AMERICAN ORTHOPSYCHIATRIC ASSOCIATION
POLICY ON THE HOMELESS AND THE HOMELESS MENTALLY ILL
APRIL 15, 1985

Each individual in our society should be guaranteed basic human rights: including the right to employment, a secure home; freedom of speech, association and religion; adequate nutrition, health care and education, and due process of law. Our current social institutions and system do not guarantee those rights.

One of the resultant social problems has been the escalating number of "the homeless", of which the mentally ill are a significant number. Policies and programs regarding the homeless must recognize, as has been demonstrated with the mentally ill, that they are individuals with certain common needs although possessing a range of human differences. The AOA has historically emphasized prevention as well as treatment, and the interrelationship of the individual with the total environment. People without homes are much more vulnerable to mental illness. Therefore a major priority must be the creation of stable living conditions for the homeless. Failure to do so produces a growing population with no place to live or raise a family. This in turn creates the danger of adding very large numbers to our mentally ill population. Therefore, AOA recommends the following policies and programs both to help in treatment of the mentally ill who are homeless and to prevent the creation of a new mentally ill population:

1. Provide for adequate income maintenance:
    a. Increase individual and family incomes through private and guaranteed public job programs, so people can afford to secure housing.
    b. Arrange federal and local programs to provide special work opportunities; vocational training and retraining, sheltered work shops and other alternatives.
    c. Restore SSI benefits for the mentally ill.

2. Develop housing programs:
    a. Restore and/or develop federal low cost housing assistance programs.
    b. Initiate low-interest housing construction loans.
    c. Provide flexible service programs that offer relevant services to individuals and meet their needs to achieve residential stability. Rehospitalization, institutionalization or reinstitutionalization are not adequate responses to homelessness.

3. Immediate provision of temporary shelter care programs:
    a. Develop and enforce national health and safety standards for shelters that afford privacy and dignity.
    b. Shelter families as units, allowing for privacy, health care, clothing, school attendance and other family essentials.

4. Develop transitional services to help people move from temporary homeless status to permanent security.
    a. Provide trained staff equipped to assist individuals and families in initiating action towards securing homes.
    b. Provide the necessary financial assistance and services to facilitate transition from shelter care to individually determined alternative kinds of home living.
    c. Provide experienced clinical staff trained to distinguish the "chronically mentally ill" from those reacting to intense trauma in their lives.

5. Develop special services for homeless youth:
    a. Establish statutory procedures for the emancipation of mature minors.
    b. Amend the definition of homeless youth in the run-away and homeless act to include youth after the age of 21, and increase allowable length of stay in programs designed for transition to independent living.
    c. Amend the state education laws to guarantee access to educational services for youth in temporary living situations.
    d. Provide support for services to equip youth in residential child care with skills necessary to live independently.

6. Provide for development of coordination, planning, and service delivery at local, state and national levels:
    a. Establish a formal mechanism for coordination among public and private agencies.
    b. Develop and maintain research and evaluation services for the development and improvement of the service delivery mechanism.

BACKGROUND TO THE ORTHO POLICY ON THE HOMELESS AND THE HOMELESS MENTALLY ILL

WHO ARE THE HOMELESS?

They live on the streets. They live with friends and relatives until there's no more room. Their food comes from soup kitchens or garbage cans or from handouts. They sleep under bridges or in cars or in crowded, smelly, dirty shelters. They warm themselves over sidewalk grates and they have no plans for tomorrow. It is not known how many there are, but, in a recent report, the Department of Health and Human Services estimates from one to three million people are homeless. Prior to 1984, the commonly published estimate was 2.2 million.

Homelessness is not a new phenomenon in this country. It grew to crisis proportions during the major economic depressions of 1909 and 1930. These depressions resulted in large populations of unemployed workers and increased mental hospitalizations. The loss of homes and farms led to family break ups and violence. Soup kitchens and emergency relief programs were established. Between these vast economic depressions, families and individuals with marginal incomes wandered from city to city in search of employment. They lived in shelters set up by churches or the Salvation Army. It was not until after the economic disasters of the early 1930's that the United States developed federal programs to address the problem.

The current crisis in the United States has been intensified, in comparison with that of the thirties, by a number of factors, most notably a lingering misperception that the homeless population chiefly consists of the mentally ill, alcoholics and drug abusers. Effective solutions require recognition and programs for the full range of homeless people. This problem is reflected in a statement made in 1984, by Margaret Heckler, Secretary of Health and Human Services: "The problem of homelessness is not a new problem. It is correlated to the problem of alcohol or drug dependency, and there have been a number of alcoholics who become homeless throughout the years, maybe centuries—they are still there. I see the mentally handicapped as the latest group of the homeless. But, the problem is as old as time and with this new dimension complicating it, it's a serious problem, but it has always been." Heckler's statement is a reflection of the commonly held stereotype of the homeless.

U.S. HOUSING PROGRAMS IN THE 20TH CENTURY

In the thirties as a result of the increase in homelessness the federal government began the development of housing programs ranging from public housing to home repair loans, mortgage insurance, etc. This culminated in the post World War II period with special programs for veterans. In 1949, the United States made a commitment that every American is entitled to a safe and decent place to live. However, cutbacks in housing assistance that began in the 70's, accelerated with the 1981 Federal Budget Reconciliation Act.

The Community Service Society of New York has estimated that, in 1982, approximately 2½ million Americans involuntarily lost their homes because of rent increases, renovations, or redevelopment. A half million low rent dwellings were lost through combinations of conversion, abandonment, inflation, arson and demolition. There are an increasing number of reports of landlords refusing to rent to people on public assistance, or hiring people to beat up tenants to force them out in order to charge others higher rents.

In 1982, according to the Mortgage Bankers Association 130,000 Americans lost their homes through foreclosure. In the same year the Farmers Home Association reported 1,245 bankruptcies, 5,908 liquidations and 844 foreclosures. Court ordered evictions escalated the large numbers of dispossessed families.

At the same time the HUD budget for publicly assisted housing was cut 75%. For example, in 1978, 317,026 new households were added in public housing; in 1983 this figure was only 53,732. In 1977, 57,436 new housing units were added; in 1983, more commitments for public housing unit construction were cancelled than the numbers completed. Currently, waiting lists for public housing in some of our major cities are as follows—New York City with 170,000 eligible families has a waiting list of 15 to 18 years; in the District of Columbia the waiting period is 10 years; in New Orleans 2 to 3 years; in Pittsburgh 6 years; in Detroit 6 months for larger families in public housing projects and 4 years for families desiring scattered site housing. Some people have waited six years. Public housing repairs and modernization had been traditionally underfunded. In Michigan, the number of rental households with incomes under 50% of the renter median income (or under about $10,000) is 218,310 households. The estimated number of affordable housing units available is only 97,144 statewide. This leaves a gap of 121,166 units still required to meet the present need.

In Detroit, the median rental is $216 including utilities, and even at this rate, tenants with incomes below $10,000 are paying 35% of their income for rent. In the meantime, the national administration is proposing sale of public housing to tenants, opening the door to tenants selling them to other people, with no commitment to maintaining housing for low income people.

The congressional budget authority for publicly assisted housing in 1980 was $26.7 billion. It is 6.2 billion for fiscal year 1985. This represents a 75% cutback in dollars and with inflation it adds up to 80%. The projections for 1985-6 are for a 47% cut in HUD, with elimination of section 8 housing for the elderly and handicapped. While not all those affected by the cutbacks are homeless today, it has contributed significantly to the shortage of affordable housing for low income people and the increase in numbers of the homeless. In reality the homeless are as diverse as the population as a whole.

CURRENT ANALYSIS OF THE HOMELESS POPULATION

A 1984 study of the homeless in Ohio documents that 50% of Ohio's homeless are in that condition for economic reasons: unemployment, shortage of affordable housing, and cuts in social programs. People don't have enough money to buy the basic necessities. The National Institute of Mental Health funded the Ohio study because, according to 1980 Census data, it is demographically similar to the rest of the country. The study differs from others on the homeless in that its results are based on exploration of both urban and rural homelessness. Subjects were interviewed in shelters as well as in abandoned buildings, cars, cheap hotels or in temporary arrangements with friends or relatives. Face to face interviews were conducted with nearly 1,000 people in 21 Ohio counties.

The Ohio Governor highlighted the following findings:

> More than half of those interviewed attributed their homelessness to economic factors.
>
> Thirty percent had never been hospitalized for mental illness, while 18% had been in a state hospital. 53% of these people said that if they had emotional problems again they would not want to return to a

> state hospital. The Governor concluded that 54% of those interviewed presented characteristics that may not only be related to psychiatric impairment but also could be the end result of the life of the streets, e.g., "dirty or disheveled appearance, inappropriate behavior, flattened affect and the like."

Some maintain that 90% of those in shelters are mentally ill. Unfortunately, most shelters lack expert diagnosticians. We know there are large numbers of the homeless, particularly those designated as young adult chronic mental patients, who have never been hospitalized. Harvey Brenner, Rashi Fine and other researchers have reported the almost inevitable concomitant increase in mental disturbance with massive unemployment.

The homeless population in the 1980's is much different from the stereotype. In the 1970's the homeless were mostly single men, including alcoholics and other substance abusers, as well as people without children. According to the 1984 Department of Housing and Urban Development report, 22% of the homeless in shelters (not including runaway shelters) are 18 years of age or younger. It is estimated that anywhere from 66,000 to 666,000 children are currently without adequate, permanent shelter.

A larger number of younger people in their thirties are appearing in shelters. In the 1930's Depression the average age of the homeless was in the mid-fifties. Today, the estimate is that 15% to 25% of the homeless are women, 40% to 50% are from minority groups, 20% to 30% are family groups. Also reported are the following figures on the education level of the homeless: One-half to two-thirds completed high school and 25% to 30% have had some college education. Included among this large populatin are battered women, substance abusers, Vietnam era veterans and "the mentally ill."

The homeless now include young, single men and women, and families and children, many of whom are minorities. Some have worked all their lives and are only recently unemployed; others have been without employment for a long time. A common denominator is a lack of means to afford adequate housing. Homelessness itself becomes a definite manisfestation of the increasing number of people in poverty in this country. Many, especially the families, are often referred to as the "new poor." Up until five years ago they were able to earn enough income to be able to meet the rent, or the mortgage payments and/or other

necessities of life. Due to loss of a job, or cutbacks in public aid, which result in loss of income, or domestic disruption or change, they can no longer afford the basic necessity of shelter.

Mayor Washington of Chicago characterizes the homeless population of his city as follows: "No longer are the majority of Chicago's homeless, alcoholics or drug addicts that can be accused of having participated in their own ruin. The majority are evicted, poor, and former mental patients who have been abandoned by government and other social institutions. We are also seeing increasing numbers of men, women and children among the homeless as the unemployment crisis in our city, especially among Black families, continues. We find thousands of teenagers, some of whom are really children, who have been thrown out of their homes or fled because of family problems, and some who have been evicted by their institutional parents - the state."

The federal response to this national problem has been minimal. A task force on the homeless was established in the Department of Health and Human Services to oversee the federal response and work with the private sector to meet the needs of the homeless. Its major efforts to date have been to hold hearings and publish a resource guide for the homeless which details available federal and private services. Other federal efforts have not been successful. For example, the Department of Defense appropriated $8 million for the repair and renovation of military facilities to be used as emergency shelters. In fact, only two shelters were established and only a portion of those funds were actually spent because of a combination of neighborhood resistance to shelters, lack of local funds to operate them, and the Department's less than aggressive marketing and program follow-through. HUD has written to all governors, instructing them to set aside inventories of repossessed homes for local government and charitable organizations to lease for $1/year for the homeless. Inventories of these types of units vary from city to city. In April, 1984, a total of 15 units had been used for this purpose. Governors and mayors of large cities were again informed of this program in Janury, 1985. At that time, public housing authorities were advised to give homeless families and individuals priority on their waiting lists. This has not been a viable option due to the scarcity of available adequate public housing units along with the program's need to collect rent for these units.

In order to develop effective programs for the homeless, we must recognize that certain common needs exist along with a myriad of human differences among the homeless.

HOMELESS FAMILIES AND CHILDREN

Despite the general improvement in the country's economy, the numbers of homeless people and homeless families has dramatically increased in recent years, and its population has changed significantly.

The Children's Defense Fund reports that, in 1984, Seattle's largest emergency shelter for families (the Seattle Emergency Housing Service) turned away 12,521 people of which 7,236 (58%) were children. The Cornerhouse, a 2½ year old YWCA family shelter in Baltimore, was forced to turn away 1,977 families in 1983 and 2,631 families in 1984. That shelter has been filled to capacity since the day it opened. In the past two years, the number of families sheltered by the city of New York has almost tripled, while the number of facilities used to house the homeless almost quadrupled. As of November 30, 1984, 3,277 families which included 7,667 children were living in barrack shelters, hotels or apartments provided by the city of New York.

It appears that the typical homeless family is composed of the single female head-of-household with more than one child. However, in the past year, there has been a notable increase in the number of two-parent families living in shelters. There has also been an increase in the number of battered women and their children seeking shelter. The vast majority of these families became homeless because of economic related problems. Usually, they have been evicted from their homes because of lack of money or displaced by public or private action.

When possible, after leaving their homes, families often double up with other families, relatives or friends. When this is no longer feasible, they either live in bus stations, abandoned cars, empty buildings or they eventually get into emergency shelters. Sometimes families must endure forced separation depending on shelters available. In some cases, children are separated from their parents and placed in protective care.

Poor families come to the shelter with a wide range of needs but shelters which usually are housed in private-structures vary greatly in size and types of services available. Despite the best efforts of shelter operators, the conditions at most shelters are grim. In New York City, many families are sheltered in hotels which are also homes for prostitutes and drug dealers. Health problems often exist since many of the families have lived in the streets for some period of time. The lack of facilities for cooking and recreation for children creates problems for families who stay in a shelter for more than a few weeks.

Psychological effects of homelessness and living in sheltered environments can be devastating for a child. The children in shelters lack stability, hope and any positive sense or desire for the future. A special problem is that shelters are usually located far from a child's regular school and, consequently, his/her schooling may be interrupted.

The number of homeless families and children now seeking shelter has grown to epidemic proportions especially in the nation's largest cities.

In Chicago as of mid-1984, approximately 30 emergency shelters had a total bed capacity of 1,100 - of that total, about 20% are used by families with approximately 40% set aside for women and children.

In Baltimore in 1982, the Baltimore Health and Welfare Council found that out of the 11,282 homeless inhabitants of shelters, 2,200 were children.

In Pittsburgh, an emergency shelter for women and victims of domestic violence, housed 346 women and children during the first 6 months of 1984, and had to turn away 542 for lack of space.

In Boston, between 1983 and '84, shelter staff reported a marked increase in the number of intact two-parent families with children and pregnant women who had received no pre-natal care.

In Washington, D.C. 26% of the beds in shelters are for families - all are consistently full.

In Salt Lake City, Utah the number of homeless women and children is the highest it has ever been. The 1982 Mayoral Task Force Report identified family shelters as the city's most crucial emergency need.

In Santa Clara County and San Mateo County, California, there has been 100% increase in the number of families using shelters in the past three years.

Prognosis for the coming year is not good. The State of New York estimates that there are approximately 110,000 families living in situations that are classified as the "pool of the potential homeless." Specifically, 30,000 families are doubled up with relatives or friends, and 80,000 are living in sub-standard housing. The Boston Emergency Shelter Commission conducted a pilot study in which about 1,000 families in 12 neighborhoods were "in the precrious situation of habiting with one or more families in order to avoid becoming homeless." A Pittsburgh study identified 2,700 persons in families who, because of their severely deteriorating housing structures or overcrowded living conditions, will become homeless.

These statistics and these people are found in cities throughout the U.S. Increasing numbers of children are growing up without one of the key essentials of decent life - a permanent, secure home. Inevitably, this has a negative impact on mental and physical health, education and future prospects for these children - in the end leading to the high cost of their ultimate care to the nation.

HOMELESS YOUTH POPULATION

Definitive answers regarding the numbers and problems of the homeless youth population are still unavailable. However, some attention is beginning to be given to this population because of their growing numbers and the concern that, without effective intervention, these youth will eventually swell the numbers of homeless adults and the mentally ill. What is known is that the few programs currently serving homeless youth tend to focus on the immediate crisis of homelessness and not on the longer term needs of these young people for self-sufficiency.

Homeless youth are defined as youth between the ages of 16 and 21 who are living apart from their families. Although children as young as 8 or 9 can be found living alone on the streets, there are still more resources for the young abandoned child than there are for the older homeless youth. Various reports estimate that in New York City over 7,000 unattached children are in shelters.

A difficulty in reporting on numbers of homeless youth is the absence of a uniformly accepted definition of them. Much of the available data label youth who seek shelter and other services as "run aways" because the largest proportion of available data are collected by runaway programs. However, many of the youth who are included in this group have no home to return to, have long-term shelter needs and are, in fact, homeless.

A recent Congressional report estimates that there are between 225,000 and 500,000 homeless youth in the United States. In 1983, runaway and homeless youth programs supported in part by the DFY program were limited to serving only youth under 18 and housed over 11,000 youth, providing crisis services to another 11,000. About 60% (6,500) of those housed were homeless. The number of run-away and homeless youth requesting services has increased each year since the program was established in 1979.

The homeless youth population is almost evenly divided between males and females. In 1983, 55% of the youth served by the DFY run away and homeless youth program were male. This is higher than the 43% figure for males found in a national survey conducted in 1976. While the average age of homeless males is 17, the average age for homeless females is 15. Most homeless youth seek services in the community in which they have been living.

A large number of homeless youth have previously been in foster care. A national survey conducted in 1980 found that 20-35% of homeless youth have been in foster care prior to requesting services. Other studies, including one that interviewed New York City shelter users, found that as many as 50% of those youth seeking shelter had a history of foster care placement. A 1984 study of shelter users reported that 58% of the youth interviewed came from the foster care, mental health, or criminal justice system. A large percentage of homeless youth have been victims of abuse and neglect. A 1978 national survey of runaway youth who did not return home found that 84% had been hit by their parents, 58% had been beaten at least once a month and 26% had been beaten every day. While not as prevalent as

physical abuse, sexual abuse also is a factor in the number of youth leaving home.

Service needs of homeless youth appear to be diverse. A 1978 survey of run-away youth who did not return home identified 20 services that might be needed, including shelter, medical care and advocacy. In a 1983 survey in the New York City shelter system , 52% of the homeless youth stated that securing employment was their primary goal. Although half of these youth had received some formal occupational training, they required job readiness training and other supportive services before they could secure and maintain employment. A 1978 national study of service needs of run-aways found that the most pressing need for 73% of the youth was long-term housing.

A serious problem exists around the issue of services for these young people. There is a commitment to taking care of the crisis of homeless youth at all levels of government and among numerous community gorup service providers and advocates. However, the ability of these groups to respond effectively is limited by gaps and barriers in the current service system, many of which are due to a lack of a comprehensive policy framework focused specifically on homeless youth. Perhaps the greatest deficiency in the present system for serving homeless youth is the lack of service designed to meet the needs of the older homeless youth (16 to 21 years of age).

The human service system primarily is divided between children's services and adult services. Older homeless youth share a common dilemma with other 16-21 year old youth seeking services in that their developmental and service needs straddle the child and adult systems. The state and federal Runaway Homeless Youth Act currently provides funding for the majority of runaway and homeless youth programs. However, both of these acts restrict programs to serving youth over 18 years of age. Furthermore, the program models reflect the supervision and counseling needs of younger adolescents whom the program has typically served. While a few programs, through other funding sources, have been able to serve older homeless youth, many homeless youth are forced into the adult service system that is not designed to adequately meet their needs. The adult service system provides shelter, job placement and case management services but it is not equipped to give homeless youth the support, guidance and training needed to gain self-sufficiency and to live independently.

Also, existing services for homeless youth, provided on an emergency or short-term basis, fail to address the long-term service needs of homeless youth. The current system is an extension of the service system designed to reunite runaway youth with their families or to respond to some other temporary family disruption. They are essentially crisis-oriented with limits on shelter care to crisis periods and services directed at family reunification. Unlike runaway youths, homeless youth have no home or family to which to return. Many lack basic skills, educational or vocational training, or a supportive environment within which to achieve the skills necessary to become self-sufficient.

Because homeless youth need housing, education, vocational training, health care and mental health services, substance abuse and alcohol services, it is necessary to involve many service delivery systems in their care. This is difficult because relevant service delivery systems operate independently and in response to different mandates. Too often the absence of federal or state level coordination leads to fragmentation of service delivery at the local level.

This lack of coordination creates an additional problem - an inability to identify gaps in services. While populations such as homeless youths have multiple needs across agency jurisdiction, planning is typically system-specific. The lack of a full range of mental health services including diagnostic services, crisis intervention and day treatment programs for adolescents has been consistently noted.

Serving older homeless youth is further complicated by the unique needs of specific sub-groups which seek service. The homeless youth population is made up of various sub-populations including young mothers with children, physically and developmentally disabled youth, non-English speaking youth, sexually exploited youth, and gay and lesbian youth. Each of these groups has special needs and requires a sensitivity to and awareness of these needs.

An important problem exists for a significant portion of homeless youth who were formerly in residential child care systems. These youths have not been successfully re-integrated into their families or communities, or have no families to which they can return. In New York State, at the end of 1983 over 50% of the youth in placement had a goal of independent living listed in their case records. According to many advocates, the problem results from

the lack of effective aftercare and discharge planning. A barrier identified in providing after care service is the lack of clear reimbursement plans for aftercare.

Another severe barrier to helping young people who are homeless is the lack of adequate housing. Given sufficient permanent housing arrangements, service providers could focus on the array of support services needed to help the individual live independently. However, programs designed to equip young people with the skills to succeed in a permanent living arrangement are often unable to find adequate affordable housing for them. This is further complicated by the inevitable ambiguity in the legal status of an adolescent or young adult who is living independently. Questionable legal status, particularly acute for the 16-18 year old, makes it impossible for homeless youth to establish permanent residence, to formulate adequate educational plans, to obtain their own personal records, and to receive medical or mental health services. For example, 50% of runaway and homeless youth arriving at shelters require immediate medical attention not obtainable by youth under 18 without parental permission except in life or death situations. Legal decisions over the past ten years have created a confusing set of case law concerning the liability of parents and child when the child lives apart from the parent. None of these addresses a reasonable voluntary process through which youth may seek an emancipated status. The current legal provisions for emancipation offer little guidance for those seeking to ensure the legal status and rights of homeless youth.

Another major problem for homeless youth is accessibility of educational services. State law entitles children between 5 and 21 years of age to a free and appropriate education. Homeless and runawy youth and other youth living in temporary shelters, who have made long-term or permanent arrangements to live on their own have experienced numerous problems in continuing their education. In some instances, school officials have been reluctant to allow these youth to attend classes and in some cases have denied them educational services.

HOMELESS MENTALLY ILL

At the turn of the century the mentally ill were either cared for by their families, placed in poor houses or prisons, or shifted from county to county. Dorothea Dix became their advocate and the leading voice in helping develop mental hospitals. However, by 1908,

hospitals were already known as snake pits. When Clifford Beers on his discharge from one, wrote his famous book "The Mind That Found Itself", he went on to become the advocate for humanizing the state hospitals. It was under his leadership that the organization now known as the National Mental Health Association became the advocate for adequate care for the mentally ill and more humane hospitals.

For a short period of time, what was known as "humane treatment" was developed in state hospitals. However, with the major economic depression in 1909 in this country, the numbers of the mentally ill increased, hospitals became crowded and "humane treatment" had a short life.

Hospitalization remained a major pattern for the "treatment of the mentally ill." State hospitals were built away from the cities where patients had lived. They became large institutions that primarily provided custodial care. Then in the fifties it was found that some patients improved with psychotropic medication.

In 1955, the Mental Health Study Act led to the appointment of the Joint Commission on Mental Health and Illness. Its final report in 1960 recommended the development of community mental health centers in areas throughout the country to initiate community services with the goal of a comprehensive community program to prevent mental illness. One of the goals was to prevent breakdowns and to develop community based mental health services in neighborhood areas. The commission also recommended the closing of the mammoth state hospitals with provision for needed emergency care in general hospitals and a range of alternative residential programs in the community.

The plan was for community mental health centers to be developed, initially with federal funds and ultimately financed by local communities. This also represented a possibility for reducing the cost of care of the mentally ill.

Communities for the most part, however, have not developed services to meet the needs of the discharged patients. Many patients who had been "institutionalized" in isolated hospitals a major distance from their families, lost contact with them. Long years on state hospital wards have ill-equipped many for living with families. In the interim period many lost whatever skills they had had for any kind of independent living, especially in our increasingly

complex urban communities.

The major treatment service in the community became medication, as had also been true of the state hospitals. Problems arose as increased awareness of the side affects of medication developed. Patients' rights groups became active in the 70's protesting hospital abuses, the use of electric shock treatment and questioned the adequacy of confinement. Other inadequacies and abuses came to light with growing frequency in the courts. Serious questions evolved about the quality of hospital staffing and treatment. All of these factors plus many others played a major role in the growing "deinstitutionalization" of the mentally ill.

It has been suggested that a number of the homeless mentally ill need "asylum", the care of an institution where they can be physically maintained. What is overlooked in this recommendation is that many of our state hospitals are still large, ill-equipped and understaffed institutions, in many ways not too different from our current shelters. Overlooked also is the history of care of the mentally ill in this country and some of the factors that initially lead to deinstitutionalization.

Diagnosing numbers of the homeless as "mentally ill" and solving a piece of the homeless problem by a return of major numbers to state hospital care ignores the basic needs of the homeless population. Reducing the numbers this way will make them less visible in our community, but will serve only as a further rejection of the necessity to face the problem. If some of the homeless need "asylum" rather than "a home" there are alternative possibilities that can be developed to provide for this, rather than the notion that the solution is bigger hospitals for the mentally ill. In addition, history documents that more adequate care in the community can be provided at considerably less than hospital cost.

A major factor that contributed to the increase of the mentally ill in the homeless population was the termination in late 1982 of the Social Security Administration's disability benefits to those considered no longer unable to work. By the time this practice was curtailed, almost one half million of the disabled (nearly one sixth of the total) had been dropped from the SSI rolls. The mentally disabled terminated represented roughly 11% of those receiving disability benefits - they were over-represented among those who were terminated by a factor of three. In the first year of this practice, nearly one third of the

discontinued cases were psychiatrically impaired.

CONCLUSION

The homeless represent one symptom of critical and serious problems in the structure of our socio-economic programs. Questions arise as to a serious need for basic structural reform if we are to reduce the problem of homelessness and also create potential for relatively normal living and growth for a large part of the population now living the life of "quiet desperation."

Our concern for this substantial proportion of our population in this reportedly richest country in the world raises questions as to our value system and concern for human life in the U.S. When Dr. Karen Horney, a psychoanalyst trained in Germany, started practice here in 1932 she was shocked to discover the contradictions in our culture, which she saw as a basic value conflict. In her book "The Neurotic Personality of Our Time" she described this conflict arising from the "stress on competition, individuality, and fear of failure, as being in constant struggle and conflict with our need to be loved, our stress on cooperation and the need for Christian brotherhood."

Most seriously for those in the mental health field there are at least two immediate issues to which answers need to be addressed. The most immediate one is meeting the needs of the mentally ill patients in the homeless population through making available the necessary services and providing for these services in the least restrictive settings possible. The current pressure to see this group as needing "asylum" equates the asylum solution with a return to mental hospitals. A large portion of mental health patients do not see this as a viable or necessary solution for themselves. If "asylum" is needed, the potential for developing a range of services, with emphasis on continuity and integration of those services, is the most valuable possibility for providing the care needed.

The second question of critical importance is what the impact of homelessness is on the mental health of the "one to three million" in our population (and continually growing in numbers) who are without adequate affordable housing. Mental health professionals need to address ways of creating structures that will prevent this kind of serious traumatic experience for people. If not, the potential is for a major increase of mental health

problems not only in malnourished children whose physical growth and development will be impeded, but also.in children, young adults and families among the homeless. This raises significant questions about the increase in and kinds of mental health services that are going to have to be developed.

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