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THE MYTH OF PERVASIVE MENTAL ILLNESS AMONG THE HOMELESS*

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This paper calls into question the double-edged thesis that the majority of the homeless are mentally ill and that the streets of urban America have consequently become the asylums of today. We present data from a triangulated field study of nearly 1,000 unattached homeless adults in Texas that contradict this stereotypic imagery. We also suggest that this root image is due to the medicalization of the problem of homelessness, a misplaced emphasis on the causal role of deinstitutionalization, the heightened visibility of homeless individuals who are mentally ill, and several conceptual and methodological shortcomings of previous attempts to assess the mental status of the homeless. We conclude by arguing that the most common face on the street is not that of the psychiatrically-impaired individual, but of one caught in a cycle of low-paying, dead-end jobs that fail to provide the means to get off and stay off the streets.

Public and academic discussions of America's current wave of homelessness have been riveted on two central issues: one concerns the number of homeless, the other concerns their characteristics — how many, and who? While there is still some quibbling about the number, it is generally conceded that homelessness in America is a serious and growing social problem (Baxter and Hopper, 1981; General Accounting Office, 1985; Hombs and Snyder, 1982; Housing and Urban Development, 1984; U.S. Conference of Mayors, 1985; U.S. House Committee on Government Operations, 1985). The controversy engendered by the second issue seems also to have subsided somewhat. While there is an emerging consensus that the faces of the homeless today are far more variegated than heretofore,[1] there also seems to be a growing perception that one face on the street is particularly prominent: the face of the mentally ill, especially those who were formerly institutionalized. For example, a recent *Time* essay (Krauthammer, 1985:103) contends that a conservative estimate would place "a majority of the homeless . . .near either psychosis or stupor" and then adds, presumably to mollify public fears, that the homeless do not pose a serious safety threat because "the overwhelming majority are simply too crazy to be dangerous." A *Newsweek* cover story (Morganthau et al., 1986:14–19) on the homeless mentally ill paints a similar picture by claiming that the majority of the homeless who will succumb to the effects of exposure on city streets "will be found to have a history of chronic mental illness and to have spent at least some time in psychiatric hospitals." And a *People* magazine essay (1986:27–36) on homelessness asserts rather matter-of-factly that "probably the greatest contributors to the size of the homeless population. . .are the state mental hospitals." If such claims, which are commonplace in the

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1. For a discussion of previous waves of homelessness in America, see Anderson (1923), Bahr (1973), Harper (1982:147–61), Rooney (1970), and Wallace (1965).

media, are taken at face-value, then it would appear that the modal type among the homeless today is an interactionally incompetent, conversationally incoherent, occasionally menacing, and institutionally-dependent "crazy."

Such a root image or characterization is not merely a media creation. It has substantial footing in a spate of research conducted primarily by psychiatrically-oriented investigators. One such study drew a psychiatric profile of 179 residents of an emergency shelter in Philadelphia and diagnosed 84 percent as having some form of mental illness (Arce et al., 1983). Another study of 90 homeless individuals treated at New York's Bellevue Hospital diagnosed 72 percent as schizophrenic and 12 percent as having personality disorders, impelling the researchers to conclude that "the streets, the train and bus stations, and the shelters have become the state hospitals of yesterday" (Lipton et al., 1983:821). And, in a widely-cited study of 78 residents of a Boston shelter, the finding of a 90 percent incidence of "diagnosable mental illness" prompted the generalization that "the overriding fact about the homeless is that most are mentally disabled" (Bassuk, 1984:44).[2]

However, not all research dovetails with these psychiatrically-oriented studies. For instance, a large-scale study of homeless individuals throughout Ohio found a relatively low incidence of serious psychiatric symptoms. Among the 979 homeless sampled, 31 percent were found to have one symptom, *but* only 13 percent evinced two or more symptoms, and less than 5 percent were regarded as "candidates for highly structured, protective settings" (Roth et al., 1985:113). However, such findings tend to be ignored by the media, presumably because they do not fit with the more sensational characterization of the homeless as mentally ill.

In this paper we question the empirical basis and representativeness of this media-promulgated image. We present data from our research on homelessness in Texas that contrasts rather strikingly with most research findings on mental illness among the homeless. Additionally, we question the evidential basis of most research claims and estimates on both conceptual and methodological grounds, and we suggest a set of factors that underlie the root image of the homeless as mentally ill. We begin by considering the nature of our data and the procedures through which they were generated. We then present our findings, and conclude by examining the disparity between this evidence and what appears to be conventional wisdom regarding the relationship between homelessness and mental illness.

DATA AND PROCEDURES

Although we use the terms "homeless" and "street people" interchangeably in the following analysis, we view homelessness as a generic concept, with street people constituting only one variety. Other variants include disaster victims, political refugees, and perhaps undocumented migratory workers. However, our study focuses on unattached, adult, homeless street people — individuals living in urban areas whose lifestyle is characterized by the absence of permanent housing, supportive familial bonds, and consensually defined roles of social utility and moral worth.[3]

2. For a review of these and other studies with data bearing on the measurement and prevalence of mental illness among the homeless, see Arce and Vergare (1984), Bachrach (1984:16-20), and Hopper et al. (1982:9–12).

3. A review of research reports from around the country indicates that the vast majority of the homeless fall into this focal category. See U.S. House Committee on Government Operations (1985) for a compilation of numerous research reports.

The data were collected during the course of a 20-month team field study of homeless men and women living in or passing through Austin, Texas. Although Austin is a "booming" sunbelt city that has grown from 345,000 in 1980 to approximately 435,000 in 1985, it has not been sheltered from the problem of homelessness that has besieged most of urban America. Estimates of the number of homeless in Austin have ranged from a low of 639, based on a street count in August of 1984 (Baumann et al., 1985), to a high of around 4,000, based on the assumption that perhaps 1 percent of the population may be homeless (Austin-Travis County Health Department, 1984). A more reasonable estimate, issued by the city Task Force on Homelessness, places the number around 1,500 on any given day. This is roughly four-tenths of 1 percent of Austin's current population, which approximates the estimated proportion of homeless in New York City in relation to its population (roughly one-half of 1 percent 36,000/7,000,000; Baxter and Hopper, 1981:8–9). An even clearer sense of the scope of the city's homeless problem is provided by local Salvation Army figures, which indicate that the number of different people who were served from 1979 through 1984 jumped from 4,938 to 11,271, an increase of 128 percent. That the vast majority of these individuals were indeed destitute and undomiciled is suggested further by the quantum jump in lodgings and meals that Salvation Army provided during the same five year period — from 16,863 to 156,451, an 828 percent increase. Since there were no significant changes in either the Salvation Army's accommodative policies or shelter space during this period, these figures dramatically reflect the recent growth in Austin's homeless population.

We employed two major research strategies in studying this pool of homeless individuals. One entailed extensive ethnographic fieldwork among the homeless and in the private and public agencies that deal with them. One of us "hung out" with the homeless for 12 months. Time was spent with them on a daily basis in a variety of settings — in meal and shelter lines, under bridges, in parks and plasma centers, and at day labor pick-up sites; minor necessities were provided from time to time, such as clothes, rides, and cigarettes; and a sounding board and sympathetic ear were provided for their hopes, troubles, and fears. The basic aim was to acquire an appreciation for the nature of life on the street from the standpoint of the homeless themselves. We followed them through their daily routines and listened not only to what they told us, but also to what they told each other. Overall, 405 hours were spent in 24 different focal settings with numerous homeless men and women.[4] From this pool of homeless individuals we compiled observational and life history information on a non-probability sample of 164. Field encounters with these 164 individuals totalled 488, averaging three per person, with a high of 22. Our understanding of homelessness and of mental illness on the streets in particular is grounded, in part, in our observations of and encounters with these 164 individuals.

The second research strategy was to track a random sample of homeless individuals from the street back through the maze of institutions with which they have varying degrees of contact. One of the problems hampering research on the homeless has been the difficulty of securing reasonably accurate estimates of their institutional contacts and careers. Institutions that have a broader constituency than the homeless rarely track their clients in a systematic fashion beyond their orbit of influence. This is one of the reasons why it has been difficult to document empirically the presumed relationship be-

4. By focal settings, we refer to the major institutions or agencies (e.g., city hospital, city police department, Salvation Army), commercial establishments (e.g., bar, restaurants, plasma centers) and territorial niches (e.g., particular campsites, bridges, parks, street corners) that are most relevant to the daily rounds, lifestyle, and prospects of the homeless living in or passing through Austin.

tween deinstitutionalization and homelessness. Additionally, institutional records are seldom organized in a fashion that separates the records of the domiciled from the undomiciled. Consequently, research on the institutional contacts of homeless individuals has been limited primarily to interviews on streets or in shelters. Such research has been plagued by two problems. First, the samples are typically non-representative and non-random; and second, there has been little effort to validate respondents' self-reports. We attempted to circumvent both problems by tracking a random sample of homeless people from the street through a cross-section of core institutions that have contact with them. Four major problems were encountered in this endeavor: construction of a reasonable sampling frame; securing identifying information on each case; selection of the core institutions; and negotiation of access to institutional records.

We resolved the problem of constructing a reasonable sampling frame by using as our population the homeless men and women who had one or more contacts with the local Salvation Army between January 1, 1984 and March 1, 1985. This yielded an unduplicated count of 13,881 unattached men and women. The decision to use this population was based on the assumption that the total number of homeless men and women who had contact with the Salvation Army in any given time period during the past several years comprised a reasonable approximation of the number of unattached homeless men and women who had been in Austin for one or more days during that same time period. Several considerations justified this assumption. Foremost was the fact that the Salvation Army operated Austin's *only* public shelter for the homeless, whereas most cities of several hundred-thousand or more residents have numerous shelters.[5] Moreover, it is also the only facility in Austin that provided free breakfast and dinner. As a consequence, nearly all homeless men and women living in or passing through Austin will have had occasion to utilize the Salvation Army at least once for food or shelter.

However, subsequent inspection of Salvation Army records, along with our ethnographic fieldwork, revealed that two subgroups of homeless were underrepresented in this population: women and a scant number of street men whose daily routines did not encompass the Salvation Army. Women were underrepresented for two reasons. The majority who use the Salvation Army have children and utilize its family services. As a consequence, their records are kept in a family file. We chose not to sample from this file because of the difficulty of disentangling individual from family data and because the women and children in that file comprised less than 9 percent of the individuals who had contact with the Salvation Army in 1984. The other reason for a low proportion of women in the sample is that the majority of childless women seemed to have developed means of survival independent from the Salvation Army. They typically attached themselves to men with some income or resources that allowed them to stay away from the Salvation Army. As one woman who had been on the streets of Austin for over two years explained, "Some of them hook up with guys even though they don't want to, just to get off the streets. They stay in a bar in the daytime while the guy goes to work, and they get a motel room at night." The other subgroup underrepresented in the sampling frame was the relatively small number of "hardcore" homeless men, comprising 4.9 percent of our field sample, whose daily orbits and routines seldom, if ever, brought them

5. That Austin is indeed peculiar in this respect is clearly indicated by reports on the shelter situation in other large cities. A state report on homelessness throughout Texas indicated, for example, that Dallas and Ft. Worth each have seven shelters, San Antonio four, and Houston around 40 (Texas Health and Human Services Coordinating Council, 1985). Similarly, a report by the U.S. Conference of Mayors (1985) indicates that St. Louis, which is only slightly larger than Austin, had 23 shelters in 1983.

into contact with the Salvation Army. Since both of these subgroups comprised a comparatively small proportion of the homeless in Austin, and since a concerted effort was made to ensure their representation in our field sample, we felt justified in using as the sampling frame for our tracking sample the 13,881 homeless men and women who had registered at least once at the Salvation Army during the 14-month period.

The problem of securing identifying information for the purpose of tracking sampled cases through the other selected institutions was resolved by the Salvation Army's practice of requiring all first-time users to fill out a small face sheet that asks for name and social security number, if any, as well as some demographic and background information. Upon receiving permission from Salvation Army officials to use this identifying information for tracking purposes, we drew a random sample of 800 names and then negotiated access to the records of six other local and state agencies. These included Austin's city hospital, a local private agency for the poor and needy called Caritas, the city police department, the Texas Employment Commission, the state department of mental health and mental retardation (MHMR), and the local community mental health center. These agencies were selected because of their centrality to the lives of the homeless living in or passing through Austin and because each had amassed data that bear directly on much that has been conjectured and hypothesized about today's homeless. Since all but one of the agencies had computerized their records, nearly all of the tracking was computer assisted. When a match was made, all data on that case were coded onto a survey-like instrument that had been constructed on the basis of prior inspection of the record forms of the agencies. Once these data were computerized and cleaned, we were left with a useable tracking sample of 767 cases.[6] For this paper, we are primarily concerned with the data on cases that match with the state and local mental health agency records, which span an 11-year period from 1974 to 1985. In order to place these tracking data within a broader and more meaningful context, we also compiled demographic and diagnostic information on all adult males institutionalized in Texas state mental hospitals in 1984.[7] We will compare this population with our tracking sample at various points in our analysis.

We have noted that many of the homeless within our samples were not permanent residents but only passing through Austin, thereby suggesting that many are quite mobile or transient. Our data clearly indicate that this is the case. Upon initial registration at the Salvation Army, for example, only 6 percent claimed local residency, with the majority (52 percent) indicating that they had come from another Texas city. In light of such mobility, the question arises as to whether these individuals would under-utilize various social services and elude the mental health system in particular, thus biasing the data from our tracking sample such that the mentally ill would be underrepresented. Four observations suggest that such underrepresentation is unlikely. First, since nearly two-thirds of the tracking sample is from Texas, there is no reason to assume that those individuals within our sample from other Texas cities would be any less likely to show up in state MHMR records. Second, admission to state hospitals is not contingent on state residency. The homeless who have filtered into Texas from other states can thus be institutionalized within the state MHMR system. Third, the local community mental health center has an open-door policy of accepting those in need of mental health services

6. At this point, all names and social security numbers were expunged from the computer files in order to ensure the anonymity of the sampled individuals.
7. These data were provided in aggregate form by the Texas Department of Mental Health and Mental Retardation (MHMR).

for outpatient treatment regardless of place of residence, and our field research indicates transients who are in need frequently utilize these services. Finally, our field research also indicates that the chronically mentally ill are among the least mobile of the homeless. With but few exceptions, they are "homeguards" in the sense that they seldom stray voluntarily beyond their daily orbit in a particular locale. In light of these considerations, we feel reasonably confident that the incidence of prior institutionalization and chronic mental illness are not seriously underrepresented within our tracking sample.

Before examining these tracking data, as well as those based on our field sample, it is necessary to specify the criteria used for assessing the mental status of the homeless within our two samples. Those within the tracking sample were classified as "mentally ill" if they had had contact with one of the mental health agencies and were simultaneously diagnosed by agency personnel as having one or more mental health problems. In these cases, assessment of the presence, nature, and severity of problems was based on standard psychiatric diagnostic criteria. (e.g., the American Psychiatric Association's *Diagnostic and Statistical Manual, Third Revision*) and was thus independent of our own judgment.

We classified individuals within our field sample of 164 as mentally ill if they met at least two of the following three criteria: prior institutionalization; designation as mentally ill by other homeless individuals; and/or conduct that was so bizarre and situationally inappropriate that most observers would be likely to construe it as symptomatic of mental illness. The first criterion is the most straightforward. Prior institutionalization generally indicates mental illness at some point in one's past. But, since prior institutionalization does not necessarily mean current dysfunctionality, it cannot be used as a sufficient indicator of one's current mental status. Indeed, we encountered several individuals who had been institutionalized but were currently functioning quite competently in light of their present circumstances. Even if prior institutionalization were a reliable indicator of current mental functioning, it would not have been sufficient since we were unable to ascertain whether each of the 164 individuals in the field sample was previously institutionalized. Even if we had been able to determine this for each case, the possibility would remain that some individuals who might be clinically diagnosable as mentally ill had never been institutionalized. Thus, we needed additional criteria.

The use of typifications by the homeless themselves as a second criterion rests on the assumption that however mental illness might be conceptualized, it is, from a sociological standpoint, "bizarre behavior" that makes face-to-face interaction improbable, risky, or exceedingly difficult for other individuals who occupy similar positions within the same sociocultural context (Eaton, 1986; Goffman, 1961, 1967). If so, then individuals who share similar sociocultural niches ought to be able to reach some understanding as to who among them is "crazy" or "mentally ill." Accordingly, we were sensitized to such designations and judgments among the homeless, and we sought to elicit and confirm them via conversational interviewing when appropriate.

The third field criterion is based on the premise that some behaviors and patterns of talk prompt the designation or label of "madness" or "mental illness" across subcultural groups and populations (Edgerton, 1969). These typically tend to be behaviors and streams of talk that are so grossly incongruent with the context or situation that they would appear strikingly bizarre, aberrant, and inappropriate to most observers. The following encounter, excerpted from our field notes, provides a graphic illustration of such behavior:

> A heavy-set, middle-aged woman who had been walking alone on the sidewalk and singing came over and sat

beside me on the curb as I was waiting to catch a bus to a church service for the homeless. Immediately after telling me her name, she said, "I'm from one of 5,000 planets which have beings superior to humans. People on those planets watch earthlings on TV, but they find them repulsive. You're ugly to me too." She went on, adding that, "I have been reincarnated on earth and trained to be a scientist so that I can inform God about scientific developments on earth. But earth science is bullshit! I know because I saw a picture on the front of *Scientific American* that was supposed to be a nebula in space, but I recognized it was a photograph I took a long time ago of a dirt clod under a microscope." Then when asked if she knew who we were waiting for, she replied, "We are waiting for the last pure descendants of the Romans who are going to feed us."

While many behaviors might be construed as peculiar or deviant, relatively few are so dramatically beyond the pale of everyday discourse and rationality that they unambiguously indicate mental illness. However, when these do surface, designation of the person associated with them as mentally ill "usually proceeds with relative ease and consensus" for both insiders and outsiders (Edgerton, 1969:51). The stream of talk above struck us as being of that genre, and thus illustrates the sort of behaviors that we took as symptomatic of mental illness, providing that they were recurrent and trans-situational or verified by one of the other criteria.

To summarize, we have collected data derived from two different but complementary and supplementary samples of unattached homeless men and women. One is a non-probability field sample of 164 individuals encountered in a range of situations from September 1, 1984 to August 31, 1985; the other is a random sample of 767 homeless individuals, predominantly men, who had at least one contact with the local Salvation Army between January 1, 1984 and March 1, 1985 and who were computer tracked through the state department of mental health and the local community mental health center. With these data we attempt to shed empirical light on the relationship between mental illness and homelessness by examining the following questions: What proportion of the homeless in our two samples has a history of mental health treatment and/or meets our criteria for mental disorder? For those with a history of mental health treatment, what are the diagnoses of the problems that presumably led to such treatment? How do these individuals and those who met our field criteria compare demographically with each other, the non-mentally ill in our sample, and with the statewide population of male hospitalized psychiatric patients? How does the hospitalization experience of these individuals compare with those previously institutionalized in the tracking sample? And, what is the character of life on the street for the homeless mentally ill?

FINDINGS

Proportions Mentally Ill and Institutionalized

The most basic question concerns the proportion of homeless living in or passing through Austin who can be designated as mentally ill. Table 1 provides this information for the street and tracking samples, as well as the proportion of each sample that was formerly institutionalized.

In the street sample, 9 percent were classified as mentally ill in that they met at least two of the three previously elaborated criteria. In the larger tracking sample, 16 percent of the homeless had contact with either the Austin local mental health center or with the Texas state psychiatric hospital system and were diagnosed as having mental health problems. Twenty individuals appeared in both samples, four of whom met our criteria for classification as mentally ill. All totaled, 15 percent of the 911 homeless individuals in our two samples showed some evidence of mental illness. Since not all of these individuals were previously institutionalized, it is useful to separate these two categories. When this finer distinction is made, we see that only 10 percent of the two samples

TABLE 1

Indication of Mental Illness and Institutionalization in the Street and Tracking Samples

Sample	Sample Size	Mental Illness Indicated		Institutionalization Indicated	
		N	%	N	%
Street Sample	144	13	9.0	10	7.0
Tracking Sample	747	120	16.1	79	10.5
Overlap[a]	20	4	20.0	4	20.0
TOTAL	911	137	15.0	93	10.2

Note:

a. This category encompasses homeless individuals who appeared in both samples.

combined had been institutionalized one or more times.[8]

These proportions are by no means trivial, as they well exceed the proportion of the Texas population hospitalized for mental illness.[9] Nevertheless, they do not approach the one-third to three-quarters of the homeless population reported as mentally ill by the media and in much of the research literature. Again, we stress that these figures are based on a variety of indicators. In sum, they indicate that, at least for Austin, previous estimates of mental illness in the homeless population have been greatly exaggerated.

Diagnoses Among the Tracking Sample

As noted earlier, indication of mental illness in the tracking sample comes from two sources: the records of the local mental health center and the records of the statewide psychiatric hospital system. If an individual had contact records at either of these sites, that individual would be classified as "mentally ill." But there is presumably a qualitative difference between contact with the local mental health center and state hospitalization. People are most likely to go to local centers for acute psychiatric treatment and substance abuse detoxification, and to state hospitals for more chronic conditions. Thus, it is important to determine what kinds of diagnosis and treatment these homeless individuals received. Table 2 identifies the sites of psychiatric service and the primary diagnosis of the mentally ill in the tracking sample.

Table 2 indicates that contact with the mental health system is spread fairly evenly across the service sites. This comparison further bolsters the contention that far fewer of the homeless suffer from profound psychiatric illness than much of the literature claims. The diagnostic information contained within the table also corroborates this point. While a considerable proportion of the mentally ill in the tracking sample was diagnosed as having psychiatric problems, most often schizophrenia, the most common diagnosis was substance abuse — drug addiction and alchoholism — especially at the local mental health center, where fully two-thirds were there for detoxification.

When these data are considered in conjunction with the information presented in Table 1, we see not only how many of our tracking sample have a history of mental health treatment, but also what specific problems they had and what kind of care they received. The resultant picture is that of a relatively small subsample of homeless individuals who

8. An August 1984 street survey of 500 Austin homeless also found that only 10 percent had been previously hospitalized for mental health problems (Baumann et al., 1985).

9. Texas MHMR statistics indicate that 13,252 men 18 and over were institutionalized in state hospitals at some point in 1984. This figure is less than three-tenths of 1 percent (.26) of the estimated adult male population of Texas for 1984.

TABLE 2
Diagnoses by Site of Service for Tracking Sample (in Percent)[a]

Diagnoses	Local MHMR Contact Only (N = 45)	State Hospitalization Only (N = 40)	Both State and Local (N = 31)	Total Diagnoses (N = 116[b])
Psychiatric	24%	45%	35%	34%
Mental Retardation	4	0	3	3
Drug Abuse	11	12	10	11
Alcohol Abuse	58	30	52	46
Other Diagnoses	2	5	0	3
Uncertain	0	7	0	3
Total	100%	100%	100%	100%

Note:
a. Columns may not sum to 100 percent due to rounding error.
b. Diagnostic information missing on 8 of the 124 cases.

have a history of treatment primarily for substance abuse and only secondarily for psychiatric problems at both local mental health centers and state hospitals.

Demographic Comparisons

The next question we examine is how the "mentally ill" in our two samples compare demographically with their counterparts in the samples who did not display evidence of mental illness and with the statewide population of male hospitalized psychiatric patients. Do the homeless mentally ill most resemble the balance of the homeless population or the psychiatric population? Table 3 provides some relevant demographic comparisons.

The gender distribution in Table 3 reflects the tracking sample's underrepresentation of women. The street sample includes a much larger proportion of women than the sample based solely on institutional records. Still, in both cases, we are dealing with an overwhelmingly male population. Similarly, our homeless samples are predominantly Anglo. However, both of the mentally ill subsamples and the state hospitalized population have more blacks and Hispanics among their numbers than do the non-impaired samples.[10]

Table 3 also shows that while the homeless mentally ill in the samples are slightly younger than both the non-impaired homeless and the state hospitalized population as a whole, they are closer in age to their non-impaired counterparts. Finally, there are only slight differences in marital status across the tracking subsamples and the state hospitalized population, as more than three-quarters of each group is single.

Taken together, these comparisons indicate that the mentally-ill homeless, non-impaired homeless, and the state hospitalized population are not dramatically different demographically. Several demographic comparisons in Table 3 are significant at the .05 level, but the differences are slight and are quite likely a function of the large samples.

10. These findings are quite consistent with research noting modest ethnic and class disparities in public hospitalization rates for the U.S. population in general. For an overview of these data, see Cockerham (1981:218–22).

TABLE 3

Demographic Characteristics of Homeless Individuals in Samples and Adult Males in State Mental Hospitals in 1984 (in percent)

Demographic Characteristics	No Mental Illness Indicated		Mental Illness Indicated		Adult Males in State Mental Hospitals[a]
	Street (N = 147)	Tracking (N = 643)	Street (N = 17)	Tracking (N = 124)	(N = 13,252)
Gender					
Male	88%	99%	71%	99%	100%
Female	12	1	29	1	0
Ethnicity[b]					
Anglo	85%	74%	71%	69%	65%
Black	8	11	18	15	18
Hispanic	4	11	12	14	16
Other	3	2	0	1	1
(Missing)	0	(1)	0	(1)	0
Age[c]					
17 and under	6%	0%	0%	0%	0%
18 - 25	14	21	18	13	24
26 - 35	44	39	59	51	33
36 - 45	15	24	12	18	18
46 - 55	10	9	6	10	11
56 & older	11	6	6	8	14
(Missing)	0	(1)	0	0	0
Marital Status[d]					
Single	—	76%	—	86%	80%
Married	—	6	—	8	18
(Missing)	—	(8)	—	(6)	(2)

Notes:

a. Since the tracking sample is overwhelmingly male, the male segment of the state mental hospital population serves as the most appropriate comparison group.

b. Mentally-ill homeless significantly differ from non-impaired homeless in ethnic composition: $X^2 = 3.09$, df = 3, $p < .05$

c. Mentally-ill homeless significantly differ from state hospital population in age composition: $X^2 = 20.08$, df = 4, $p < .05$

d. Mentally-ill homeless significantly differ from non-impaired homeless in marital status: $X^2 = 6.84$, df = 1, $p < .05$

Comparison of Institutionalized

As shown in Table 4, a comparison of the mentally ill in the tracking sample who have experienced hospitalization versus the state population of male psychiatric patients reveals significant differences. First, the two groups differ in terms of primary diagnosis. The principal diagnosis among the hospitalized homeless was substance abuse (alcohol or drugs), followed closely by psychiatric illness. Adult males in the state population were most likely to be diagnosed as having a psychiatric problem, with substance abuse a distant second.

The living situation of the patient prior to admission reflects further differences between the homeless sample and the state population. Over half of the homeless sample lived alone before admission, with only 20 percent living with friends or family. In contrast, the majority of the state population came to the hospital from the homes of family or friends. Furthermore, homeless mentally-ill patients were more likely to have come

TABLE 4

Hospitalization Variables for Institutionalized Part of Tracking Sample and Adult Males in State Mental Hospitals in 1984 (in Percent)

Hospitalization Variables	Tracking Sample Hospitalized (N = 84)	Adult Males Hospitalized (N = 13,252)
Diagnoses[a]		
Psychiatric	36%	56%
Mental Retardation	0	2
Drug Abuse	9	9
Alcohol Abuse	30	27
Other Diagnoses	5	1
Uncertain	5	5
(Missing)	(15)	0
Primary Living Situation at Admission[b]		
Alone	57%	26%
With Others	22	56
Institutional	1	8
Other/Unknown	7	10
(Missing)	(13)	0
Primary Type of Commitment[c]		
Voluntary	59%	42%
Involuntary	27	58
(Missing)	(13)	0
Primary Length of Hospital Stay[d]		
Less than 30 days	64%	44%
1 to 3 months	28	32
3 months to 1 year	0	12
1 to 5 years	0	7
5 years or more	0	5
(Missing)	(7)	0

Notes:

a. $X^2 = 15.06$, df = 5, $p < .05$

b. $X^2 = 60.42$, df = 3, $p < .001$

c. $X^2 = 20.34$, df = 1, $p < .001$

d. $X^2 = 29.97$, df = 4, $p < .001$

into the hospital voluntarily, while the state totals indicate that the majority of commitments overall are involuntary, through family or court action. Finally, the homeless mentally ill appear to stay in psychiatric hospitals for a much shorter time than is the case for the state overall. The primary length of stay for two-thirds of the homeless sample was 30 days or less, with none of them staying longer than three months.

Data on frequency of hospital commitments for mentally ill individuals in the tracking sample indicate that most of them have been hospitalized infrequently. While frequency of commitments among the institutionalized in the tracking sample ranged from 1 to 15, two-thirds had only one or two commitments. The remaining third with three or more commitments experienced a revolving-door pattern of brief, repeated voluntary stays — entering from the streets and exiting back to the streets. However, the modal pattern is one of an isolated encounter with the state hospital system, in which the homeless person

enters voluntarily for a short period of time and, upon release, has no further contact with the state institution.

Survival on the Streets

Given that the homeless mentally ill spend most of their time on the streets, the question arises as to the character of that life, particularly for those previously institutionalized. Conventional wisdom envisions street life for this population as one of continued institutional dependence on public shelters and soup kitchens. Deinstitutionalized individuals are also presumed to be too impaired to seek employment.

Our data indicate that this conventional view may be misguided. Institutional dependence, as measured by use of the Salvation Army's accommodative services, is no more prevalent among the "mentally ill" portion of the tracking sample than among the non-mentally ill. Neither group made extensive use of the Salvation Army's services. While food and lodging contacts at the Salvation Army ranged from one to several hundred, 80 percent of both the mentally ill and non-mentally ill had less than 60 contacts, and over half had only 1 to 10 contacts. This picture is similar when lodging contacts are considered separately. While the mentally ill in the tracking sample are slightly more likely than their non-impaired counterparts to have lodging records of six months or more (6 percent versus 1 percent), the vast majority of both subgroups can be found in the range of one to seven nights in the shelter. Clearly, the basic accommodative services in Austin are no more likely to become regular alternatives for the mentally ill than for the non-impaired homeless.

Employment data on the homeless mentally ill in the tracking sample also demonstrate the ability of many of them to function outside of an institutional setting. Fifty-six percent of the mentally ill in the tracking sample registered at least once for job referrals at the Texas Employment Commission (TEC).[11] Furthermore, their referral records indicate that the mentally ill were fairly successful in gaining employment once registered. Roughly one-quarter of those with mental illness histories who registered at TEC were hired on the majority of occasions they were sent on referrals. While this figure is lower than that for the non-impaired population (24 versus 43 percent), it is testimony, nonetheless, to the fact that many of the homeless mentally ill are quite interested in and persistent about finding work. This tenacity is also indicated by the fact that most of the unsuccessful referrals for the mentally ill were due to employer rejection or the job having already been filled. Very few of the applicants failed to report for their referral interviews. These findings do not erase the differences between the deinstitutionalized and the non-impaired in the job market. However, they do indicate that the efforts of the homeless mentally ill to survive on the streets are not as chaotic and irrational as they may appear from a distance. There are, of course, mentally ill individuals on the street who do not seek employment on a regular basis and whose lives are highly disorganized. A case in point is a young man who was observed for several days wandering the streets of downtown Austin, whispering to himself, and carrying a box full of telephone books. At other times this young man was seen standing silently at street corners, with a dazed grimace on his face.

Such examples notwithstanding, our field observations indicate that most long-term unemployed, mentally-ill individuals are generally less institutionally dependent than

11. The Texas Employment Commission is the major employment service within the state which provides referrals for permanent and day labor jobs.

might be expected. Many of them have established daily routines and means of survival that seldom intersect with the major agencies for the homeless in Austin. For example, one 42-year-old Hispanic male, who had been on the streets of Austin for nearly 20 years after running away from the Austin State Hospital, had established a personal circuit in the vicinity of the University of Texas. He virtually never moved beyond this circuit except when he was occasionally arrested for minor infractions. Within this circuit he survived by taking handouts, scavenging for food from garbage receptacles, and panhandling. Even those who do utilize the service agencies tend to do so more for meals than for shelter. For instance, a schizophrenic 30-year-old black male ate dinner at the Salvation Army regularly, but slept in his personal camp in an abandoned wrecking yard several miles away. While it might be argued that it is people such as these who have particularly felt the sting of deinstitutionalization, it is questionable whether many of them would be willing to give up the personal autonomy they have on the streets for the security of an institutional setting.

DISCUSSION AND IMPLICATIONS

We have presented data bearing directly on the mental health of two samples of unattached homeless adults living in or passing through Austin, Texas at some point during a 20-month period. Findings derived from the nonprobability street sample of 164 homeless men and women indicate that approximately 10 percent might be classified as having psychiatric problems of varying degrees of severity. Since these findings are based on criteria that might be construed as too lenient within psychiatric circles, we paid particular attention to other evidence derived from tracking a random sample of 767 predominantly homeless men through the Texas mental health system. These findings revealed that approximately 16 percent have had contact with the system at the state or local level and that only 10 percent have been institutionalized one or more times. Moreover, the greatest proportion of the contacts, according to the system's standard diagnostic criteria, has been for substance abuse, primarily for alcohol, rather than for purely psychiatric problems.

These two sets of findings not only corroborate each other, but they contradict most of the estimates and claims regarding the presumed relationship between homelessness, deinstitutionalization, and mental illness. As one recent review of research on mental illness among the homeless concludes: "It is evident that in most universes of homeless people, between 25 and 50 percent have serious and chronic forms of mental illness" (Arce and Vergare, 1984:88). When milder and less serious forms of mental illness are added, estimates of the proportion of homeless purportedly afflicted frequently jump to 80 to 90 percent. Given the magnitude of disparity between such estimates and our findings, we are confronted with the intriguing question of how this difference might be explained. We think that such differences — as well as the root image of the homeless as predominantly mentally ill — can be explained by four interconnected factors: (1) unwarranted emphasis on the causal role of deinstitutionalization; (2) the medicalization of the homeless problem; (3) the greater visibility of the homeless mentally ill vis-a-vis the non-impaired homeless; and (4) the questionable procedures generally used to assess the mental status of the homeless.

First, because the residential population in state and county mental hospitals has declined by 450,000 since 1955, and since space in community residential facilities is insufficient to absorb these numbers, it is widely assumed that those unable to secure placement in residential programs end up on the streets. We think that this is an erroneous assump-

tion. The limited impact of deinstitutionalization is suggested not only by our findings but also by comparison of the net changes in the resident population of Texas state hospitals with the change in the number of local Salvation Army users between 1979 and 1984. During that five-year period, the state institutionalized population declined from 5,508 to 4,928, a 10.5 percent decrease, while the population of local Salvation Army users was growing almost exponentially from 4,938 to 11,271, a 126 percent increase. Since the rate of increase in Salvation Army users, and thus in the homeless population living in and passing through Austin, far exceeds the rate of deinstitutionalization during the same period, it seems clear that the contribution of deinstitutionalization per se to the problem of homelessness in Austin, and presumably throughout Texas, is relatively miniscule in comparison to other factors. We suspect that this is the case nation-wide, as even the most conservative estimates of the number of homeless throughout the country far exceeds the contribution of deinstitutionalization since the early 1970s.[12]

An almost natural corollary of this excessive emphasis on deinstitutionalization is the medicalization of homelessness. When a social condition or problem is medicalized, several important consequences follow. First, the medical profession becomes the major source of expertise, functioning to define in large measure the nature and parameters of the problem. Second, the problem is framed from the standpoint of the medical model such that it is both individualized and depoliticized. And third, this perspective frequently comes to function as the screen through which the problem is viewed and debated publicly (Conrad, 1975; Conrad and Schneider, 1980). Each of these tendencies seems to be readily apparent with respect to the current wave of homelessness. The problem seems to have been defined in large part in medical terms, as the bulk of the research linking mental illness and homelessness has been conducted by the psychiatric branch of the medical profession (see Arce and Vergare, 1984; Bassuk, 1984; Lamb, 1984). Additionally, attention has been focused primarily on "flaws" and "impediments" within homeless individuals and the mental health system, rather than on the larger social structure. As a consequence, socioeconomic factors — such as the lack of jobs with decent pay, dislocations in the job market, and decline in the availability of low-income housing — tend to be ignored or discounted as the major causes of homelessness. The general result is that the prevalence of mental illness among the homeless is exaggerated and the stereotypic image of the homeless as mentally ill is fortified.

Also contributing to this imagery is the greater visibility of the homeless mentally ill vis-a-vis the rest of the homeless population. Not only has the medicalization of homelessness focused attention on the mentally ill, but their bizarre behaviors and appearance also make them highly visible on the street and in other public places. These two factors, coupled with the previously noted demographic similarities among the different groups of homeless, have two important consequences. They create a perceptual trap wherein the behaviors and appearance of the most conspicuous element among the homeless are seen as typifying all the homeless, thus giving rise to an illusion of homogeneity that shapes public perceptions and media dramatizations of the problem.

In light of the foregoing observations, it is not surprising that much of the research on the homeless has found an unusually high incidence of mental illness among them. But we think the evidential basis of much of that research is itself highly questionable on both conceptual and methodological grounds. Nearly all of this research has attempted to assess the mental status of the homeless by conducting structured interviews with them

12. For an extensive discussion of deinstitutionalization and its ramifications, see Bachrach (1976), Goldman et al. (1983), Gronfein (1985), Lamb (1984) and Lerman (1982).

on the streets or in public shelters and by using various psychiatric inventories that have been standardized on more domiciled populations (Bassuk, 1984; Baumann et al., 1985 Brown et al., 1982; Robertson et al., 1985). Inherent in the application of such procedures to special populations, such as street people, are a number of difficulties that we believe have led to inflated estimates of mental illness among the homeless. First, many of the communications and behaviors interpreted as symptomatic of dysfunction or impairment — such as inappropriate affect and appearance, depressed mood, sleeping and eating difficulties, agitation, and unresponsiveness — may instead be adaptive responses to the arduous nature of life on the streets or patterned manifestations of a subculture or way of life different from the larger normative order. Our field observations indicate that many of the behaviors from which psychopathology is inferred might be better understood as behavioral adaptations to the trying exigencies of street life rather than as symptomatic of psychiatric impairment. While mental disturbances and inappropriate or disturbing behavior may be related, there is no necessary or automatic connection between them (Eaton, 1986; Edgerton, 1969; Goffman, 1967; Miller, 1983; Sarbin, 1969), especially in the case of the homeless, for whom subsistence needs frequently go unmet, and private doings and transactions typically unfold in public places.

The findings of many previous studies are also confounded by the fact they are typically derived from brief interviews conducted during a single encounter in a single setting. For the homeless, behavior, mood, and affect can vary significantly both situationally and temporally as they constantly adapt to a variety of difficult situations. Thus, research based on single encounters runs the risk of premature diagnosis and generalization by treating a strip of "inappropriate" behavior or communication as indicative of a psychiatric pattern. A related problem concerns the number of symptoms on which a diagnosis is based. Typically, in clinical settings, medical and psychiatric diagnosis are predicated on the conjunction of multiple symptoms that comprise a symptom complex. Given the difficult and alien nature of street life and the practice of categorizing situationally adaptive responses as indicative of internal disturbances, it seems especially prudent to base psychiatric diagnoses of homeless individuals on multiple symptoms. However, we suspect that researchers often use only a single symptomatic behavior as the basis for diagnostic classification of homeless people as mentally ill.

In light of these potential diagnostic biases in much of the research on the mental status of the homeless, it is not surprising that a disproportionate number of the homeless are labeled or perceived to be psychologically impaired. Because we attempted to correct for these tendencies in our research, it is also not surprising that our findings are strikingly discrepant with those of most other studies.

In sum, we feel that the linkage between homelessness and mental illness has been overstated. The likely reasons for the stereotypic image of the homeless as mentally ill are the growing medicalization of the problem, the corollary emphasis on deinstitutionalization as the primary cause, the heightened visibility of the minority who are mentally ill, and the exaggerated estimates of much of the research.

Without denying that there is a disturbingly significant number of impaired and dysfunctional individuals among the homeless, we would argue that their face is not the most common one on the street. Instead, we suggest that the modal type among the homeless is a psychiatrically non-impaired individual trapped in a cycle of low-paying, dead-end jobs which fail to provide the financial wherewithal to get off and stay off the streets. Such an image is consistent with our findings and is in keeping with the logic of the structural precipitants of homelessness. To the extent that this picture from one city

can be generalized throughout the country, it is demeaning and unfair to the majority of the homeless to focus so much public attention on the presumed relationship between mental illness, deinstitutionalization, and homelessness. To do so not only wrongfully identifies the major problems confronting the bulk of the homeless, it also deflects attention from the more pervasive structural causes of homelessness, such as unemployment, inadequate income for unskilled and semi-skilled workers, and the decline in the availability of low-cost housing. For the homeless affected by such structural factors, the cause and solution to their plight clearly lie outside the psychiatric arena.

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