

Responding to the Needs of the Homeless Mentally Ill

SHERVERT H. FRAZIER, MD

Dr. Frazier is Director of the National Institute of Mental Health (NIMH), a component of the Public Health Service's Alcohol, Drug Abuse, and Mental Health Administration. This paper is adapted from a speech he presented on May 15, 1985, at the Staff College, Division of Communications and Education, NIMH.

Tearsheet requests to Shervert H. Frazier, MD, Director, NIMH, Parklawn Bldg, 5600 Fishers Lane, Rm 17-99, Rockville, MD 20857.

Synopsis

The homeless mentally ill represent a pivotal and urgent challenge to the mental health field in the 1980s. Those homeless who have extended histories of psychiatric hospitalization stand as harsh reminders of the failures of deinstitutionalization, while young mentally ill homeless adults who never have been treated as inpatients testify to the gaps and unrealized promises of community-based care under deinstitutionalization.

Homelessness and mental illness are social and clinical problems, respectively, distinct in some ways but intertwined in others. Some of the factors that contribute to homelessness—such as economic deprivations, a dearth of low-cost housing, discontinuities in social service systems, and radical changes in the composition of American families—are felt particularly keenly by many persons who are mentally ill. And symptoms of mental disorders, in turn, frequently impede an individual's capacities to cope with those, as well as other, stressors.

Developing appropriate and effective responses to the needs of homeless people who are mentally ill requires precise definition and identification of the target population, innovations in the mental health service system, encouragement of those who staff it to work with homeless mentally ill patients, and public education. Ultimately, however, fundamental answers will be found in an improved understanding of severe mental illness, enhanced treatment capacities, and greater attention to the rehabilitative needs of mentally ill persons.

I WANT TO TALK TODAY ABOUT mentally ill people who are homeless. This requires, but is not the same as, my talking about homelessness and about mental illness.

Also, I want to comment on the role of the National Institute of Mental Health (NIMH) in responding to the needs of homeless, mentally ill people. This requires, but is not the same as, my talking about the role of other health and social service institutions in addressing the specific needs of the homeless mentally ill.

When we see people who are alone and frightened, living on the streets, scrounging through garbage dumpsters for food to eat, it is easy to be impatient for answers—for action. But the stark needs of homeless mentally ill people obscure the complexity of the problem and the difficulty of answers. Discriminating questions will be more effective than global answers; in the long term, patient-oriented, systemwide solutions will be more humane than quick fixes.

The Contemporary Picture

Between 1955 and 1984, the census of residents in public mental hospitals was quartered, declining from more than 559,000 to fewer than 130,000. The rate of episodes of mental health care provided in outpatient settings during the same period increased by a factor of 12 (1). A pluralistic system of services emerged, comprising public and private facilities, organized settings and office-based practices, and an increasing number of ambulatory and inpatient services provided in general health settings. And along the way, in the midst of these advances, the "Shame of the States," as Albert Deutsch (2) described public mental hospitals in 1948, was transformed, in the words of John Talbott (3), into the "Shame of the Cities."

The contemporary shame is evident in the sight of ragged men huddled on steam grates on freezing nights; of tired, disheveled women washing themselves in the restrooms of train or bus stations or in

the water of a hydrant on a busy corner. It is heard in the hoarse voice of a young man standing on a traffic island screaming fearful obscenities at the world.

These are familiar sights and sounds. To describe them in 1985 has become almost cliché. That is the shame.

Homelessness

The issue of homelessness in America has recently received a great deal of attention. Indeed, on an NBC Nightly News segment in February, Tom Brokaw described 1985 as “the year of the homeless in America.”

“Homelessness” is a powerful concept. It can be, and is being, used to mobilize societal action, to rally partisan opposition to political agendas and bipartisan concern about economic realities. In some instances, it is being used to argue for a return to the more simplistic policies and practices of the past.

With increased attention to homelessness and the high frequency of use of the term, the concept is becoming blurred. What do we mean by “homelessness”? Sociologists Theodore Caplow, Howard Bahr, and David Sternberg (4a) note that the Germanic term “home,” connoting warmth, safety, and emotional dependence, has no precise equivalent in other linguistic systems. It does not, they say, imply a family, for unrelated persons can make a home together. It does not suggest a household, because various institutional “homes” may be much larger. Nor, in a mobile society, does “home” mean any degree of fixity.

Homelessness has always been a feature of this country’s demographics. If we look back in history, we see a nation founded by homeless people. In the 19th and early 20th centuries, agriculture, mining, logging, and construction required a large number of workers able to follow seasonal demands for labor. “Skid row” derived its name and, later, its connotation from the collection of lumbermen who wintered at the terminus of “Skid Road” in Seattle, the route over which logs were moved into the city for shipment out via Puget Sound.

The homeless population was highly visible in Chicago, too, where the convergence of rail lines formed a hub not only for commerce but for hobos. In one of the first formal sociological studies of homeless men, Nels Anderson (5) in 1923 estimated their numbers to range from 30,000 in “good times”—or about 1 percent of what was then the population of Chicago—to 75,000 in “hard times.”

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As many as half a million homeless men passed through the city in the course of a year.

While our culture assigns a certain allure to the image of the hobo—Anderson compared him to the cowboy—these men were not a scrubbed and diligent frontier labor force. They were on the fringes of society, and, being there, they tolerated behaviors that might not have been accepted elsewhere. Alcoholism was common; mental illness was evident. In a 1911 study titled “One Thousand Homeless Men,” Alice Solenberger (6) found 89 men, or about 9 percent, to be “insane, feeble-minded, or epileptic.” And in his study of “hobohemia (5),” Anderson listed “defects of personality and crises in the life of the person” as major factors that led men to leave home.

With changes in technology and demands for labor in the early 20th century, the permanent population of homeless men began to shrink. Those who remained gave rise to what for many years was the stereotype of the “homeless” person: the Bowery bum, the skid row vagrant. They were men, for the most part middle-aged and older, who met the sociological criterion for homelessness: “the absence or attenuation of the affiliative bonds that link settled persons to a network of interconnected social structures” (4b). In other words, they were disconnected from meaningful social relationships.

How many homeless? While pegging the homeless person as an inhabitant of skid row was a convenient way of encapsulating the problem, typically neither the image nor the count of the homeless was accurate. (In 1964, sociologist George Nash (7) estimated the number of homeless people in New York to be 30,000, in addition to the 7,500 residents of the Bowery.) Moreover, if one put aside the stereotype and attempted to ask the harder questions—Who are the homeless, and why are they so? What are their needs?—the answers were

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likely to be sketchier than the counts and to be based more in theory than in data.

To this day, we have not made significant progress in defining and counting the homeless in this country. Estimates of the number of homeless Americans at present vary widely. In early 1984, the Department of Housing and Urban Development estimated that 250,000 to 350,000 homeless Americans were seeking shelter on an average night in January (8a). At the other end of the scale, the Community for Creative Non-Violence, in Washington, DC, places the number of homeless at 2 million to 3 million people (9).

The true number is widely believed to be somewhere in between, nearer the high end of the scale than the low, and thus a rate—roughly 1 percent of the total U.S. population—comparable to that found by Nels Anderson in Chicago more than 60 years ago.

We know that the homeless are an increasingly heterogeneous group. In addition to the traditional middle-aged, white, alcoholic males, the homeless today include increasing numbers of younger and older people: women, families, and children. We know that an increasing proportion of the homeless are minorities. But we don't know much more than that, and, in the absence of better information, we need to guard against the emergence of new stereotypes.

Causes of homelessness. If the numbers and descriptions of homeless people are fuzzy, so is our understanding of the causes of the problem.

Numerous reports, hearings, and position papers in recent years have attempted to describe causes of the new homelessness in some detail, but one must accept these only with an appreciation of the possible biases of the source. On a more general level, three categories of homeless people have been iden-

tified: those who have suffered recent economic setbacks, those who have experienced severe personal crises, and those who are severely disabled by mental illness or substance abuse disorders.

For the majority of the homeless, the immediate precipitant is straightforward: a lack of economic wherewithal. The causes for this may be some of the same that Anderson (5) listed: fluctuations in the demand for labor, or shifts in the industrial base, or even the lure of the open road. Or they may be more modern—alterations in public reimbursement criteria, for example.

Caught between minimum wage rates and the cost of rent, or between interest rates and gentrification, many people lose their tenuous grasp. Writing in *The New Republic* recently, Dorothy Wickenden (10) cited estimates by the Community Services Society that about 2.5 million Americans every year lose their homes; that about 500,000 low-rent apartments every year vanish as a result of conversion, abandonment, arson, inflation, and demolition.

The homeless who are mentally ill. We have only a slightly better understanding of the complex constellation of factors associated with homelessness among the mentally ill. For some people, the nature and symptoms of their illness may be a direct cause of homelessness. For others, the cause may be a function of the economics or design of mental health care and social service systems and may reflect the difficulties patients experience in attempting to deal with large and unresponsive bureaucracies. One cause, certainly, is the loss of inexpensive housing; between 1970 and 1980, nearly half the single-room rental units in this country were converted or destroyed (10). Homelessness may also result from stigmatization of people who are or have been mentally ill.

Data on the number of homeless people who are mentally ill are imprecise at best. Estimates range from a low of 15 percent, based on a New York State Office of Mental Health study (11) of 107 users of men's shelters, to a high of 100 percent, based on speculation and supposition.

Recently, we have begun to see a somewhat more consistent range of estimates. In 1984, the American Psychiatric Association's Task Force on the Homeless Mentally Ill estimated that 25 to 50 percent of homeless Americans have serious and chronic forms of mental illness (12). The Department of Health and Human Services estimated 33 to 66 percent (13). And in a Department of Housing and Urban Development sample of shelter resi-

dents, 22 percent of those surveyed were found to be mentally ill (8b).

That more accurate data do not exist, nearly two decades after deinstitutionalization began in earnest, may be inexcusable in the minds of some, but it is not surprising. Until the process of mass hospital discharges began, there was little cause for focus on the needs of homeless mentally ill patients. For more than 100 years, the vast majority of the identified mentally ill had been housed in public institutions. While a rich body of research was accumulating about the nature of social affiliation and disaffiliation, vagrancy, and the organization of street life, the presence of mentally ill people among the various populations in question often was difficult to discern.

Even after the process of dehospitalization was underway, there was little apparent cause to view deinstitutionalized persons as homeless or potentially homeless. The assumption was made—both by those discharging patients and by those setting up community-based systems of care—that because treatments for the most disabling symptoms of severe mental illness existed, and because the resources and the mechanisms for continuity and comprehensiveness of care existed, the pieces would fall into place. For the vast majority of patients discharged over the past 20 years, the pieces *have* fallen into place—but not without struggle. The success of these many patients has required the support of their families and friends; the understanding of employers; and the support of hospital staff, caseworkers, and other community mental health personnel. With this support, severely mentally ill patients throughout the country are leading lives that would have been unimaginable 30 years ago.

But for a minority of patients whose number is not known, the pieces did not fall into place. It is within this group that the homeless mentally ill are found.

Deinstitutionalization and the homeless. Deinstitutionalization has been described by some as a failure, by others as a success, and by many as a process that never occurred. But it *has* occurred. That this controversy exists suggests why mentally ill persons constitute a significant proportion of the homeless as well as why their needs are poorly understood.

For many of us in 1985, the naivete or shortsightedness of decisions made two and three decades ago now seems obvious. Yet, because many of the same problems exist today, and be-

cause new demands, challenges, and opportunities threaten to create new blind spots, it is important that we do not lose sight of the obvious.

The ideals of deinstitutionalization, as described in the mid-1970s by the National Institute of Mental Health (14), were the following:

- to prevent inappropriate hospitalization through the availability of community alternatives,
- to release to the community patients who were prepared for such a change, and
- to establish and maintain systems of support for noninstitutionalized persons receiving mental health care in the community.

But by the 1950s and 1960s, calls for change in patterns of mental health care were being prompted as much by the needs of “the system” as by the needs of patients themselves. If the existing mental health and related service system had been working in the best interests of all mentally ill persons, this point would be moot. But the system had not been working. And, as Goldman and colleagues have noted (15), while each of the major strategies of reform undertaken in the past 30 years has had as its objective more appropriate and effective mental health care, each has identified the problem differently.

- Those who viewed the problem as “institutional neurosis” or “institutionalism”—the clinical syndrome of psychological and social deficits associated with hospital care—saw need for changes in the ways that hospitals were run (16,17).
- Those who viewed the problem as the larger one of “institutionalization”—the debilitating effects of institutions *per se*—called for changes not only in the methods used by hospitals but also in the patterns of hospital use (18).
- Still others have viewed the concerns just mentioned as a condemnation of all hospital care; the tendency, noted by John Wing (19), to regard all hospitals as “total institutions” prompted questions about the fundamental value of all psychiatric hospitalization.

But the point most relevant to the contemporary needs of mentally ill persons, and particularly to the needs of those who are homeless, is that while the debate goes on, patients, resources, and policies are too frequently moving in opposite and conflicting directions. Thus, we see the bulk of State mental health monies tied up in inpatient settings, but an emphasis on the provision of outpatient care. We

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see public demands for the provision of appropriate care, but an inflexibility in permitting patients access to such care.

While the debate has gone on, large numbers of mentally ill patients have moved and continue to move—some untended—from hospital to community. In the absence of even minimal followup, rehabilitation services, or social supports and contacts outside the hospital, an undetermined number of these individuals today are counted among the homeless.

Also, an entire new generation of persons—the so-called “young adult chronic patients”—has come of age during the era of deinstitutionalization. Many of these young people have had little exposure to any system of care. For them, our system is a nonsystem. Rootless and drifting, they are contributing in increasing numbers to the ranks of the homeless. And because the number of young adults who are at highest risk for the onset of serious mental disorders is just now peaking as a proportion of the total population, the extent of their need is likely to increase in years ahead.

Resolving the ambiguities of deinstitutionalization will not resolve the needs of all homeless mentally ill persons. But resolving the divisiveness within the field will do much to free resources and energies required to address the needs of deinstitutionalized patients.

Impact of illness on homelessness. A second “obvious” issue that warrants comment pertains to the nature of serious mental illness, and particularly the course of the illness and the factors that impinge on it. In this regard, let me focus on schizophrenia. Patients with schizophrenia, if not most dominant in terms of number, are likely to be the most distressed and distressing subgroup among the homeless mentally ill.

As John Wing and his colleagues (19) have noted, it was in the 1950s that empirical studies of long-

term mentally ill patients began to identify specific aspects of disability seen in patients that were a function of psychiatric diseases and thus to distinguish the disease process from the picture of progressive deterioration that was associated with the institutionalism and effects of institutionalization to which I referred earlier.

While investigating the types and causes of impairment, these researchers found that a lack of social stimulation contributed to a worsening of the negative symptoms of schizophrenia—the underactivity, the poverty of speech and affect, the social withdrawal. Conversely, reasonable levels of social stimulation had the opposite effect, often reducing negative symptoms to baseline levels.

A decade later, research showed that the reactivity of schizophrenic patients to environmental events was not limited to the effects of understimulation. Studies (20,21) of the impact on patients of such various environmental factors as social interactions, vocational situations, and iatrogenic processes suggested that, to many patients, overstimulation was equally damaging. And in contrast to understimulation, which fostered withdrawal, overstimulation was more noticeable in exacerbating the positive symptoms of schizophrenia: the hallucinations, delusions, and bizarre behavior associated with the disease.

It seemed that these patients could operate successfully only between narrow limits of social stimulation, with an excess of stimulation producing a relapse of schizophrenia and a paucity of stimulation producing withdrawal and clinical poverty. This changeability of symptomatology, reflecting neurophysiological arousal and attention states, defines the field of research on “pathoplasticity,” an endeavor that is not yet clearly enough defined.

This line of research obviously is highly significant as we consider the plight of homeless mentally ill people, particularly those who have schizophrenia. The interaction between clinical and social problems is the most fundamental issue in the provision of community care to severely mentally ill patients. But in research as well as in the provision of services, there too frequently is a tendency to look at the problem only from a systems perspective, forgetting that the most crucial element is an individual patient who is suffering from disease. The system is relevant only insofar as the disease occurs in a social context.

Role of the NIMH

Given these problems and considerations, what must be done?

I won't elaborate here on past tendencies of the mental health field, as well as the National Institute of Mental Health, to assume responsibility and promise—often beyond a capacity to deliver—answers to social problems of comparable scope and complexity to that presented by the homeless who are mentally ill. But to make note of that tendency, or to cite the evolving “mission” of NIMH, is not to suggest that the Institute will retreat from responding to the needs of these persons. NIMH is involved now in a variety of activities that attempt to address these needs, and I believe that, within the bounds of the Institute's broad research and leadership responsibilities, we ought to sharpen our involvement. But doing so effectively requires a clear understanding of the problems, the needs, and the Institute's role in bridging the two.

Research. The primary strength of NIMH is research, and the immediate problem requiring research is one of definition. How ought “homeless” to be defined in reference to the deinstitutionalized or the never-institutionalized mentally ill person? Is it a matter simply of shelter and basic support needs? Or should the definition include an assessment of the quality of social supports and relationships? Similarly, how should “mental illness” be defined for such research? Too restrictive a definition will understate the problem; too loose a definition runs the risk of trivializing it.

Excellent research designs exist, but these will be of little value if we lack basic ground rules and definitions of the problem. Without them, the generalizability and the credibility of research will be weakened.

Research on homelessness and the mentally ill. The estimates of the numbers of mentally ill among the homeless population that I mentioned earlier are just that—estimates. Recently, initial results of more rigorous research have begun to be reported. An example of this is seen in a survey, supported by NIMH, of nearly 1,000 homeless persons in 32 counties of Ohio (22). Fewer than one-third of the respondents were found, at the time of interview, to evidence behavioral symptoms sufficiently severe to require specialized mental health care. Fewer than 5 percent of the total sample were judged to require psychiatric hospitalization at the time of the interview.

These findings are contrary to the experience of some front-line health and human service personnel who are working with the homeless. And, in fact, the study has been criticized for the expansive definition of “homeless” that was employed by the

researchers (23). The fact that this aspect of the study has come under fire serves to illustrate the point that I am making here, and one that others have made previously: that is, the importance of methodology.

The NIMH Office of State and Community Liaison currently has seven studies underway. Four of these, being conducted through Community Support Program (CSP) grants, focus on the nature and extent of homelessness among severely mentally disabled adults being served through CSP programs. Two other studies are being conducted by New York City and State mental health authorities. In June 1985, a 2-year, NIMH-funded investigation of the service needs of homeless mentally ill persons began in Baltimore.

While this research is underway, attempts are being made to address methodological questions. NIMH has convened researchers for this purpose, and a conference report has been published (24).

This targeted, system-oriented research is needed. But in the long run, the more telling contributions of mental health research to the problems of the homeless mentally ill will stem from a rededication of the mental health field to basic and clinical research on the nature of treatment of major mental illness.

Research on chronic mental illness. Earlier in this paper, in my comments on the pathoplasticity of schizophrenia, I emphasized the importance of this type of research. Robert Drake and David Adler made a related point in the American Psychiatric Association's Task Force Report on the Homeless Mentally Ill (25). They noted that for some patients, particularly those who are severely psychotic and have never been institutionalized, the availability of adequate community resources does not in itself ensure that treatment will—or even can—be provided. The disease interferes. This is a clinical reality, and until we are able to address that reality, service needs will continue to mount, as will the human costs of mental illness, whether those who suffer it are homeless or not.

National leadership. A second major component of the contemporary NIMH mission is provision of national leadership, in the form of professional consultation and other forms of technical assistance, to the many parties of the mental health enterprise in this country. Here, as in the area of research, the opportunities for NIMH leadership and participation are too numerous to list, much less discuss in any detail. Still, let me suggest a few general areas

to which the Institute can contribute in a productive way.

Policy needs. One problem today is a lack of focused and substantive policy positions, within some sectors of the mental health field, regarding the directions that we ought to take collectively, as a field. There is genuine concern, obviously, over the needs of this tragic population, the homeless who are mentally ill. And there has been some evidence of a bandwagon effect, a knee-jerk reaction. This is not necessarily bad for the purposes of raising awareness and mobilizing resources. Still, we need to look realistically at the long-term nature of the problem and the capacities of the field.

Excellent statements have been developed by various groups and organizations, and NIMH has played a useful role. One example is the Institute's recent collaboration with the American Public Health Association in convening 14 national mental health organizations to discuss and assess public policy affecting the homeless mentally ill (26). This must be a continuing process, capable of refining policies as the quality of data and an understanding of the problem improve.

Personnel needs. A second problem is the insufficient numbers of people who are interested in working with severely mentally ill persons and are clinically knowledgeable about their special needs. Chronic mental illness has infrequently received the attention it demands from the mental health professions. We need to encourage mental health and other clinical and social service personnel to exchange outmoded, nihilistic notions of the "chronic" patient for a more accurate appreciation of the fluctuating levels of disability associated with many forms of severe and persistent mental illness. Connotations of the term "chronic" are often more damaging than the condition the term denotes.

NIMH is currently working with the Public Health Service to develop a conference designed to determine how nurses can assume a more effective role in meeting the health and mental health needs of homeless persons. Similar activities involving other health and human service professions would be useful.

The NIMH Community Support Program has had extraordinary success in demonstrating opportunities for effective interventions targeted to severely mentally disabled populations in communities throughout the country. In September 1985, the program will be supplementing several CSP grants to extend these services to the homeless mentally ill.

Public education needs. A third, critical problem is lack of public understanding of the problem of homelessness and the homeless mentally ill. Awareness of the problem may be superficial among some sectors of the public, but it exists. There is considerably less awareness of strategies being considered to address the problem and of the true costs and benefits of these strategies.

As health and mental health professionals we all share a responsibility for the necessary educational tasks. An example that comes immediately to mind is the furor that frequently erupts in a neighborhood when a shelter is proposed for the homeless or for mentally disabled people.

Dr. Harvey Veith and his staff of the Federal Interagency Task Force on Food and Shelter for the Homeless have made significant contributions to public education in this area. So, I might add, has the popular press. Characteristics of homeless persons who are severely mentally ill make the task of education more difficult, but no less urgent.

Summary

The frustration I feel with homeless, chronically disabled, severely mentally ill persons is the same emotion I feel when I encounter persons with the same illnesses who are disabled and who are being housed in jails, which are not homes; in correctional hospitals for the criminally insane, which are not homes; in private psychiatric hospitals, which are not homes; in rehabilitation hospitals, which are not homes; or in developmental centers, which are not homes, for the mentally retarded.

Our interim responses are necessary and useful: teaching severely disabled individuals how to cope; designing work projects that are responsive to specific individual needs; creating special worlds in which individuals can cope on a limited scale. These may provide some semblance of normal life but they do not satisfy the frustration.

Schizophrenia, particularly, evokes pain in helpers and in people who care; it renders helpers helpless while it defies resilience and hardening to the process on the part of the clinician. Persons who have the disease often are unable to cope adequately with the vicissitudes of urban life. In the absence of family members or supportive friends, people with schizophrenia are helpless before the facts of the disease, helpless before the system, helpless in the face of our great ignorance. It is a devastating disease that works in the young at a time of great promise and little experience, one whose effects are compounded by a deterioration in

coping skills and a greatly diminished ability to socialize.

We may philosophize the homeless away or we may intellectualize the inadequacies of coping; we may provide half-a-loaf of shelter or a structured environment. But we cannot write off a disease or group of diseases which attacks our youth, causing one-third of them to deteriorate before our eyes; a disease which has no evident brain pathology, yet is so greatly disabling; a disease in which learning and loving and relating are so greatly hampered. This is our frustration, and our task is clear.

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