

The Physical and Mental Health Status of Homeless Adults

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Abstract

This paper reviews recent research on the physical and mental health status of homeless single adults and briefly summarizes definitional, sampling, and measurement problems. It presents findings from research examining the physical health status of homeless adults; the data suggest that homelessness places people at greater risk for specific health problems and also complicates treatment. The authors then review findings on the mental health status of homeless adults from several methodologically rigorous studies that carefully define and measure mental illness among the homeless population. The final section discusses what is known about the short- and long-term service needs of the physically and mentally disabled homeless population.

The studies reviewed suggest that individuals with chronic physical or severe mental illnesses are more vulnerable than others to homelessness. Homelessness exacerbates physical and/or mental conditions and complicates their treatment. Despite myths to the contrary, research and demonstration programs have shown that most homeless individuals are willing to receive assistance. By linking health and mental health services to appropriate housing, such individuals can be treated and cared for in community settings. However, local communities often do not have the necessary resources to meet the long-term needs of severely mentally ill or physically disabled homeless people.

Introduction

Over the past decade, research has shown that the homeless population is comprised of many subgroups—families, unaccompanied youth, and single adults—each with a range of skills, disabilities, needs, and preferences that must be taken into account when planning housing and services. Individuals in all these subgroups are at greater risk for and exhibit higher levels of severe mental illness, alcohol and/or other drug abuse, and acute or chronic physical ailments than their counterparts in the domiciled population. In 1988, the Institute of Medicine examined the relationship between health and homelessness and concluded that¹

1. some physical problems and psychiatric disabilities, particularly those that prevent people from working, precede and precipitate episodes of homelessness;
2. homelessness represents a serious health risk, particularly for those who are severely mentally ill or are already in poor health; and
3. homelessness complicates the treatment of physical and mental health problems in ways that fundamentally challenge practitioners and standard treatment practices of both systems.

Assessing the physical and mental health needs of homeless adults

The prevalence of physical and mental health problems among homeless adults varies depending on (1) the way in which the homeless population is defined and sampled; (2) the operational definitions of physical and mental illness used in the study; (3) the methods used to determine physical health status and psychiatric impairment; and (4) the manner in which such physical and mental conditions are reported.² While individual studies contribute to our understanding of the homeless population, it is important to be aware of study methodology and to draw conclusions appropriately.

For example, four types of measures typically have been used, alone or in combination, to assess the physical and mental health status of homeless persons. These measures include (1) self-reports of treatment history, (2) self-reports of current symptoms or problems, (3) abstraction of clinical data from records, and (4) standardized diagnostic assessments or clinical exams.³ Although easily collected and often reported as a proxy for current status, treatment history does not necessarily reflect current physical or mental health status or functional level.⁴

Self-reports of health problems, psychiatric symptoms, and previous treatment are also relatively easy and inexpensive to collect, but they are imprecise and unreliable. However, their value lies in providing a general overview of perceived health and use of health care.⁵ Symptom scales designed to detect mental illness often measure signs of distress. But distress is common and expected among homeless persons and does not necessarily indicate psychopathology.⁶ In addition, these efforts rarely take into account functional disability, so there is no reliable way to translate findings

from these scales into diagnoses or to determine necessary treatment and prognosis.⁷

Many of the studies on physical health problems of homeless persons derive clinical data from the abstraction of records of individuals who have had contact with health care providers. Samples drawn from clinical populations do not represent all homeless persons and, therefore, cannot be used to determine the prevalence of specific disorders. However, such data often provide rich descriptions of the range and types of health problems among homeless persons who seek help. When comparisons are made with domiciled clinical populations, these studies can also suggest the degree to which health problems among homeless persons are different.

Although clinical assessment or standardized interviews are the preferred measures of physical and mental health status, large-scale assessment by clinicians has been rarely used because it is expensive, time-consuming, and difficult to standardize. For this reason, researchers are increasingly turning to the use of standardized instruments, particularly to assess mental health status. Many investigators are using the Diagnostic Interview Schedule (DIS), which can produce psychiatric diagnoses and can be administered by trained lay interviewers.⁸ The validity of these diagnoses in homeless populations remains controversial.

To further complicate matters, this range of measures has been used with representative and nonrepresentative samples of homeless persons. Clinical record abstraction, by definition, biases results toward those individuals who have sought help. Even random samples may be sampling specific segments of the homeless population (e.g., shelter users, males, families). On the basis of a single interview, it is difficult to determine whether psychiatric symptoms are due to severe mental illness, physical health problems, substance abuse, environmental factors, or a combination of these factors.

In their review of 23 studies of the physical health of homeless persons, Gelberg and Linn found that 30 percent of these studies were limited to samples of health care seekers and data from medical records; 47 percent were studies that included only shelter residents; and 22 percent of the studies used more representative samples but relied on self-reported ratings of physical health. Fewer than 1 percent of the studies reviewed used self-reports in combination with a brief physical exam.⁹ Similar confounding factors are found in studies of severe mental illness among the homeless.¹⁰

It is impossible to generalize from a single study, even if methodologically rigorous, to the entire homeless population in the United States. For this reason, the understanding of both the physical and mental health status of homeless persons is based largely on synthetic reviews of large numbers of studies. Although a number of reviews and comparisons of the methods and findings of studies have been conducted on mental health and substance abuse,¹¹ such reviews are relatively rare in the area of physical health status among homeless populations.¹² Given these caveats, the next two sections examine findings on the physical and mental health status of homeless adults.

The physical health status of homeless adults

When Philip Brickner wrote in 1985 about the medical aspects of homelessness in the United States, it was as if he were describing some other century and certainly some other place:

The medical disorders of the homeless are all of the ills to which the flesh is heir, magnified by disordered living conditions, exposure to extremes of heat and cold, lack of protection from rain and snow, bizarre sleeping accommodations, and overcrowding in shelters. These factors are exacerbated by stress, psychiatric disorders and sociopathic behavior patterns.¹³

Ample evidence now exists that such conditions are far from the exception among the homeless population in this country. Other risk factors for medical disorders that are commonly associated with homelessness include communal bathing and eating, lack of facilities for washing and toileting, unsafe and unsanitary shelters, exposure to crime and trauma of every kind, inadequate nutrition, no place for bedrest, no place to store medications, excessive smoking and drinking, little or no income, no access to health care, and absence of family and other support to fall back on in times of illness.¹⁴

Physical health consequences

The list of physical health problems seen more frequently among homeless than domiciled adults includes viral and upper respiratory diseases; traumatic injuries of every sort; skin disorders such as leg ulcers and infections secondary to scabies and lice infestations; nutritional disorders; hypothermia; untreated hypertension; advanced dental and periodontal disease; venereal diseases;

tuberculosis; hepatitis; and, increasingly, AIDS (acquired immune deficiency syndrome).¹⁵ This paper examines some of these common afflictions, paying attention to how homelessness places individuals at greater risk for specific health problems, exacerbates preexisting conditions, and complicates the provision of treatment.

Upper respiratory diseases. Common viral respiratory diseases are the most frequently seen acute health problems among the Robert Wood Johnson Foundation Health Care for the Homeless Program (HCHP) clients.¹⁶ Crowded shelters and soup kitchens, environmental stresses, and poor nutrition may predispose homeless people to respiratory illnesses, which are easily transmitted from person to person. Because common remedies such as bedrest, nutritious meals, and over-the-counter medicines are not easily available, homeless persons often suffer from longer and more serious colds or influenza, with increased potential for life-threatening sequelae.¹⁷

Trauma. Trauma is the second most frequently seen acute health problem among HCHP clients, with lacerations and wounds being the most common traumatic injuries, followed by sprains, bruises, and fractures. Homeless persons are at high risk for traumatic injuries because they are often victims of violent crimes such as rape, assault, and attempted robbery.¹⁸ In a review of trauma among homeless persons in San Francisco, one investigator found a variety “of severe injuries, including stab wounds, head trauma, blunt trauma, multisystem trauma, gun shots, suicide attempts, burns, complex facial fractures, hip fractures, pneumothoraces, and lacerations of the neck, chest, liver, large and small bowel, and tendons of the hands.”¹⁹ Increased victimization and assault is particularly notable among the homeless mentally ill subgroup.

Infestations. Scabies and lice are commonly found among homeless persons. Although these infestations are easily treated under ordinary circumstances, crowded conditions in shelters and the lack of facilities for bathing and showering make them difficult to eradicate. Untreated, they can cause secondary disorders, such as skin infections as a result of scratching; these, in turn, can become systemic infections and lead to complications that include kidney failure and septic shock.²⁰

Peripheral vascular disease. Poor circulation in the legs caused by prolonged periods of standing, sitting, or sleeping in an upright position predisposes homeless people to swelling of the feet and legs, which can be followed by cellulitis, skin breakdown, and ulceration. Homeless patients are 15 times more likely than age-matched domiciled patients to have significant peripheral vascular disease.²¹

Treatment of leg ulcers requires immobilization with leg elevation to reduce swelling in the lower extremities; daily or more frequent use of soap, water, and sterile dressings; and the use of support stockings. It is easy to see how individual factors, such as the lack of a place to sleep or rest, little access to other basic necessities, and co-occurring substance abuse or mental illness, “can render a relatively simple medical regimen ineffectual and contribute to life-threatening and costly complications” such as gangrene requiring amputation.²²

Tuberculosis. Based on data from the HCHP and findings of others, Wright estimates the rate of tuberculosis among the homeless population to be at *least* 25 times higher than it is in the general urban population.²³ Scanlan and Brickner also report that, despite the availability of effective treatment regimens for tuberculosis detected in its early stages, the spread of infection beyond the lungs—and even death—have become more frequent in the homeless population.²⁴ This indicates the difficulty of reaching those who have been exposed and of providing the long-term therapy necessary to treat active tuberculosis. Because tuberculosis is spread by personal contact, it poses a significant public health threat, given the fluidity of the homeless population and the often-crowded environments associated with shelters. There is a very thin and permeable line between homeless and domiciled poor people, with a great deal of movement back and forth. In addition, there is considerable movement between the shelters and the streets, and daily interactions between homeless people and the general public on subways, in transportation centers, and in other public spaces.

AIDS. Rising rates of AIDS and human immunodeficiency virus (HIV) infection among urban homeless populations have been expected, but published reports thus far are scant.²⁵ A comparison of HCHP clients with domiciled clinic users shows that, in 1986, the rate of AIDS infection among the homeless population (230 cases per 100,000) exceeded that among the general population by a factor of 10.²⁶ Recent research suggests an even higher risk factor for the homeless mentally ill population.²⁷ The complex interrelationship between homelessness and HIV infection is yet to be fully explored. Clearly, homeless persons who abuse drugs or engage in prostitution (trading sex for shelter) or other unsafe sex are at risk for HIV infection. But it is also clear that the onset of a major physical disability such as AIDS can result in homelessness among individuals whose economic or social circumstances change or are marginal in the first place. Treatment for homeless people with AIDS, like caring for others with disabling physical and mental

health problems, requires comprehensive, long-term care regimens that are only just beginning to be acknowledged and developed.²⁸

Findings on prevalence of specific physical health conditions

Few studies have used clinical exams of representative samples of homeless persons to determine the prevalence of specific health problems among homeless adults. In one such study, Breakey and colleagues conducted extensive clinical exams on a sample of 120 homeless men and 75 homeless women in Baltimore.²⁹ On average, 8.3 physical health problems were found in the men and 9.2 such problems were identified in the women.

The following physical health problems were found: Two-thirds of those homeless persons examined had obvious dental problems; skin problems, including scabies and lice, were found in more than half; cardiovascular problems were noted in half, with one-fifth of the men and one-eighth of the women having untreated high blood pressure; vascular problems in the lower extremities, including leg ulcers, were seen in one-quarter of both men and women; arthritis and other musculoskeletal disorders were found for more than one-third of the men and for 45 percent of the women; more than one-third of the women and one-fifth of the men were anemic; and nearly one-third of both sexes reported prior episodes of sexually transmitted diseases, with 8 percent of the men and 11 percent of the women testing positive for gonorrhea or syphilis.

Comparisons of homeless and domiciled patients

In a study comparing homeless clinic patients in New York City with a domiciled sample of urban patients in the National Ambulatory Medical Care Survey, Wright and his colleagues found diseases and disorders of the extremities to be higher among the homeless sample by a factor of 14; neurological disorders were higher by a factor of 6; liver and related hepatic diseases were higher by a factor of 5; nutritional disorders, acute upper respiratory ailments, and teeth and mouth diseases were higher by a factor of 4; and infectious and parasitic diseases, venereal diseases, blood diseases, eye and ear disorders, gastrointestinal ailments, skin ailments, and trauma were 2 to 3 times more common among homeless persons.³⁰ Similar patterns were found using data from 16 Robert Wood Johnson Foundation and Pew Charitable Trust's HCHPs.³¹

Compared with national samples, homeless adults in Los Angeles County were 3 times more likely to report fair or poor physical health status, 1.5 times more likely to report a physical health disability, and twice as likely to have been hospitalized in the past year. They were also 9 times more likely to be uninsured and 5 times more likely to have no regular source of care.³²

When compared with poor domiciled clinic patients, homeless patients were again found to be more disadvantaged and disabled. Gelberg and associates found that homeless patients were more likely than poor domiciled patients to perceive their health as fair or poor (44 percent versus 32 percent), to have been hospitalized in the past year (30 percent versus 18 percent), to report functional limitations (two or more limitations versus none), and to report a chronic physical health condition (one versus none).³³

These findings suggest that homeless persons present a more advanced state of illness and are less likely, due to their homeless situation, to follow even the simplest of treatment regimens. These findings also suggest that individuals with functionally disabling chronic illnesses and other physical disabilities may be more vulnerable to homelessness.

Mental health status of homeless adults

Determining the prevalence of mental illness among the homeless population is fraught with even greater difficulties than assessing their physical health. The lack of uniform definitions of mental illness and of reliable methods of assessing mental health status account, in large part, for the range of estimates of the prevalence of mental illness. Reviews of the earlier literature found rates of mental illness that ranged from 2 percent to 90 percent among the homeless population.³⁴ Over time and with improved research designs, a consensus has emerged, and it is estimated that roughly one-third of the single, adult homeless population have a severe and persistent mental disorder.³⁵

Severe mental illness is defined as a diagnosis of major mental illness of long-standing duration and accompanied by significant disability.³⁶ The major mental illnesses primarily include schizophrenia, affective disorders (bipolar and depressive), and schizoaffective disorders. Duration is difficult to ascertain, even when treatment history is used as an indicator. Because not everyone who shows signs of major mental illnesses is equally affected by them, disability is a critical component of the definition. The degree

of impairment experienced in one's everyday environment is perhaps the best indicator of severity.

Severe and persistent mental illnesses, as opposed to other, less severe emotional sequelae, are unlikely to result from the trauma of homelessness but are likely to be exacerbated by conditions under which homeless people live. More commonly, severe mental illness—untreated or refractory to treatment, and in the absence of formal and informal supports—can cause a level of disability and impaired social functioning that may increase the risk for homelessness. Other psychiatric illnesses, such as anxiety and milder depressive reactions, either can be contributing factors to homelessness or, more commonly, can result from the stress of homelessness. Becoming homeless is traumatic and may be accompanied by symptoms of anxiety, depression, sleeplessness, and loss of appetite.³⁷

In addition, various physical conditions can cause psychiatric symptoms, reinforcing the need for thorough physical health, mental health, and substance abuse assessment. For example, dementia, which is a deterioration of mental faculties resulting from degenerative brain disorders, may be the result of Alzheimer's disease, AIDS, chronic alcoholism, cerebrovascular accident, or other medical conditions.³⁸

From 1982 to 1986, the National Institute of Mental Health (NIMH) funded ten studies investigating various aspects of homelessness and mental illness.³⁹ Their findings on the prevalence of severe mental illness are consistent with those of other studies reviewed.⁴⁰ These studies include six of the most methodologically sophisticated studies of homelessness and mental illness completed to date.⁴¹ For this reason, our discussion of the prevalence of mental illness is limited to the NIMH-funded studies.

Those studies that used standardized instruments to assess the current psychiatric status of adult homeless populations found prevalence rates of severe mental illness ranging from 28 percent to 37 percent.⁴² Two of the three NIMH studies, which were able to determine specific diagnoses using the DIS, found similar proportions of homeless persons with major mental illnesses. Schizophrenia was found in 11 percent to 13 percent of the homeless populations studied, and affective disorders were found in 22 percent to 30 percent.⁴³ The third study found much lower rates of severe mental illness, which may be due to a small sample size and biases in site selection.

Although most of the homeless population is not mentally ill, the prevalence of mental illness among homeless persons is much higher than that found among domiciled populations. In Los Angeles, a randomly selected sample of homeless adults was compared with a probability sample of a general population sample in the same locale using the DIS.⁴⁴ The researchers found that homeless individuals were 38 times more likely to have a diagnosis of schizophrenia, 5 times more likely to be diagnosed as having a major depressive disorder, and 3 times more likely to have a primary diagnosis of alcoholism.⁴⁵ In a similar study in Baltimore, the prevalence of psychiatric diagnoses, excluding personality disorders, was 45 percent for homeless men and about twice that for domiciled men.⁴⁶

The NIMH-sponsored studies also investigated the prior treatment histories of respondents and found that one-quarter to two-fifths of the study populations had been hospitalized for psychiatric illness at some time in the past.⁴⁷ In a study of homeless persons in Ohio, Roth and colleagues found that half of those with prior psychiatric hospitalizations were not currently symptomatic and that half of those who were symptomatic had never been hospitalized.⁴⁸ In St. Louis, 38 percent of those who had been hospitalized for psychiatric illness scored in the “normal” range on the Brief Symptom Inventory.⁴⁹ Clearly, people do recover from psychiatric episodes or, at the very least, have periods during which they are able to think clearly and function normally. Therefore, hospitalization history alone is insufficient to diagnose current psychiatric disorders.

Based on their review of the NIMH studies, Tessler and Dennis conclude that homeless persons with severe mental illnesses are similar to their nonmentally ill counterparts in terms of age, sex, ethnicity, and extent of substance abuse.⁵⁰ In addition, nearly two-thirds of both groups tended to be long-term (over a year to “all my life”) residents of the geographic areas in which they were studied. However, the differences between the two subgroups point to greater disadvantage and disability in several respects among those with severe mental illness. Homeless mentally ill persons are homeless for longer periods of time, are in poorer physical health, and have more frequent contact with the criminal justice system. As might be expected, they are less likely to have worked in the past year, have higher job turnover, have longer periods of unemployment between jobs, and date their last job further in the past.⁵¹

For those unable to work, access to and continuity of entitlements is a prerequisite for stable housing. Despite their high level of disability, fewer than one-third of the severely mentally ill individuals

studied were receiving public benefits of any kind.⁵² In addition, homeless mentally ill individuals have fewer supportive relationships and more strained family relationships than other homeless persons. Specifically, this means fewer contacts with relatives,⁵³ poorer relations with family, more negative early family experiences, and stronger feelings of detachment from family.⁵⁴

Research indicates that maintaining a stable residence during cycles of psychiatric illness is a serious problem for a large proportion of mentally ill individuals. In a survey of new admissions to a state psychiatric hospital in Detroit,⁵⁵ nearly half (47 percent) had lived at their prior residence for six months or less. Moreover, despite extensive psychiatric histories among those who were homeless upon admission (with the mean number of prior hospitalizations being 5.8), only 30 percent were receiving Supplemental Security Income. Lack of a stable income and deteriorated relations with family members were among the most frequently cited reasons for mentally ill individuals becoming homeless.

In a study of discharged inpatients from hospitals in Boston,⁵⁶ fewer than half (47 percent) of the sample were located three months after discharge despite rigorous follow-up procedures. Of those who could be located, nearly half (47 percent) had changed their residence at least once during the three-month interval. Only one in five appeared to have a stable residential living situation. Those persons with the greatest degree of residential instability and those not found at follow-up were least likely to have been assigned a case manager at discharge.

Alcohol and other drug problems are significant problems among homeless mentally ill persons. The NIMH studies found that between 8 percent and 22 percent of the total samples of homeless people had both a severe mental illness and a substance abuse disorder.⁵⁷ Among homeless mentally ill individuals studied in Los Angeles, 46 percent were estimated to have a substance abuse disorder.⁵⁸ In Baltimore, 54 percent of homeless persons with a major mental illness also were alcohol dependent and 22 percent were drug dependent.⁵⁹ Findings of greater numbers and severity of physical health problems among the severely mentally ill homeless population, particularly those with co-occurring substance abuse disorders, further confirm the vulnerability of this subgroup.⁶⁰

Responding to the physical and mental health needs of homeless adults

Clearly, physical and mental health needs must be met in the context of meeting basic needs for food, clothing, shelter, employment, and entitlements among homeless persons.⁶¹ Over the past decade, programs designed to meet these needs—emergency shelters,⁶² soup kitchens, health clinics,⁶³ mobile outreach and drop-in centers⁶⁴—have proliferated in almost every state. Although the availability of such services still falls far short in relation to the need in most local areas, a great deal has been learned from such interventions about the physical and mental health care needs of the population and about how to develop both short- and long-term responses to these needs.

Short-term needs

Although their illness renders a small proportion of severely mentally ill homeless persons unable to recognize a need for services, several studies indicate that most homeless persons do recognize a need for and are willing to receive services.⁶⁵ Yet for a multitude of reasons, these persons do not receive needed physical and mental health care. These reasons include their giving higher priority to other basic needs, such as procuring food and shelter on a daily basis; the location of services; attitudes among health workers toward indigent patients; lack of health insurance; and the effects of previous experience with providers.⁶⁶ Thus, the need to make physical and mental health services accessible, acceptable, and a part of other social services for homeless persons has been an important lesson learned.

Drop-in centers, which offer essential services (e.g., food, clothing, showers, mailboxes), have been found to provide powerful incentives for individuals to become involved in services.⁶⁷ Mobile outreach to engage those who are hardest to reach is often critical to establishing trust, rapport, and acceptance of services.⁶⁸ Such outreach activities are required in the McKinney HCHPs,⁶⁹ in the NIMH McKinney Demonstration Program for Homeless Mentally Ill Adults,⁷⁰ and in the new McKinney Projects to Aid the Transition from Homelessness (PATH) program. Many HCHP clinics are located alongside multiservice drop-in centers. At the So Others Might Eat (SOME) soup kitchen in Washington, DC, for example, an on-site medical clinic's location close to a feeding program engenders trust and use of the clinic's services.

Long-term needs

Most studies emphasize that the vast majority of homeless persons can be cared for in community-based programs.⁷¹ In one recent study, clinicians recommended long-term, institutional psychiatric care for fewer than 1 percent of homeless persons after their acute medical and/or psychiatric problems were stabilized.⁷² Emergency care or hospitalization prior to longer-term efforts to provide community-based treatment, housing, and supports have been recommended for between 5 percent and 17 percent of homeless adults.⁷³ But once homeless persons are medically and psychiatrically stabilized, those among them who have severe and disabling physical or mental health problems, such as AIDS or severe mental illness, will require (1) comprehensive systems of care, (2) a range of housing options, and (3) intensive and long-term follow-up and support.⁷⁴

Need for comprehensive systems of care. One of the most important lessons learned from NIMH demonstration programs for the homeless mentally ill was that single service elements alone, such as outreach or case management, cannot address the needs of homeless people.⁷⁵ Outreach for the purposes of engagement in physical or mental health treatment is fruitless unless there are service providers willing and able to accept ongoing responsibility for the full range of intensive treatment and support needs of the homeless population. Likewise, decent and affordable permanent housing must be available to provide alternatives to continued homelessness or residential instability.

Depending on the disability, comprehensive service systems need to include outreach and engagement in nontraditional settings; intensive case management (characterized by smaller caseloads, increased frequency of contact between client and case manager, and the provision of services wherever they may be needed); the availability of inpatient and outpatient treatment and rehabilitation services; staffing and operation of supportive housing programs; and management and administrative activities designed to link these services together.⁷⁶ This linkage is essential if medical problems of a psychiatric population and mental health problems of a medical population are to be adequately assessed and treated.

Need for a wide range of housing options. Thus far, no research has focused on the relationship between housing, homelessness, and physical disability,⁷⁷ but few doubt that the need for affordable community-based, residential care will grow exponentially among persons with AIDS alone in the near future. Were it available now,

such care would effectively eliminate homelessness among this vulnerable subgroup.

Evidence from studies of homeless persons with severe mental illness shows that residential stability in housing of various types can be maintained for extended periods. Lipton and colleagues found that, one year after placement in a supported residence, 69 percent of their homeless mentally ill sample were still housed.⁷⁸ In another study, 54 percent of those homeless mentally ill clients placed in housing by an outreach and case management program remained housed at the end of the three-year study period.⁷⁹ Such findings clearly challenge the prevailing perception that homeless mentally ill individuals are unwilling to become domiciled, receive treatment, and live in the community.

Factors among severely mentally ill homeless persons that appear to be related to such persons remaining housed are preplacement counseling and preparedness,⁸⁰ the degree to which client housing preferences can be accommodated,⁸¹ the availability of on-site and off-site supportive services,⁸² and intensive and extended follow-up of clients.⁸³

It is becoming increasingly clear that homeless mentally ill persons require a wide range of housing options with varying degrees of supervision and support. The nature and relationship of these and other factors to residential stability is the focus of a second round of NIMH McKinney research demonstration projects that received funding in FY 1990.⁸⁴ The lessons learned thus far about the housing and support needs of the psychiatrically disabled—the need for choice, flexibility, and support—can teach us much about responding to similar needs among persons with disabling physical health conditions.

Need for extended follow-up. The need for extended follow-up has become increasingly apparent as health clinics and outreach programs struggle to serve new clients while the number of existing clients in need of continued follow-up grows. Among persons with severe mental illnesses, persistent follow-up with clients and the service providers on which they depend is critical to maintaining residential stability.

While many communities do not have sufficient resources to meet the emergency needs of the homeless population, increasing attention must be paid to developing long-term solutions to homelessness for all persons, particularly those whose physical or mental health status makes them dependent on others for their very lives.

Conclusion

The litany of physical and mental health problems emphasized in nearly every review of homelessness has increasingly been cited as evidence of “victim blaming” or “medicalization” of homelessness, deflecting attention from more systemic factors in the rise of homelessness—a fluctuating economy, lack and loss of affordable housing, and the lack of resources for adequate community mental health care.⁸⁵ But as seen here, it is the most vulnerable citizens who suffer most in the face of systemic malaise. Serious physical health problems become chronic or life-threatening ones, leaving many physically ill homeless people to die preventable or undignified deaths. Persons with severe mental illnesses recede further from reality and safety until society gives them a reason to trust and accept help and treatment.

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33. L. Gelberg et al., "Health, Homelessness, and Poverty: A Study of Clinic Users," *Archives of Internal Medicine* 150 (November 1990): 2325-30.
34. Fischer and Breakey, "Homelessness and Mental Health"; Robertson, "Mental Disorder"; and U.S. Government Accounting Office, "Homeless Mentally Ill."
35. Tessler and Dennis, "A Synthesis," Institute of Medicine, *Homelessness, Health and Human Needs*; Fischer and Breakey, "Epidemiology of Psychiatric and Substance Use Disorders."
36. L. Bachrach, "Defining Chronic Mental Illness: A Concept Paper," *Hospital and Community Psychiatry* 39: 383-88; H. Goldman, A. Gatozzi, and C. Taube, "Defining and Counting the Chronically Mentally Ill," *Hospital and Community Psychiatry* 32(1) (1981): 21-27.
37. Institute of Medicine, *Homelessness, Health and Human Needs*.
38. Ibid.
39. For reviews of these studies, see Tessler and Dennis, "A Synthesis"; J. Morrissey and I. Levine, "Researchers Discuss Latest Findings, Examine Needs of Homeless Mentally Ill Persons," *Hospital and Community Psychiatry* 38(8) (1987): 811-12; I. Levine and D. Rog, "Mental Health Services for Homeless Mentally Ill Persons: Federal Initiatives and Current Service Trends," *American Psychologist* 45(8) (1990): 963-68.
40. Fischer and Breakey, "Epidemiology of Psychiatric and Substance Use Disorders"; Susser, Conover, and Struening, "Mental Illness in the Homeless"; Institute of Medicine, *Homelessness, Health and Human Needs*; and Robertson, "Mental Disorder."
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42. For an in-depth discussion and review, see Tessler and Dennis, "A Synthesis."

43. Fischer and Breakey, "Epidemiology of Psychiatric and Substance Use Disorders."
44. Koegel, Burnam, and Farr, "Prevalence of Specific Psychiatric Disorders."
45. Ibid.
46. Fischer et al., "Mental Health and Social Characteristics."
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48. Roth et al., "Homelessness in Ohio."
49. Morse et al., "Homeless People in St. Louis."
50. Tessler and Dennis, "A Synthesis," 32-36.
51. Farr, Koegel, and Burnam, "A Study of Homelessness."
52. Tessler and Dennis, "A Synthesis."
53. Farr, Koegel, and Bumam, "A Study of Homelessness." Two other NIMH-funded studies conducted in Boston and Milwaukee report similar findings: see V. Mulkern et al., *Homeless Needs Assessment Study: Findings and Recommendations for the Massachusetts Department of Mental Health* (Boston: Human Services Research Institute, 1985); M. Rosnow, T. Shaw, and C. Concord, *Listening to the Homeless: A Study of Homeless Mentally Ill Persons in Milwaukee* (Milwaukee: Human Services Triangle, 1985).
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61. I. Levine, "Service Programs for the Homeless Mentally Ill"; S. Goldfinger and L. Chafetz, "Developing a Better Service Delivery System for the Homeless Mentally Ill"; F. Lipton and A. Sabatini, "Constructing Support Systems for

- Homeless Chronic Patients,” in H. R. Lamb, ed., *The Homeless Mentally Ill: A Task Force Report* (Washington, DC: American Psychiatric Press, 1984).
62. U.S. Department of Housing and Urban Development, *The 1988 National Survey of Shelters for the Homeless* (Washington, DC: U.S. Department of Housing and Urban Development, 1989).
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 66. P. Brickner et al., “Homeless Persons and Health Care,” *Annals of Internal Medicine* 104(3) (1986): 405-409; and D. Rog, *Engaging Homeless Persons with Mental Illnesses into Treatment* (Alexandria, VA: National Mental Health Association, 1988).
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 68. Rog, “Engaging Homeless Persons”; and I. Levine, A. Lezak, and H. Goldman, “Community Support Systems for the Homeless Mentally Ill,” in *The Mental Health Needs of Homeless Persons, New Directions for Mental Health*, ed. E. Bassuk (San Francisco: Jossey-Bass, 1986).
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 71. For research on this subject, see reviews by Dennis et al.; “A Decade of Research”; Tessler and Dennis; specific studies by Breakey et al., in “Health and Mental Health Problems”; and E.L. Struening, *A Study of Residents of the New York City Shelter System* (New York: New York State Psychiatric Institute, 1966). For clinical discussions of the appropriateness of community-based care, see, among others, Goldfinger and Chafetz, “Developing a Better Service Delivery System”; Levine, Lezak, and Goldman, “Community Support Systems”; and Lipton and Sabatini, “Constructing Support Systems.”

72. Breakey et al., "Health and Mental Health."
73. Using standardized clinical assessments, Breakey and associates in "Health and Mental Health" are on the higher end of the need for acute care (17 percent). Other researchers range between 5 and 7 percent. See Mulkern et al., "Homeless Needs Assessment Study"; Roth et al., "Homelessness in Ohio"; and Struening, "A Study of Residents of the New York City Shelter System."
74. Dennis et al., "A Decade of Research"; K. Hopper, D. Mauch, and G. Morse, *The 1986-1987 NIMH-Funded CSP Demonstration Projects to Serve Homeless Mentally Ill Persons: A Preliminary Assessment* (Rockville, MD: National Institute of Mental Health, 1989); and P. Brickner et al., eds., *Under the Safety Net*.
75. Hopper, Mauch, and Morse, "CSP Demonstration Projects."
76. Levine and Rog, "Federal Initiatives"; National Institute of Mental Health, *Request for Applications: McKinney Research Demonstration Program for Homeless Mentally Ill Adults* (Rockville, MD: National Institute of Mental Health, 1990); Brickner et al., eds., *Under the Safety Net*; and Lamb, *The Homeless Mentally Ill*.
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78. F. Lipton, S. Nutt, and A. Sabatini, "Housing the Homeless Mentally Ill: A Longitudinal Study of a Treatment Approach," *Hospital and Community Psychiatry* 39(1) (1988): 40-45.
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83. Hopper, Mauch, and Morse, "CSP Demonstration Projects."
84. National Resource Center on Homelessness and Mental Illness, "NIMH McKinney Awards Total \$5.3 Million for Housing and Services," *Access* 1(2) (1990): 1-3; and NIMH, *Request for Applications*.
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