelessness, has no evidentiary basis, and denies a range of other factors, including social and economic, that are likely to intermingle in producing episodes of both homelessness *and* psychological distress.

Aside from the failure to explore in any systematic way the role psychiatric hospitalization or mental illness has played in producing episodes of homelessness, these studies have also lacked the data from which they could determine that any of these discharges from hospitalization occurred during *deinstitutionalization* policies from the 1950's, 1960's and 1970's. Ropers (1988) reviews the literature on deinstitutionalization, and concludes that most of the deinstitutionalization process, which began in 1955, was complete well before the rise in homelessness in the 1980's. Studies that have followed deinstitutionalization furthermore confirm that nearly all of the deinstitutionalized were placed in board and care facilities, in nursing homes, with families and in community residences for the mentally ill, years before the growth of homelessness in the 1980's (see Brown, 1985; Waters, 1984). While many mentally ill joined the ranks of the homeless as a result of insufficiencies in case-management and in funding for residential services for the mentally ill in the 1960's and 1970's, and perhaps some continue to fall through those cracks through to the present, with the

boom in homelessness in the 1980's, the homeless mentally ill declined in proportion to the rest of the homeless population, though they may have remained its most visible segment. In support of this conclusion, a study by the Ohio Department of Mental Health (1988) found that only 6% of their 1,000 homeless survey participants had been hospitalized during the 1960-1980 period when Ohio had its dramatic decline in hospital census. Such evidence further confirms the idea that many of the "previous hospitalizations" which are presumed to be products of "deinstitutionalization in the 60's and 70's," might really be the result of recent episodes of distress, perhaps linked to episodes of homelessness, and that more *recent,*and maybe even *existing* mental health policies may really be to blame for the homelessness of many of the mentally ill, instead of those from two decades back. In Boston, for example, many public psychiatric hospitals maintain a policy whereby patients with few or no resources for aftercare are discharged into shelters for the homeless as a cheaper and simpler alternative to providing residential housing for the disabled (Massachusetts Coalition For the Homeless, 1987). New York City has recently announced a plan for easing over-crowding in state psychiatric hospitals that similarly places people in public shelters (*Boston Globe*, February 25, 1989). Ropers also cites a conclusion by HUD on the issue that "If deinstitutionalization is defined narrowly as the release of long-term residents of mental institutions, its effect (on the homeless problem) has been minor" (HUD, 1984; p. 24).

In concluding this discussion of deinstitutionalization, it appears that the visibility of the homeless mentally ill has nurtured distorted stereotypes about who the homeless are, and where they come from, and that careless research set out to confirm this assumption has failed to do so. But perhaps even more importantly, these attempts to determine prevalence of previous hospitalization among the homeless have not been able to enlighten the relationship between psychiatric hospitalization and homelessness, and

why, in fact, there is such a relationship.

In concluding this section on mental illness and the homeless, it should first be remembered that the extent of mental health problems among the homeless have often been exaggerated, and that at the most, it appears that 25%-35% of the *single male* population suffers from some mental illness. Secondly, though some of this group may have had prior hospitalization for psychological distress, there is no evidence that most or all of these persons are products of deinstitutionalization. Thirdly, and perhaps most importantly, to say that many of the homeless are mentally ill, in and of itself, is not a very enlightening statement regarding the *causes* of the homeless problem, and should not be misinterpreted as providing evidence that mental illness is the primary cause of homelessness. Given the well-documented relationship between lower socioeconomic status and mental illness (see Dohrenwend, 1975; Fried, 1969); Liem & Liem, 1978), one would expect that stress-induced mental illness among the homeless would be higher than for the general population. But even when mental disability *precedes* the onset of homelessness, are we to assume that it is the mental disorder itself that causes homelessness? Or was homelessness a result, perhaps, of discrimination and neglect of the disabled person by the family, the community, or the social welfare and mental health systems? Or did the episode of homelessness result from the impoverishment and limited choices associated with social judgements of competence in the housing and labor markets? The danger of reports on rates of mental illness among the homeless, besides their overestimations, is that they are typically reported with little, if any, of the relevant social, economic, or even personal contexts of the health problems among the homeless, the mentally ill, and the impoverished. Indeed, taken alone, they represent a re-framing of the homelessness problem within a much more narrow discussion of medical issues. Such portrayals of homelessness, without adequate consideration of the

more complex issues that link poor health and homelessness, might well be misinterpreted as providing evidence that homeless people, particularly mentally ill homeless people, are incompetent, and in the extreme case of misinterpretation, that such people should be "institutionalized" in shelters or hospitals, even if against their will. Future investigations might try to understand how homeless people perceive mental health problems, when they report having them. And if there is a history of mental illness for a homeless person, a good goal for research would be to better understand why disabled people are not better protected in our social and economic system, or why the disabled would reject existing treatment modalities. In fact, a survey by Ball, et al., (1984) found that among homeless who were *consumers* of mental health services, solutions to income and housing problems were ranked as their first and gravest worries, not their mental health problems. Perhaps future research could better take account of such concerns as they are given voice.

Alcoholism, Drug Addiction and Criminality

Another defect model of homelessness centers on alcoholism and drug dependence. In fact, it may well be that with the growing recognition that the mental health deficiencies among the homeless have been exaggerated, that there has developed a willingness to view homelessness as primarily a problem of substance abuse, particularly alcoholism and addiction to cocaine. Historically at least, alcoholism is the most popularly associated problem with homelessness, even though researchers have not found alcohol use to be a central etiological factor - even in the days of skid row. For example, Bahr and Caplow (1973) found 20% of the Bowery men as alcoholic, though the title of their book, *Old Men Drunk and Sober*, implies that alcoholism is the central feature of homelessness. Spradley's (1970) ethnography, *You Owe Yourself a Drunk,* is in a similar genre. Popular stereotypes almost equate "the drunk" with "the homeless." Like most stereotypes, it is inaccurate, and accepts a more simplistic formulation in place of a

the ability to demonstrate consistent findings has been problematic, as has been the more difficult task of establishing causal relationships between discovered deviance or health deficiencies and homelessness. Indeed, as will be shown in this review, these studies have answered far fewer questions than they have raised regarding the contexts in which homelessness and "deviance" develop.

Mental Illness and the Homeless

The most common *image* that has come to be associated with the urban homeless problem in the 1980's is that of a mentally ill population roaming the streets, sleeping on subway heating grates, and refusing the help of social service agencies. The source of this image is most likely influenced by the *highly visible*, yet statistical *minority* of homeless people who live on the streets and refuse to go to shelters. Campaigns to "institutionalize" or force into the shelters this population of resistant persons have also received considerable media attention, undoubtedly reinforcing the image of the homeless as incompetent persons, who will never voluntarily seek to improve their situation. This kind of homelessness among the mentally ill, accompanied as it is by a suspicion, fear and rejection of the shelters, deserves attention by researchers and administrators of the mental health system, and will be considered as part of this study. But recalling the findings of the recent demographic surveys, the homeless who refuse to live in the shelters are not the typical case. Of course, the number of people living on the street is conditional on the number of available shelter beds and the quality of shelter facilities in a given locality - a situation that is likely to change across time. And even refusing shelter services is not necessarily a sign of mental illness, though that is what is commonly assumed. However, most of today's homeless do live in congregate shelters, and though they may often be the subject of stereotypes based on those who refuse shelter services, they have most likely never been the target of high profile campaigns to "forcibly shelter" the homeless, because they have already chosen

complex understanding of the social processes that produce both homelessness and alcoholism. Among the more recent demographic profiles, such as the urban Ohio study (Roth, et al. 1985), 19% of the homeless report "doing a lot of drinking." In the two Phoenix samples (Brown, et al, 1983), one sample had 19% reporting to be "daily drinkers," the other 11%, with the vast majority (70%) reporting to be either occasional drinkers (one or two days a week) or nondrinkers. The vast majority of the homeless do not report being heavy drinkers. Of course, since the data relies on self-report measures, there are some reasonable suspicions as to the reliability in the reporting, though better methods of obtaining the information are not available.

Even taking account of those suspicions, it is important to recognize that alcoholism and alcohol use, when identified, are not necessarily the primary etiological factors in the homelessness of alcohol users or alcoholics, and should not be presumed to be so. Other factors may be linked to both the onset of homelessness and a deepening abuse of alcohol. Like all homeless people, alcoholics and alcohol users have a personal history that includes a number of factors - social, economic, familial - that have a potential influence on their homelessness, and their alcohol use. The process of becoming homeless may itself have an influence on alcohol consumption. Indeed, writers from the days of "skid row," when alcoholism was more a focal point of research, paid considerable attention to how "hitting the skids" implied an acculturation or socialization process to excessive alcohol use (see Bogue, 1958; Spradely, 1973). Consider also for a moment the social functions that alcohol serves for the "homed" population, and then consider how for the homeless, too, alcohol might provide one of the few legal forms of relatively affordable entertainment and stimulation, relief from stress, and a means of socializing - but all without the advantages of a home within which to partake in, or even sometimes hide, such consumption. Of course, there are

cases of extreme alcohol abuse, where alcoholism is both a contributing cause and sustaining force in a person's homelessness. But as was the case with prior hospitalization and mental illness, the extent of such a phenomenon has often been exaggerated beyond the evidence. Furthermore, on the basis of existing evidence, it is just as valid to hypothesize that homelessness causes increased drinking, as it is to argue that increased drinking places one at greater risk of homelessness. Hence, it is important neither to generalize about the excessive use of alcohol among the homeless - as the evidence does not support such a generalization - nor to romanticize the role of alcohol among people who are both homeless and alcoholic - as has been done in the past in some studies of skid row.

It should also be briefly mentioned that the public health system bears some responsibility for the adequacy of alcohol rehabilitation programs available (or not) to homeless people. Studies of the skid row alcoholic population in prior decades have made frequent mention of the "revolving door" of detoxification and prison programs that have been found to do very little in the way of helping homeless people to secure a more stable existence, with most of the programs ill-equiped to deal with the resource-deprived circumstances facing the homeless alcoholic, including providing needed access to housing, health care and income.

The situation with drugs is similar, although the rising prominence of cocaine and its potent derivatives, such as crack, may require a re-evaluation of the existing literature on drug abuse and homelessness. Prior to the now growing dominance of crack, the use of "street" or non-prescribed, illegal drugs, was found to be limited to about 24% of the homeless population in the urban Ohio samples (Roth, et al., 1985), and to about 25% in the Phoenix samples (Brown, et al., 1983). When followed-up with how frequent the drug use is, only 4% of the Phoenix homeless reported to be daily drug users. These figures, too, are based on self-report and for that reason might warrant some

skepticism. Moreover, since the great impact of crack usage in the United States was not really felt until 1985, many of these statistics could be considered out-of-date. Lacking more precise and recent data, there are limitations in being able to address more fully the relationship between drugs and homelessness. But, as with alcohol, and mental illness, it can at least be said that the coexistence of drug use with being homeless, does not mean that a causal relationship has been determined, nor that there always *is* a causal relationship. In many instances peoples' drug use may have been a contributing factor in the path to homelessness. But in other cases, drug use may be "casual," or not addictive, and unrelated to a person's homelessness, or it may even become aggravated by becoming homeless. Of course the addictive nature of cocaine and heroin, as compared to other drugs, make specification of the type of drug being used critical for assessing the degree to which drug use may cause or sustain a person's homelessness.

Overall, it could be said that a more in-depth exploration of the drug economy, drug use and the availability of drug treatment as they relate to the problems of the impoverished and the homeless is very much needed. Like alcoholism and mental illness, it should be understood that things like drug use occur in concrete social, economic, and personal contexts. Many of those contexts are likely to have some interaction with drug problems in producing episodes of homelessness, and that should be more fully explolred. Consider for a moment the problem for addictive drug users. Many have social and economic protections from the dangers of drug use, while many do not. Consequently, drugs may play a role in precipitating homeless for those persons who lack resources to protect their housing, or to pay for drug treatment programs, while it may be less likely to occur among those who have broader personal, familial, social and medical protections. Since poor and other low-income people do not have as much access to drug treatment facilities, and in particular, to private, in-patient programs, as do other income groups with private, third-party insurance coverage, many of the

uninsured victims of drugs, especially the poor, do not have sufficient access to treatment like similar people from higher social classes, and the treatments that can be obtained do not always help rebuild (or build what has never been) the job, income or housing resources of the recovering addict. While an area largely unresearched, these problems undoubtedly have a role in homelessness, and that too should be explored. However, any investigations should be careful not to exclude the relevant contexts of drugs and homelessness, in favor of an explanation that simplifies and reduces the problems of homelessness, the drug culture and the drug economy to some aberrant behavior by a small number of deviant persons.

One final defect model of homelessness that has actually received little attention in the professional literature, but which has been mentioned in other characterizations of the homeless, is the problem of criminal mischief. Piliavin and Sosin (1988) found that 21% of their sample had prior prison experience, and Rossi et al. (1986) found that figure to be about 17%. Without getting too in-depth here, once again, the link between imprisonment and homelessness should be understood by taking account of the relevant contexts. People with prior prison experience may become homeless following release from prison, if no other arrangements for housing and income have been made for the ex-offender. Many of the homeless may become imprisoned or involved in criminal mischief because of desperation, need for money, food or drugs. Again, both the subjective experience regarding criminal mischief and imprisonment, as well as the concrete social and economic contexts of crime and prison over-crowding, must be considered if we are to understand the relationships between crime and the criminal justice system, and homelessness.

In concluding this review of the defect models of homelessness, it is apparent that such investigations have been unable to inform us on the contexts or causes of

homelessness, or how personal experiences and characteristics of people interact with the forces that impel people into the margins of our social and economic system. Besides being fraught with methodological problems, defect studies have largely ignored the relationship between discovered deviant behavior and the structuring of inequality in the United States. By framing the homelessness problem within a narrow medical discourse on the individual traits of homeless people, these studies have informed public policy and public discussion on homelessness in an ahistorical fashion, and without a more rigorous consideration of the social, economic and political conditions that could be related to the growth of the homeless problem, and the development of "deviant" behavior. The presence of disabled people and people with personal problems, as well as those without disabilities or any personal "problems," and the growing dominance of minorities, young adults and children among the homeless, raise important questions about how the extrusion and stratification processes of our social and economic order operate. Hopefully, this study will help inform us as to some of those processes, and how people manage the tensions of those processes. However, the existing literature on homelessness, with some notable exceptions (see Kozol, 1987; Hopper & Hamberg, 1987; Ropers, 1988), has largely failed to enlighten the relationship between discovered deviant behavior and homelessness, by using the inspecting eye of objectification, individuation and "medicalization" to create a discourse around homelessness that is lacking both in scientific credibility and in historical sensativity.

Conclusion

This review has taken two paths to help introduce the reader to the professional literature on homelessness. First, the demographic profile of the homeless from the 1980's has been contrasted with the profile of "skid row" members in the 1950's and 1960's. This was done, not to establish a continuity between the two periods of homelessness, nor to show the slow evolution to its new forms, but to dramatize the

distinctive break in both the professional conception of what is defined as homeless, and who actually falls victim to it. To be sure, certain remnants of the skid row stereotype have filtered into this new period of homelessness in the 1980's, though it is usually more a consequence of images offered by the mass media and social science, and reinforced by the visible segment of homeless who refuse the institutionalization of the shelters, than has been found in the data from the most recent research. Compared to the days of skid row, the homeless today are much younger, including a significant number of children; they count among their numbers women, and an increasingly dominant percentage of "minorities"; and they show a diverse background of work and housing histories, including shorter periods of homelessness compared to skid row - in other words, they are not out to establish a "career" in homelessness. Definitions of who qualifies for being "homeless" are also significantly different from those of the days on "skid row." While the "homeless" of prior decades once rented their own rooms in rooming houses and cubicle hotels - a situation that presently wouldn't qualify has homeless - today the homeless are much more "shelter-needy," typically living in large open dormitories, that can sleep up to several hundred people a night.

Though there has been a significant break from the days of "skid row" in who becomes homeless, and where they live, there has not, however, been a corresponding break in the images of homelessness offered in the professional literature. (Nor, would I argue, has there been such a dramatic shift in the popular media's portrayal of homelessness, though such an analysis is beyond the scope of this project.) Guided by the "skid row" stereotype of drop-outs, cast-offs and derelicts, the contemporary professional literature set out to identify the homeless population and investigate its reasons for being there by focusing primarily on the deviant or defective characteristics of homeless people. Rather than investigating the broad shift in demographic groups among the homeless, the professional literature, led primarily by psychiatrists, chose

instead to inspect the psyche, biology and behavior of the homeless as individuals. Very often, the assumption of this path of research has been that defects, when identified, can be presumed to be the primary causes or sustaining forces of homelessness. Thus, this research has proceeded to locate the most important level of causal analysis at the individual, and sometimes more sympathetically, with the systems who fail to provide adequate theraputic treatment to those individuals. In what could be called a "psychiatrization" of the homeless problem, we have been led to conclude that theraputic means of resolving individuals' crises will probably be the most important way to resolve the homeless problem, or in the extreme case of interpretation, that the homeless may have to be further institutionalized.

It is not the intention of this review to deny or minimize the fact that homeless people have personal, health or social problems. Quite to the contrary, this review was meant to demonstrate that knowledge of these individual problems has not helped us to understand how those factors might interact with other social, economic and personal events and conditions that precipitate episodes of homelessness, if and when they do. It was the intention of this review to show that there are two major gaps in our understanding of the homeless problem, which the remainder of this project will hope to fill. First, there is a need for some historical circumscription of the existing literature in order to understand the demographic shift in who becomes homeless. Why, in fact, do more young people, women, children and minorites seem to be residentially unstable and at greater risk for homelessness than at other more recent periods in time? It would seem that some historical, social, economic and political analysis would be required to explain, even partially, this fundamental demographic shift, or at the least, the contexts of this shift. Secondly, given that some shifts or dislocations have occurred making poor young adults and minorities more residentially unstable and at greater risk of

homelessness in the 1980's than in prior decades, and given that those who become homeless have a greater prevalence of personal, health and social problems, what has happened in the lives of these people to produce their homelessness and these other manifestations of discovered "deviance"? To answer that, it would seem necessary to explore the housing, work, family and social biographies of the victims of homelessness to better understand their choices and circumstances that led to their homelessness. Hence, this study investigates the intersection of these two domains, the macro and the personal-social, and how they have been mediated in the lives of the individual victims of homelessness to create their current subjugation. Through a combination of sources - social scientific reports, interviews with homeless people, and participant observation - these two areas of inquiry will be pursued, and a richer understanding of the homeless problem reached.