Homelessness and Housing Policy: A Game of Musical Chairs

Despite mounting evidence from such studies as the one presented by Wood, *et al*, in this issue of the Journal[1] policy approaches toward the social epidemic of homelessness continue to be informed more by prejudice than fact. The *New York Times*, which regards itself as our national newspaper of record, has steadfastly maintained that the essential problem is one of bungled policies for emptying mental hospitals.[2,3] The homeless are the neglected mentally ill, they say. The solution is essentially to reinstitutionalize (lock up?) single, homeless, mentally ill adults.

It is important to know what the *New York Times* thinks because it frequently provides a guide to the way liberal policy-makers think. In late 1987, then Mayor Edward Koch announced that New York City would round up the homeless judged to be mentally ill, against their will if necessary, and treat their condition. The program had political popularity, but little factual understanding of the complex social demographics of the issue. Not surprisingly it failed. It failed not just because of health care service system inadequacies and issues of civil liberties but, more importantly, because the stereotypical single, homeless, psychotic, and mainly male individual who was the target of the effort proved to be a far scarcer commodity than popular myth suggests.[4]

If the *New York Times* represents liberal enlightenment, what do the less liberally enlightened think about homelessness? The *National Review*, for one, published what it reputed to be a scientific study demonstrating that homelessness is caused by rent control![5] I will not take the reader through the tenuous chain of assumptions, shaky statistics and logical leaps which created that conclusion. It is beside the point. The point is that as with the liberal *Times*, the conservative *National Review* also provides a boundary to the discourse from which national social policies emerge. The policy thread here runs directly to the attempts of the United States Department of Housing and Urban Development to define our housing crisis as mainly the result of too much public regulation of the housing stock.

That neither side yet seems willing to allow facts to dilute cherished social dogma is particularly troubling. It is a sign that the political will necessary to solve the debilitating problem of homelessness as distinct from using the problem to further other political agendas has yet to materialize.

However, every scholarly study in the, by now, sizable literature on homelessness which has empirically examined the nature of the problem and its cause has arrived at the same overall conclusion: homelessness is generally synonymous with poverty. What the studies help to do is fill in the information gaps about the social processes through which the losses of our weakening national economy are distributed across the population. As the Wood *et al*,[1] and similar studies demonstrate, the lack of economic resources alone, although necessary, is never sufficient to explain who will be homeless. It is usually found that economic plight in combination with psychological, physical and/or social impairment conspire to render particular individuals homeless. When groups of homeless are compared with demographically and economically similar control groups of the still housed, the latter usually have less psychosocial and/or physical pathology than the former.

The danger in such studies comes not from the skilled researchers who carefully note the elements of co-variation and carefully circumscribe the implications of causal inference in their data. Rather it comes from a public eager to seize only those findings which validate the view that problems arise either from defects inherent in the individual victims or our attempts to solve them. To think otherwise is to confront ourselves on a host of larger policy, taxation, and spending issues about which we currently have no consensus. It is far easier to think the problems are beyond control.

Dynamically the linkage between the structural loss of housing resources and the personal loss of shelter is analogous to the children's game of musical chairs; a game with n players and n−1 chairs. When the music stops, each player is supposed to find a chair and be seated. Persons left standing are out of the game. The winner is the last of the final two players able to grab the remaining chair. The early dropouts are the physically least adept. By the end of the game, timing and more psychologically subtle characteristics begin to separate the continuing players from the drop-outs. No doubt luck has much to do with determining the ultimate winner.

The social construction of homelessness is the creation of a situation in which, as a matter of policy, too many poor people are asked to chase too few low cost housing units. In 1981, the federal government spent approximately $30 billion per year on subsidizing low cost housing. By 1988 that figure had dropped below $7 billion. Remember these are not inflation-adjusted dollars, so the impact is worse. During the initial rounds of funding cuts, it was unambiguously the physically, psychologically, and socially most vulnerable among the poor who hit the streets. As the funding cuts have continued and the scarcity of affordable housing has spread further up the social scale, such sharp noneconomic distinctions between the housed and the homeless, as Wood, *et al*,[1] demonstrate, have begun to dissolve. Initially many of the homeless *were* the former mental patients; by decade end, those without housing look disconcertingly similar to those with roofs over their heads.

It is therefore important that public health professionals give special prominence to explaining the linkage between the structural factors which create the potential for a high prevalence of homelessness and the personal ones which determine who are most susceptible. The essence of good public health practice must be to attack the structural elements to help eliminate future victims. In this case, the elements relate to the decisions made a decade ago to restrict public spending on housing for the poor. This is especially tragic because the history of national housing policy amply demonstrates that we know how to ameliorate this problem whenever we wish.

Given the complex political agendas in which this issue is enmeshed, it is also imperative that all professions concerned with public well-being make unambiguously clear the direct connection between the pain and suffering caused by homelessness and our public policies. Responsibility for identifying the societal root of individually manifest pathologies rests with many professional disciplines. The front line ones are Public Health, Urban Planning, and Social Work. In the late 19th century, when the social, environmental, and health problems of an industrializing nation threatened to bring economic and social progress to a standstill, it was the concerted effort of the founding members of these interre-

lated disciplines who awakened the nation to the dangers of and cures for those problems.

Now, as many of the social and health problems from our past are once again with us—seemingly in a more virulent form—it is time that we resurrect the coalitions of public health, urban planning, and social work professionals who were so effective in that earlier age. Social and public health problems such as those linked to homelessness are not discrete pathologies. If we wish to arrest the rise in infant mortality, tuberculosis, AIDS, drug abuse, and the other individual manifestations of a tattered social contract, we must convince a cynical nation that good schools, decent housing, good transportation, day care, rational health planning and good nutrition for *all* our citizens are imperative social policies for many reasons. They are important because the children of America are all our children, because they are the only effective way to make urban streets civil places to live and work, and finally because they help us to be effective competitors in a new world economy in which we must be team members and not club owners.

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Can Genetic Constitution Affect the 'Objective' Diagnosis of Nicotine Dependence?

Accurate diagnosis of nicotine dependence and detection of relapse in treated tobacco dependent persons can be augmented by quantitative biochemical assessment.[1] The reliability of biochemical assessment may, however, be limited by the genetic constitution of the individual. Three studies published in this issue of the Journal describe possible sources of measurement error and indicate the need for more basic research in the biochemical verification of cigarette smoking and other forms of tobacco use.[2–4] As suggested by these reports, individual genetic heritage may quantitatively affect the expired air carbon monoxide (CO) and plasma cotinine levels measured in cigarette smokers.

In brief, McNeill, *et al.*,[2] demonstrated that the elevated expired-air hydrogen levels which occur in the expired air of lactose intolerant persons can result in considerably elevated measurements of expired air CO. Lactose intolerance is common in persons of Asian and African heritage.[5] Wagenknecht, *et al*,[3] found that serum cotinine levels were higher in a group of young Black smokers than in young White smokers even though the latter had higher estimated daily nicotine exposure and serum thiocyanate. The authors ruled out a reporting bias and differences in nicotine intake as explanations for the population difference, and suggested that either the rate of metabolism of nicotine or the rate of excretion of cotinine differed between these populations. These findings supplement a previous report of racial differences in serum cotinine levels of young children exposed to environmental tobacco smoke.[6] Finally, Perez-Stable, *et al*,[4] found that among a Mexican-American cohort, more than one in five persons who reported smoking less than 10 cigarettes per day had higher than expected ratios of serum cotinine levels to daily cigarette consumption. Perez-Stable, *et al*, concluded that the Mexican American smokers were underreporting their cigarette consumption; the possibility of genetic differences in nicotine metabolism and/or cotinine excretion was considered as an alternative explanation of their findings. These authors also speculate that lighter smokers, regardless of genetic background, may metabolize nicotine and/or clear cotinine more slowly than their heavier smoking counterparts.

Although the findings of these three studies are preliminary, the possibility of heritable population differences and the likelihood that expired air CO levels are affected by lactose intolerance persons confirms the need for more developmental work in the area of biochemical assessment of tobacco use status. Idle[7] also discussed individual variability in nicotine metabolism and other factors that could complicate biochemical measures of tobacco use. Idle, however, probably overstated the demonstrated variance in saliva assays, as well as the apparent degree of individual variability[8] and contamination by non-tobacco vegetable sources of nicotine/cotinine.

Some perspective may be gained from the biochemical assessment of other forms of drug use, since these issues are not unique to the assessment of tobacco use and nicotine dependence. It has long been known that individuals vary considerably in their metabolism and elimination of drugs and that some differences are related to the genetic constitution.[9] Such variation in the pharmacokinetic profile of drugs across individuals can complicate clinical pharmacotherapeutics by altering the duration and magnitude of the effects of the medication. It seems to be less generally appreciated, however, that individual variation in drug kinetics can also complicate the use of bioassays in quantifying prior drug exposure. The accuracy of individual estimates of the amount of drug taken as well as the estimate of time since its administration is limited by a variety of factors, including the rate at which that individual metabolizes and eliminates the drug, and by other individual differences in the production of drug-by-products.[10]

These issues are of practical significance in the treatment of drug dependent persons where practitioners must be able to objectively determine whether or not a person has ingested a target substance of abuse. The value of the threshold criterion ("cutoff" point) for the conclusion that drug use has occurred can affect the frequency and type of errors that are