

Alcohol and Other Drug Problems Among the Homeless: Research, Practice, and Future Directions

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Abstract

At least 50 percent of America's homeless people have significant current problems with alcohol and other drugs. These problems are important risk factors in the selection of the undomiciled from the larger population of extremely poor people. This paper reviews what is known about homeless people with alcohol and other drug problems; assesses the relationship between such individual problems and the larger phenomenon of homelessness; and describes selected aspects of projects funded through the National Institute on Alcohol Abuse and Alcoholism/National Institute on Drug Abuse Demonstration Program for Homeless Persons with Alcohol and Other Drug Problems. It concludes with observations about future directions for research and practice.

Introduction

Alcohol and other drug problems have a long association with the ambiguous condition of extreme poverty called homelessness. Today, scholars and the general public are rediscovering homeless people who abuse drugs other than alcohol, though such people have been around for at least 100 years.¹ In the case of alcohol, it is almost unnecessary to mention the link. The outcast "drunkard in the gutter" was a stock character of the temperance movement by the early 1840s and whether known later as a "whisky bummer," "tramp," "rounder," "wino," or more recently and most politely a "public inebriate," the homeless drunk has been eminently visible for generations. Indeed, in popular, professional, and academic understandings, no condition has been so closely connected with homelessness as chronic alcohol dependence.²

While alcohol- and other drug-dependent people long have been among the homeless, there is no way to tell what fraction of the population they comprised. Enormous improvements in research methods notwithstanding, the obstacles to such historical precision are the same ones that are troubling today: variable definitions of

homelessness that yield incomparable samples and different definitions of dependence and abuse that yield wildly disparate estimates of prevalence. While contemporary estimates are more reliable than earlier ones, they are far from perfect. Even so, it seems that at least 50 percent of today's shelter residents and those who "sleep rough" have significant, current alcohol or other drug problems.³ Further, such problems among homeless people appear to be several times more prevalent than in the domiciled population.⁴

Today's investigators also have much the same difficulty as earlier students of homelessness when they try to move beyond its simple correlation with alcohol and other drug problems. The causal relationship is complicated. First of all, the rigors of homelessness magnify or rekindle old problems and create new ones. Thus, while most homeless people with alcohol and other drug problems experience at least their first symptoms before becoming undomiciled, a substantial minority do not.

Further, and most important, socioeconomic conditions shape the experiences of troubled individuals. These conditions include not only changes in the economy, the housing supply, and relief practices, but transformations in the institutional environment of social welfare and social control. The "loop" of skid row's "therapeutic stations" studied by Jacqueline Wiseman⁵ in the 1960s was not much different from the constellation of local and state institutions that existed in the 1890s, but it has been altered profoundly in recent years. The shortcomings of deinstitutionalization and community care have affected not only the severely and persistently mentally ill and their relations, but also poor and working-class alcohol- and other drug-dependent people, who have sometimes had enduring symbiotic relationships with state hospitals, trading labor useful to the hospital for medical care and respite.⁶ We should neither romanticize this relationship nor necessarily seek to restore it, but its absence clearly influences the terms on which today's shelters are used and the characteristics of the people in them.⁷

This paper describes what is known about today's homeless people with alcohol and other drug problems. It appraises the relationship between homelessness and such problems and emphasizes that alcohol and other drug problems are intervening risk factors in the social production and maintenance of undomiciled status. It discusses some recent approaches to ameliorating alcohol and other drug problems among the homeless; these include attempts to create greater coherence in systems of social welfare and social control and attempts to create forms of housing that both augment and modify the existing low-income housing supply. The paper

concludes with observations about what the future may hold for research and practice.

By way of introduction, two conceptual and methodologic problems that complicate such an overall appraisal must be addressed briefly: definitions of homelessness, and assessments of alcohol and other drug problems.

Conceptual and methodologic problems in studying alcohol and other drug problems among the homeless

Definitions of homelessness

The greatest barrier to speaking precisely about homelessness is the ambiguity of the term. Since its invention by Victorian charity organizers, it has been one among many related terms intended to capture various nuances and facets of being without the spatial, social, and psychological features of home.⁸ These terms have emphasized the absence of two conditions traditionally considered necessary to being settled in a home: possession of a domicile; and durable, affective, and instrumental links to other individuals, particularly kin.

Even these minimal definitional dimensions are ambiguous, however, particularly the affiliative aspect, for disaffiliation is neither necessary nor sufficient to being undomiciled. While disaffiliation can play an important role in the selection of the undomiciled from others of the desperately poor, and while it can also prolong homelessness, relations that lack significant material exchange (as between thoroughly impoverished people) cannot prevent homelessness—whatever the psychological value. Further, according to an old but lively school of thought, compelling affiliations may even provide the basis for deviant socialization, thus “entrenching” homelessness.⁹

An operational definition of homelessness based on domiciliary status has significant advantages over a definition grounded in affiliation. The classic skid-row studies (which rarely employed the term “homelessness”) used an implicit ecological definition of homelessness that mixed an overt urban renewal agenda with received wisdom about “natural areas” inhabited by disaffiliates.¹⁰ A domicile-based definition, on the other hand, allows homeless people to be identified and sampled according to delineated housing circumstances. Such a definition is less likely to confound sample

construction with causal assumptions or unexamined political objectives.

Even so, the domiciliary dimension of homelessness is not clearly bounded. Reasonable people will quarrel about which housing circumstances ought to be included: Should an operational definition of homelessness include those doubled up with friends and relatives, or the inmates of jails, prisons, nursing homes, or treatment facilities? (The federal definition finesses this point by designating such people as “at imminent risk of becoming homeless.”) Should it include people living without basic necessities such as indoor plumbing and heat, as the United Nations definition suggests? Should it, as some feminists have argued, include abused women and children trapped in their euphemistic “homes” because they perceive no economic alternative? Such questions remind us that there is a fine line between being undomiciled and being “precariously housed,” to borrow the felicitous term used by Peter Rossi and his colleagues.¹¹ And such questions are inevitable given that many—perhaps most—of the homeless move back and forth from precarious housing to undomiciled status, scrambling along the “common edge of extreme poverty.”¹²

Nonetheless, housing circumstances are *relatively* easy to define for sampling purposes, though the task is not without difficulties.¹³ In most instances, while investigators might debate the nature of the universe, they can speak pretty clearly about sample parameters and can sort out grate dwellers, shantytown denizens, shelter patrons, single-room occupancy (SRO) residents, jail inmates, and so forth for comparative analysis. This clarity is indispensable to comparing studies of homeless people, especially in view of the huge variation by site in the prevalence of major mental disorders and alcohol and other drug problems.¹⁴

Assessing alcohol and other drug problems

The problem of sample comparability dictates great care in estimating the prevalence of any problem in the homeless population, but with respect to alcohol and other drug problems, further difficulty is introduced by the variety of indicators used to measure them.

At the extreme of dubious reliability, a few studies have used so-called “provider surveys.” These surveys involve asking key informants—usually service providers—to render their best guesses about the prevalence of alcohol and other drug problems among

their clients. John McCook used this method in his “tramp census” 100 years ago, and the Canadian Council on Social Development employed it in a nationwide census of shelter residents as recently as 1986.¹⁵ The method’s main virtue is that it is cheaply implemented; however, it relies on the judgments of people whose interests, angles of vision, and discernment are entirely unknown. Similarly, estimates based on agency records rely on the artifacts of unstandardized, even untrained, judgments.

Another source of bias in prevalence estimates is reliance on self-reported consumption. A number of recent studies have found significant discrepancies between self-reported alcohol consumption and other measures like laboratory tests or collateral reports.¹⁶ A recent Institute of Medicine report on the treatment of alcohol problems observes that the validity of self-reports is decreased when items on the assessment instrument are vague or overly general; contact with the respondent is brief; or the respondent is experiencing withdrawal symptoms or acute distress, has a clear motive to distort information, or is not aware that self-reports will be checked against other sources of information.¹⁷

Estimates based on standardized assessment instruments and psychiatric interviews are most reliable, particularly when used together. For instance, in Baltimore, Maryland, Pamela Fischer and William Breakey found a high correlation between diagnosis of alcohol abuse by psychiatric examination and diagnosis of alcoholism by the Short Michigan Alcoholism Screening Test (SMAST).¹⁸ Although expensive to employ, such multiple measures are greatly to be desired.

Optimally, research like that conducted by Kim Hopper and his colleagues in Manhattan or Peter Rossi and his associates in Chicago would generate painstaking prevalence estimates from meticulous samples of people in specified housing circumstances.¹⁹ Unfortunately, Hopper’s only measures of alcohol or other drug problems were questions about help-seeking and the lifetime use of cocaine and/or heroin 50 or more times. Rossi’s principal measure of alcohol and/or other drug problems was a question about previous detoxification. Hopper’s findings are not yet available, but like Rossi’s results, they will be impossible to interpret confidently because of the historical character of the questions, their brevity, and their inapplicability to the large numbers of abusers who are never treated. To be fair, however, it should be emphasized that both studies necessarily used short interview protocols and thus faced hard decisions about item selection.

Lacking reports from geographically diverse studies that optimize both sampling procedures and measurements of alcohol and other drug problems, this paper summarizes what the best current studies have found. For the most part, these studies sampled homeless people from shelters, from the streets, and occasionally from jails, and used multiple or standardized measures of alcohol and other drug problems.

Alcohol and other drug problems among the homeless

Supported by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute of Mental Health (NIMH), Pamela Fischer conducted an exhaustive review of studies of homeless people published since 1980. She found widely varying estimates of prevalence based on sample sites, sample composition (i.e., demographic characteristics of the sample), and methods of problem assessment. However, based on what Fischer judged to be the most technically adequate research, it seems fair to say that at least 10 percent of the homeless have current drug problems, and a minimum of 40 percent in addition have current alcohol problems.²¹ The combination of alcohol and other drug problems among the homeless has been little considered, but in a well-designed study of shelter and jail samples in Baltimore, Breakey and Fischer found 27 percent of the whole group to have an alcohol disorder only, 5 percent to have a separate drug disorder only, 6 percent to have combined alcohol and other drug disorders, and 24 percent to have an alcohol and/or other drug disorder combined with a major mental disorder. More than 60 percent of the sample had some current alcohol and/or other drug disorder as determined by psychiatric examination.²²

Adult men unaccompanied by children comprise the vast majority of homeless people in most regions, and they are several times more likely than homeless women to have alcohol problems. However, this gender difference has not been found consistently among abusers of drugs other than alcohol. The best evidence suggests that other drug abusers are more likely than nonabusers to be African-American and Hispanic, that other drug problems are found disproportionately among the younger homeless (those under 50), and that older homeless people are more likely to have alcohol problems. However, age-related patterns of other drug abuse vary according to the substance in question, by race and ethnicity, and by region.²³ Further, little is known about homeless adolescents, although the findings of Marjorie Robertson and her colleagues from

a small sample in Hollywood, California, are disconcerting, suggesting high rates of abuse and comorbidity associated with parental alcohol dependence and child abuse, formal removal of the child from the home, and criminal involvement of the adolescent while homeless.²⁴

Taken together, such findings suggest some discernible cohorts among the homeless with alcohol and other drug problems, although these are subject to regional variation and can be expected to change over time. There are older, white men with conventional work histories and long-standing drinking problems who closely resemble skid-row men of the post-war decades. Younger, African-American and Hispanic men, more likely to be other drug abusers, have grown up under conditions of endemic unemployment and the widespread use of a variety of drugs. There has been recent growth in the number of homeless, crack-dependent women with children, though alcohol and other drug dependence does not appear to be anywhere near as common among homeless adults with families as among homeless adults without children.²⁵

Homeless people with alcohol or other drug problems appear to have a tougher time on the street and in the shelters than others. In particular, they suffer disproportionately from serious health problems. Among the alcohol-dependent, health problems are often a combined function of their drinking and more advanced age.²⁶

Homeless intravenous drug users are at great risk of HIV infection, and some evidence suggests that they are more sexually active than others of the homeless and are more likely to be bisexual or homosexual and to engage in prostitution.²⁷ Those with alcohol and other drug problems suffer disproportionately from traumatic injuries and victimization and are arrested more frequently than others who are homeless.²⁸ Summarizing their findings from a large sample of the homeless without children in New York City shelters, Elmer Struening and Deborah Padgett put the matter simply: There is “a direct relationship between poor physical health and the degree and kind of involvement with drugs, alcohol, and mental problems.”²⁹

Even so, remarkably few homeless people, regardless of their psychiatric status, currently collect welfare or Social Security benefits of any kind. However, those with alcohol or other drug problems are far less likely than the mentally ill or the dually diagnosed to be collecting social security payments for disability, whether as insurance (Social Security Disability Insurance or SSDI) or welfare (Supplemental Security Income or SSI).³⁰

Published studies of today's homeless have not provided much useful information about affiliations. Some general social support and social network questions have been asked, but they have been framed mainly in terms of social contacts or resource potential rather than actual contacts or resource exchange. In some part, this situation may reflect an overly psychologistic interpretation of disaffiliation, but it is more likely the result of the necessary economies of survey research. Detailed social network interviews are time-consuming and therefore expensive to administer. In any event, several studies suggest that alcohol-dependent men, in particular, are more likely than others among the homeless to have no family contact. This fact probably is related both to their drinking habits and to their older age. On the other hand, members of this group are less likely to report that they have no friends, although, as suggested above, it is difficult to know what to make of this as the exchange content of the relationships is not specified.³¹

Alcohol-dependent homeless people also appear to have histories of recurrent and enduring homelessness. They tend to be chronically rather than episodically homeless. Although few studies have included life history interviews, Paul Koegel and M. Audrey Burnam found that 80 percent of those with alcohol problems experienced their first symptom before their first episode of homelessness, and more than half experienced their first symptom at least five years before first becoming homeless. However, they also found that about 25 percent of the long-term homeless developed their first symptom after a bout of homelessness.³²

In sum, the following can be said with assurance. First, current alcohol and other drug problems are widespread among the homeless, involving, as a conservative estimate, 50 percent of the population. Second, homeless people with alcohol and other drug problems are in poorer health than others of the homeless, are victimized more frequently, and are arrested more often. In short, there are a lot of them, and they are suffering a great deal even by comparison with others who are suffering enormously compared with the domiciled population. As Koegel and his colleagues observed about the homeless in inner-city Los Angeles, in spite of the "leveling effect" of homelessness, "those who suffer from chronic substance abuse, particularly those who have a combination of substance abuse and chronic mental illness, . . . appear most distinctive and most unable to meet subsistence needs."³³

Appraising the relationship between homelessness and alcohol and other drug problems

Alcohol and other drug problems are serious matters in their own right. However, such problems do not cause homelessness, except in a limited sense. A brief, historical digression will make the point clearly.

The vast majority of skid row residents studied during the 1950s and 1960s were domiciled in spite of the drinking problems from which perhaps one-third of them suffered. Most lived in the workmen's hotels that came to be called single-room occupancies, or SROs, or in cubicle or "cage" hotels. Others lived in rooming houses, and a small number lived in missions.³⁴ Similarly, impoverished alcohol- and other drug-dependent people of earlier periods found refuge at this bottom end of the housing market.

The historical exceptions were the severe depressions of the late nineteenth and early twentieth centuries and the Great Depression of 1929 to 1941. During these periods, vast numbers of people could purchase no housing at all and the ranks of the undomiciled grew prodigiously, the drinking and other drug-taking habits of the dispossessed notwithstanding. On the other hand, the two world wars each ended periods of economic distress, and the tight wartime labor markets absorbed even the most unproductive workers, including many who were dependent on alcohol and other drugs.³⁵ The point is simple: At bottom, homelessness is an economic phenomenon. It occurs when people cannot purchase housing.

Straitened economic circumstances do not affect all people in the same ways, however. The growth of a working-class temperance movement following the Panic of 1837 reflected, in part, the understanding that heavy drinkers were hurt quickly by their impaired ability to manage hard times.³⁶ In the 1890s, John McCook was the first student of homelessness to address this matter directly. Writing at a time when far more people were vulnerable wage laborers than during the 1840s, McCook observed that during prolonged economic slumps the number of tramps grew enormously. At the same time, his data suggested that a large percentage of tramps were "intemperate" in their use of alcohol and that most were single men. He concluded that when employers were faced with laying off workers, they first discharged single, heavy drinkers; that is, those whom they took to be their least productive workers and who did not have families to support. These were also the last men rehired.³⁷ McCook thus modified his earlier view that intemperance, plain and simple, was at the root of tramping. His revised, more

subtle understanding foreshadowed subsequent analyses of the relationship between homelessness and drinking habits.

Like disaffiliation, then, alcohol and other drug problems should be viewed as intervening factors in the social production and maintenance of undomiciled status. They are liabilities—“risk factors” in public health parlance—and their burden is magnified greatly by conditions of scarcity and mitigated by prosperity.

Today, the poorest Americans live in conditions of scarcity that have become increasingly stark over the past decade and a half, or roughly since the “stagflation” of the mid-1970s. Structural changes in the economy have added high-skill, well-paid technical jobs and low-skill, poorly paid service positions, but these changes have simultaneously produced job losses among semiskilled but highly paid workers, primarily in manufacturing. This process of deindustrialization has been especially consequential for younger, lower-class and working-class members of the huge baby boom cohort who have entered a glutted labor market without the advantage of prolonged higher education or advanced technical training.³⁸ At the same time, the 1980s brought a hyperinflation of rental housing costs and a steep decline in the real value of benefits under Aid to Families with Dependent Children (AFDC), SSI, state and local General Assistance (GA), and unemployment insurance (UI).³⁹ Contrary to what was believed a decade ago, more recent research shows that large pools of people experience profound and prolonged “poverty spells” of years’ duration.⁴⁰

As the poor have become poorer, they have been pitched into competition for a dwindling supply of housing at the bottom of the market. Of particular importance is the decline in numbers of SRO, cubicle hotel, and rooming-house units. The virtual destruction of this housing stock has all but eliminated the last resorts of the most marginal among the poor. What remains of this housing generally is beyond the means of welfare recipients or even those with minimum-wage jobs. Further, the seller’s market for such housing allows landlords and managers to be choosy about their tenants, a matter of great importance to those whose behavior is sometimes objectionable.

The exclusion of homeless people with alcohol and other drug problems from even the most rudimentary housing is a little-researched but important problem, for the practice appears to be widespread. Reports from the field suggest that some homeless people—how many is unknown—have lost Section 8 certification as a result of behavior related to their drinking or abuse of other drugs. Most

shelters do not admit people they judge to be intoxicated, and virtually every shelter has evicted, permanently or temporarily, scores of abusive or disruptive alcohol- and other drug-dependent people, even shelters where staff regret the necessity and earnestly worry about the consequences.⁴¹ In Montreal, an all-night drop-in center called *Dernier Recours* (The Last Resort) has become a collecting point for people bounced from that city's shelters; among these people, the dually diagnosed seem to be disproportionately represented. Roughly 80 percent of the clients of *Dernier Recours* were found to have lifetime diagnoses of alcohol and other drug problems, singly or in combination. *Dernier Recours*, which offers sleeping space on a concrete floor, appears to provide refuge for a large group of homeless people who, on any given night, are not sufficiently sober or cooperative to be acceptable to other shelters. They are involved in a pattern of episodic, unilateral or mutual rejection.⁴²

Thus, people with alcohol and other drug problems become undomiciled because they are poor, because they have exhausted the capacities of whatever resource-endowed kin and friends they may have had, and because they are pegged as bad tenants. It should come as no surprise, then, to find them represented disproportionately among the chronically homeless who do not move rapidly in and out of undomiciled status.

Of course, this understanding of the relationship between homelessness and alcohol and other drug problems has important implications for policy and services. It suggests that attention must be paid simultaneously to material needs and to the health and behavioral liabilities attendant upon chronic intoxication.

Responses to the problems of the homeless with alcohol and other drug problems

Just as there is a long association of homelessness with alcohol and other drug problems, there is a long history of attempts to reform, cure, and even quarantine such homeless people. Established, highly regarded programs such as the Pine Street Inn (Boston), the Public Inebriate Services Network (Portland, Oregon), the Manhattan Bowery Project (New York City), and the Salvation Army Harbor Light programs descend from efforts that can be traced back 150 years.⁴³

This paper describes some approaches that are part of a national, multisite research demonstration effort funded by NIAAA in consultation with the National Institute on Drug Abuse (NIDA). The

NIAAA/NIDA Community Demonstration Grant Projects for Alcohol and Drug Abuse Treatment of Homeless Individuals was funded with \$12.5 million under Section 613 of the Stewart B. McKinney Homeless Assistance Act (P.L. 100-77). The demonstration's mission is to implement and evaluate a variety of approaches to community-based treatment for individuals who have alcohol and other drug problems and who are homeless or at "imminent risk" of becoming so. The program's primary goals are to ameliorate alcohol and other drug problems among homeless people and to increase their access to emergency, transitional, and permanent housing. The secondary goals of the demonstration are (1) to improve the economic status of the target population by assisting with benefit acquisition, vocational training, and job finding; and (2) to increase cooperation among local human services providers.

Grants were made on a competitive basis to nine programs in May 1988. The programs are in Anchorage, Boston, Los Angeles, Louisville, Minneapolis, Oakland, Philadelphia (two), and New York. They represent an array of approaches to a heterogeneous population that includes women with children and single people of all races, those with alcohol and other drug problems singly or in combination, and those whose alcohol and other drug problems are combined with mental illness. In addition to providing basic food and shelter, their services include outreach and engagement, including low-demand sobering stations that accept intoxicated persons and serve as a first point of contact with the human service system; detoxification; alcohol and other drug treatment, including referrals to self-help and mutual aid programs like Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Cocaine Anonymous (CA); case management; transitional housing and alcohol-free living centers; and vocational training.

The demonstration program emphasizes evaluation. Projects are required to conduct client-level process evaluations and, where possible, outcome evaluations of the larger project. All nine projects participate in a national, cross-site evaluation intended to further knowledge about what interventions work best for which subpopulations of the homeless, and why they work. The salient features of these projects and their evaluation designs are summarized in table 1.

Challenges in service design

There are a number of well-known challenges in designing and implementing services for homeless people. This paper discusses

three particularly challenging issues and how selected demonstration projects address them. These problem areas are access to alcohol and other drug services; the development of comprehensive and continuous care; and the development of housing that is appropriate, affordable, and supportive of abstinence.

Accessibility

In many communities, alcohol and other drug services are available but not accessible. Accessibility does not mean simple geographic proximity, although this is sometimes an issue.⁴⁴ Rather, accessible services reduce the social distance, role expectations, and organizational rules that complicate providing help and deliberately or inadvertently alienate potential consumers.⁴⁵ Concerns of this sort informed design of the demonstration project in Louisville, Kentucky.

At the heart of the Louisville project is a sobering station, a 20-bed facility in a renovated four-room house on a side street of the city's skid row. It is open 24 hours a day to allow homeless men with alcohol and other drug problems to shower, change clothes, eat, and "sleep it off." Staff members are drawn from among those who have similar life experiences, and rules are limited to those necessary to preserve health and safety. Roughly 90 percent of the station's clients are self-referred; the rest are sent by other shelters, the police, medical units, or formal treatment programs. The sobering station is a point of first contact at which relationships with these men can be established over time with a goal of involving them in AA, NA, CA, and intensive case management.

The Louisville project also has an active outreach component. Case managers follow up on their clients in the streets or under bridges over the Ohio River when necessary. A jail liaison interviews homeless men incarcerated mainly for public drunkenness, and the program has a formal agreement with the local court that allows multiple public drunkenness offenders to be diverted to mandatory case management. While relying primarily on voluntary engagement, the project participates in coercive measures for a clearly specified group of homeless men.

Preliminary evaluation suggests that the program will engage about 25 percent of clients who use the sobering station repeatedly. Early outcome reports from case managers are reasonably encouraging, particularly with respect to getting men off the street at

Table 1. NIAAA Summary of Demonstration Grants

Project Name	Target Population	Key Service Elements	Related Services	Evaluation Methodology
Treating Homeless and Dual Diagnosis Substance Abusers, Anchorage, AK	Adult men Adult women Alaskan natives	<ul style="list-style-type: none"> • Drop-in/sobering-up station • Diagnostic screening and medical treatment services 	<ul style="list-style-type: none"> • Residential treatment opportunities • Mental health services • Supportive housing 	<p>Quasi-experiment comparing clients who enter recovery components with an untreated group identified at screening.</p> <p>Comparison of groups at two points using an instrument developed by the evaluators.</p>
Stabilization Services for Homeless Substance Abusers, Boston, MA	Adult men Adult women	<ul style="list-style-type: none"> • Intensive case management • Residential treatment centers • Supportive housing 	<ul style="list-style-type: none"> • Coordination of substance abuse rehabilitation services with other social services 	<p>Experiment using a 2x2 factorial design (treatment agency vs. shelter by intensive case management vs. customary aftercare).</p> <p>Comparison of groups at multiple points using the Addiction Severity Index (ASI) and the Alcohol Dependence Scale.</p>
Sober Transitional Housing and Employment Project, Los Angeles, CA	Adult men Adult women	<ul style="list-style-type: none"> • Alcohol recovery in a residential setting • Supportive housing 	<ul style="list-style-type: none"> • Vocational education • Housing assistance 	<p>Experiment with full and minimal treatment groups. Comparison of groups at multiple points using the ASI and a goal attainment instrument.</p>
Project Connect for Homeless Alcoholics and Drug Abusers, Louisville, KY	Adult men	<ul style="list-style-type: none"> • Case management • Shelter/sobering-up station 	<ul style="list-style-type: none"> • Work adjustment program • Jail liaison 	<p>Quasi-experiment comparing intensive and nonintensive case management. Comparison at two points using the ASI and a quality of life instrument.</p>

Table 1. NIAAA Summary of Demonstration Grants (continued)

Project Name	Target Population	Key Service Elements	Related Services	Evaluation Methodology
Community Treatment for the Chronic Public Inebriate, Minneapolis, MN	Adult men Native Americans	<ul style="list-style-type: none"> Intensive case management Referral for other supportive services 	<ul style="list-style-type: none"> Alcohol treatment Housing 	Experiment with two levels of case management and one minimal treatment group. Comparisons at multiple points using the ASI and service utilization data
Outreach and Engagement for Homeless Alcoholic Women, New York, NY	Women with children	<ul style="list-style-type: none"> Outreach/engagement teams in hotels/shelters Acupuncture clinic Alcohol clinic 	<ul style="list-style-type: none"> Job/housing placement Child care Basic educational/illiteracy classes 	Quasi-experiment with full and minimal treatment groups. Groups compared at multiple points using the ASI and service utilization data.
Comprehensive Alcohol Recovery Services, Oakland, CA	Adult men Adult women	<ul style="list-style-type: none"> Alcohol crisis center Street and community outreach and education program 	<ul style="list-style-type: none"> Drop-in center Alcohol inpatient services Sober housing 	Qualitative study of project participants, nonparticipants, and key staff, using semistructured interviews.
Comprehensive Services for Dually Diagnosed Homeless, Philadelphia, PA	Adult men and women with concomitant mental health and alcohol/other drug problems	<ul style="list-style-type: none"> Outreach Supportive living programs Intensive case management 	<ul style="list-style-type: none"> Individual service plans Boarding homes 	Quasi-experiment with two treatment groups. Comparison at multiple points using the ASI and level of functioning instruments.
Breaking the Cycle: The Addicted Homeless Mother, Philadelphia, PA	Women with children	<ul style="list-style-type: none"> Supportive residential recovery program 	<ul style="list-style-type: none"> Rehabilitation and socialization services 	Experiment with full and minimal treatment groups (in residential component vs. receiving outpatient services only). Comparisons at multiple points using the ASI.

night. Like all programs of this sort, the Louisville project likely will have far more initial success at keeping their clients out of harm's way than at eliciting abstinence.⁴⁶

Comprehensive and continuous care

While clinical practice is grounded in the wisdom of working with the "whole person," "beginning where the client is," and "partializing" complex problems for systematic attention, labyrinthine structures of human services virtually guarantee that clients, rather than problems, will be partialized. In response to this situation, a hallowed social casework technique has reemerged in recent years under the rubric of "case management."

Various definitions and models of case management exist, but put simply, case management involves engaging clients in a continuous helping relationship that supports and facilitates their coherent and effective use of environmental resources. The case manager, or the case management team, anchors a process whereby available resources are put systematically in the service of clients' needs. At one extreme, closely approximating traditional social casework, case managers are skilled therapists who also are adept social brokers and advocates. At another extreme, case managers are mere service auditors who make referrals and attempt to coordinate the efforts of others from a distance.

Case management approaches are being implemented in the NIAAA/NIDA demonstrations in Boston, Louisville, Minneapolis, and Philadelphia (Horizon House). The models vary, each having adapted to the unique needs of their clients and the characteristics of their community's network of human services. Because the Minneapolis project has the longest history and is focused exclusively on a test of case management approaches, it is discussed here.

The Minneapolis approach to case management was adapted from the model developed in Madison, Wisconsin, by Leonard Stein and Mary Ann Test.⁴⁷ Central to this model is a core group of professional and paraprofessional providers who, as a team, perform client assessment, clinical treatment, service planning and implementation, resource development, and case review. The team cannot shift responsibility for its clients to other organizations, thus mitigating the problem of "creaming" or "dumping" that sometimes occurs in programs that contend with people whose problems are

complicated, who improve slowly or minimally, or who may not be readily cooperative. Unlike the Madison model, the Minneapolis program assigns one team member the function of primary case manager. This person is responsible for the day-to-day implementation of the team's plan and maintenance of long-term relationships with clients.

The Minneapolis approach to intensive case management (ICM) features a number of other distinctive elements. Caseloads are small (12 clients per primary case manager); clients are classified in a tier system according to the severity of their problems and to balance caseloads accordingly; case managers actively seek clients on the street and other public settings when contact is lost; they visit regularly with clients in residential treatment; and a money management program makes resource availability contingent on behavioral change. (As in the Louisville program, a modest degree of coercion sometimes is deemed useful.)

The Minneapolis project is evaluating the efficacy of the ICM model by randomly assigning eligible participants to one of three groups: ICM; a nonintensive model of case management differentiated by higher caseloads and less frequent contact and street follow-up; and an "episodic care" modality based on referral from detoxification without case management efforts to coordinate or follow up. A variety of outcome measures are taken at several points in time, and these quantitative data are being supplemented by an ethnographic study of Native American participants, who represent about 40 percent of the Minneapolis clients.

Early evaluation data show that ICM managers reported modestly greater improvements in drinking problems among their clients than did managers in the non-ICM program. Housing and overall status, while slightly improved in both groups, did not vary between models. Perhaps most important to long-term outcomes, however, the dropout rate in the ICM group was extremely low (2 percent), only one-tenth the rate in the non-ICM group (20 percent).⁴⁸

Housing

No matter how effectively programs engage their homeless clients and no matter how sensitively and thoroughly the programs implement case management systems, homeless people remain homeless without access to permanent housing. Alcohol and other drug treatment for the homeless will fail without such resources.

The simplest way to develop durable housing alternatives for homeless people with alcohol and other drug problems is to make housing assistance part of a case management process or, in the absence of a full-blown case management system, to make it one of the supportive social services offered by a treatment program. For example, in the Women in Need project in New York City, a housing specialist assists clients applying for public housing or negotiating with private landlords. Once housing is secured, the housing specialist helps clients learn about the new neighborhood, arranges for moving assistance, and offers workshops on topics including tenant rights and home budgeting. Thus, the housing specialist's role combines social brokerage, client advocacy, and education.⁴⁹

While such assistance is valuable, the method has some fundamental limitations: It neither creates new affordable housing opportunities (through new construction, rehabilitation, and so forth) nor augments the purchasing power of homeless people. While program participants become more effective competitors for what affordable housing exists, they may be limited to an exceedingly tight submarket, particularly in cities like New York and San Francisco, or they may be limited to housing choices far removed from employment opportunities, as in the many areas where service jobs are available primarily in suburbs without affordable housing or public transportation. In any event, some combination of supply and demand-enhancement strategies appropriate to regional conditions will be of broader value than an approach based solely on social brokerage, individualized advocacy, and education.⁵⁰ However, social service agencies should not bear primary responsibility for developing these strategies, for by and large, they lack the skills and the financial and political resources.

When appropriate housing opportunities are available, the brokerage/advocacy method can reckon with the particular housing needs of homeless people with alcohol and other drug problems. These people usually require "transitional" housing that includes clinical and social services or participation in self-help and mutual aid efforts. However, as the term implies, this is a relatively short-term arrangement; tenure is limited to 30 days, or at most, a few months. Graduates of transitional housing then need permanent housing. Depending on the stability of an individual's recovery and the local housing and job markets, the brokerage/advocacy model may be very useful at this point; however, even if the job market is tight and the affordable housing market is loose—conditions that do not prevail widely—the recovery process is fragile and requires continuous support and reinforcement. Clinical wisdom suggests that for people who have long-standing problems or who have been homeless

for some time, support is best accomplished on an open-ended residential basis.

Throughout the United States, many programs have experimented with combining transitional housing that includes alcohol and other drug treatment with the development of “permanent” or temporally open-ended housing. Sometimes this supply strategy is intended to create more affordable housing opportunities. The most ambitious project of this kind is the \$14 million complex built recently by San Francisco’s Delancey Street Foundation to house 700 of its program participants. In other instances, experiments involve a transformation of housing, specifically the conversion of unexacting, commodified housing into socially controlled housing. These programs do not add housing stock but convert existing units to quasi-therapeutic use on an open-ended basis. Whether added or converted, however, these socially controlled housing projects are more like “dry” cooperatives than commercial hostels or apartment houses, and in varying degrees they partake of the spirit of the intentional community. The Arlington Hotel in San Francisco and the Railton Residence in St. Louis are notable examples of the conversion of old SROs into permanent, alcohol- and other drug-free living centers.⁵¹

Conversion of secular, affordable housing to quasi-therapeutic use is not wholly unproblematic, however. Sometimes original residents are displaced in the process, usually into a very tight market. Frequently, these are people with alcohol and other drug problems who have not joined the therapeutic fold. While the argument can be made that the converted housing represents a “higher” use that benefits both the new tenants and the neighborhood, the resulting displacement is nonetheless an instance of Shipley’s Law: One way or another, “good bums drive out bad bums.”⁵² In short, without careful planning, conversion can benefit one group of the poor at the expense of another.

The NIAAA/NIDA demonstration projects have addressed the matter of permanent housing in various ways that have been shaped by local circumstances and the needs and resources of program participants. Though not part of the original design, to capitalize on the support and pooled resources possible in group living, the Boston project developed a modified Oxford House. An Oxford House typically is a leased, single-family home in a middle-class neighborhood transformed into a self-supported, self-governed recovery home for an average of 12 residents. Residents must meet their financial obligations to the household and remain alcohol- and drug-free. Violation of these basic rules results in immediate expulsion, but residence is otherwise open-ended. Oxford Houses rely

entirely on self-help and mutual aid and have no formal relations with treatment programs.⁵³

With the cooperation of the national Oxford House organization, the Boston project adapted the model to the extensive needs of homeless people. The Boston residence permits case managers to visit residents formerly or currently participating in the project's stabilization program.⁵⁴ These visits provide an opportunity to offer continuing relapse prevention counseling. The case managers also helped residents to renovate the house, establish workable rules, and develop simple financial accounting systems.⁵⁵

Whether by supply enhancement or conversion, the development of open-ended, alcohol- and drug-free residences must be a priority during the 1990s. However, such an emphasis begs an important question: What is to become of homeless people who continue to use alcohol and other drugs excessively? This paper concludes with some observations on this and other matters that loom on the horizon of research and practice.

Future directions for research and practice

The goals of the NIAAA/NIDA demonstration program reflect two important points of consensus among those involved with homelessness, whether as policy makers, scholars, or service providers. First, research and practice should be mutually informing and reinforcing enterprises. Second, homelessness cannot be understood apart from the political and economic forces that shape individual lives. Thus, research and practice should attend to the structural factors that produce undomiciled people as well as to the individual risk factors that give the homeless population its characteristic features.

In the thousands of years over which homelessness of some kind has existed, no society ever has known as much about homeless people as does America today. At present, a great deal is known about individual risk factors, particularly alcohol and other drug dependence and persistent and severe mental illness. But "knowing about homeless people" is not the same as understanding "homelessness," a condition rooted in economic and social relations. To understand homelessness is to attend to its sources and processes, especially its episodic character. Policy must be shaped to prevent it—perhaps beginning with more generous income maintenance programs, expanded housing subsidies, and service projects aimed at preventing eviction and other forms of residential displacement. Research

must reveal how people make “stable exits”⁵⁶ from homelessness, and how to support this process effectively. To these ends, longitudinal rather than cross-sectional studies of the homeless population are needed, as well as prospective studies of high-risk groups.

The evaluation components of service projects are extremely important in this connection. In addition to providing material for an agency’s critical internal discourse, evaluation can identify barriers to success that transcend the pathologies of individual clients or the idiosyncracies of specific organizations. For instance, it is well known that homeless people with alcohol and other drug problems are difficult to engage and difficult to treat successfully, at least if the criterion of sustained abstinence is employed. Expectations should therefore be modest, and extravagant promises should be avoided. Nonetheless, it is also well known that sobriety must have an adequate material base. To have any chance at all, recovering people must have housing and jobs or, at a minimum, the support of public assistance. Program evaluations can identify deficits in these areas and assess the extent to which service approaches per se are useful interventions. Evaluation of the strengths and limitations of case management schemes is an important example of this approach.

Evaluations that focus on local system effects as well as on discrete program effects are important as well to the matter of replication. Program “models” are sometimes spoken of as if they were self-contained and effortlessly reproducible. In fact, all service and housing programs operate within local systems that inevitably shape their character and effectiveness. Thus, it is necessary to understand not only what kinds of programs work for what sorts of people and why they work or do not, but to understand as well why they work or do not in relation to their institutional surroundings.⁵⁷

Properly understood, replication rests on general principles rather than on specific, superficially reproducible program elements. Guiding principles are defined within a legal and political framework, of course. Deinstitutionalization, for instance, is not a clinical method, but a philosophy of care and control shaped by legal interpretation of statute and civil rights, and by the *realpolitik* of administrative systems.⁵⁸ Important guiding principles with respect to the homeless with alcohol and other drug problems remain unsettled. How much coerced treatment is useful or should be tolerated? Is the repeated jailing of public inebriates a violation of a right to treatment or can it be necessary to “hitting bottom”? Should strict money management be permissible but involuntary commitment be forbidden? In addition to promoting alcohol- and other drug-free

living centers, should “wet,” “damp,” or “moist” hotels be subsidized for homeless people who continue to drink excessively?⁵⁹ How should the homeless who persist in using illegal drugs be managed?

As good utilitarians, scholars can bring evidence to bear on these issues through research, and the next decade will see much empirically grounded debate about these matters. In the end, however, these are not wholly empirical questions, and utilitarian reasoning about their answers will not satisfy everyone. And in the end, of course, neither service providers nor social scientists will make whatever decisions prevail.

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Endnotes

1. Jim Baumohl, "The 'Dope Fiend's Paradise' Revisited: Notes from Research in Progress on Drug Law Enforcement in San Francisco, 1875–1915," *The Drinking and Drug Practices Surveyor*, in press; Jim Baumohl, "Alcohol, Homelessness, and Public Policy," *Contemporary Drug Problems*, 16 (1989), 296 at endnote 13.
2. There is a vast literature on alcohol and homelessness. For a useful summary, see Gerald R. Garrett, "Alcohol Problems and Homelessness: History and Research," *Contemporary Drug Problems*, 16 (1989): 301–32. For the antebellum connection, see Leonard U. Blumberg with William L. Pittman, *Beware the First Drink! The Washingtonian Temperance Movement and Alcoholics Anonymous* (Seattle: Glen Abbey Books, 1991).
3. A prevalence figure of 40 percent for only current alcohol problems represents the lower boundary of a range of estimates reported by Pamela J. Fischer, *Alcohol and Drug Abuse and Mental Health Problems Among Homeless Persons: A Review of the Literature, 1980–1990* (Rockville, MD: National Institute on Alcohol Abuse and Alcoholism and National Institute of Mental Health, 1991) (Hereafter *Alcohol and Drug Abuse*). This range of 41 to 58 percent was based on studies of adult homeless populations that were judged by Fischer to be adequate technically. The range of estimates of this sort for other drug problems was, however, considerably wider, 2 to 48 percent. Since the lowest figure derived from a single study, the present paper uses for its estimate the lowest boundary of the interquartile range of 10 to 20 percent. This figure of 10 percent is consistent with the lower boundary prevalence figures cited by other reports attempting to synthesize estimates of drug problems among homeless people. See, for instance, Institute of Medicine, *Homelessness, Health and Human Service Needs* (Washington, DC: National Academy Press, 1988), 64. There is no clear fix on the prevalence of co-morbidity, and thus, in the interest of conservatism, this group has not been included in the estimate here. It is probably small.
4. Paul Koegel and M. Audrey Burnam, *The Epidemiology of Alcohol Abuse and Dependence among Homeless Individuals: Findings from the Inner-City of Los Angeles* (Rockville, MD: National Institute on Alcohol Abuse and Alcoholism, January 1987), 141-43 (hereafter, *Epidemiology*); Fischer, *Alcohol and Drug Abuse*, 59-60.
5. "Making the loop" was the skid row man's characterization of his encounters with the various agencies of social welfare and social control that structured many of the opportunities and unfavorable contingencies of his life. His chosen metaphor was quite different, though certainly more accurate, than the linear, rehabilitative metaphors favored by functionaries within this "system," such as it was. See Jacqueline Wiseman, *Stations of the Lost: The Treatment of Skid Row Alcoholics* (Englewood Cliffs, NJ: Prentice-Hall, 1970), particularly pages 58-61. For a more recent application of these insights to the circumstances and strategies of the chronically treated mentally ill, see Dan A. Lewis and Rob Hugi, "Therapeutic Stations and the Chronically Treated Mentally Ill," *Social Service Review*, 55 (1981): 206-20.
6. For an extended example of such a relationship during the 1920s, see Baumohl, "Alcohol, Homelessness, and Public Policy." See also note 35, below; and for observations along these lines by homeless men during the 1960s,

- Wiseman, *Stations of the Lost*, 165-6. In 1960, a decade before deinstitutionalization began in earnest, 36 states had provisions specifically for the involuntary hospitalization of "alcoholics," "habitual drunkards," and "inebriates"; 34 had such provisions for "drug addicts." A total of 39 states had specific provisions for one group or both groups. In addition, many states had voluntary admission provisions for these groups. The use of existing laws varied regionally, of course, but states entirely without them were concentrated in the temperance belt extending through the Great Plains and Rocky Mountains. See Frank T. Lindman and Donald M. McIntyre, Jr., eds., *The Mentally Disabled and the Law* (Chicago: University of Chicago Press, 1961): 17-8, 82-6, 107-8.
7. Kim Hopper's historical analysis of the public shelters of New York and Chicago suggests that they have always been of a "hybrid" character; that is, they were charged simultaneously with providing custodial care for the disabled and intimidating short-term shelter for the able-bodied based on the principle of less eligibility. See Kim Hopper, "Public Shelter as a 'Hybrid Institution': Homeless Men in Historical Perspective," *Journal of Social Issues*, 46:4 (1990): 13-29. Hopper's discerning analysis is restricted to shelters for men, however. Very likely, the state hospital played a far more important role than municipal shelters in the lives of lower-class and working-class women who were a burden to their families. For suggestive studies, see Constance M. McGovern, "The Community, the Hospital, and the Working-Class Patient: The Multiple Uses of the Asylum in Nineteenth Century America," *Pennsylvania History*, 54 (1987): 17-33; and Richard W. Fox, *So Far Disordered in Mind: Insanity in California, 1870-1930* (Berkeley: University of California Press, 1978). For a fine study of the commitment of redundant and deviant middle-class women (including inebriates) to a proprietary hospital, see Cheryl Krasnick Warsh, *Moments of Unreason: The Practice of Canadian Psychiatry and the Homewood Retreat, 1883-1923* (Montreal: McGill-Queen's University Press, 1989).
 8. "Vagabond" and "vagrant" are among the oldest generic terms for a homeless person, later supplemented by "tramp" (which, like "bum," often connoted alcohol dependence) or "hobo," the more neutral "transient" or "migrant," and later, "disaffiliate" or "unattached person." For a thoughtful consideration of the cultural referents of homelessness, see Kim Hopper, "Homelessness Old and New: The Matter of Definitions," this journal.
 9. This important if obvious understanding about socialization is traceable to Victorian and, subsequently, Progressive ideas about the basis of social control. It has always been prominent in explanations of so-called "deviant subcultures," and has long figured in subcultural explanations of homelessness. A good example is Samuel E. Wallace, *Skid Row as a Way of Life* (Totowa, NJ: The Bedminster Press, 1965). For its most recent application to the homeless, see Charles Grigsby et al., "Disaffiliation to Entrenchment: A Model for Understanding Homelessness," *Journal of Social Issues*, 46:4 (1990): 141-56.
 10. An astute and oft-neglected critique of the received wisdom about "natural areas" is Leonard U. Blumberg, Thomas E. Shipley, Jr., and Joseph O. Moor, Jr., "The Skid Row Man and the Skid Row Status Community," *Quarterly Journal of Studies on Alcohol*, 32 (1971): 909-41. The ideas in this article are developed more fully in Leonard U. Blumberg, Thomas F. Shipley, Jr., and Stephen F. Barsky, *Liquor and Poverty: Skid Row as a Human Condition* (New Brunswick, NJ: Rutgers Center of Alcohol Studies, 1978). This analysis, which emphasizes the continuity of skid row conditions and other manifestations of

- poverty, has proved prophetic in many respects. For a very early study of the "new homeless" that was influenced by this work, see Jim Baumohl and Henry Miller, *Down and Out in Berkeley* (Berkeley: City of Berkeley-University of California Community Affairs Committee, 1974); or the summary of its findings in Henry Miller, *On the Fringe: The Dispossessed in America* (Lexington, MA: D.C. Heath and Company, 1991), 109-37.
11. Peter H. Rossi et al., "The Urban Homeless: Estimating Composition and Size," *Science*, 235 (1987): 1336-41.
 12. Kim Hopper, "The Public Response to Homelessness in New York City: The Last Hundred Years," in *On Being Homeless: Historical Perspectives*, ed. Rick Beard (New York: Museum of the City of New York, 1987): 97.
 13. For example, Kim Hopper and his associates in New York City have illuminated the problems of identifying the homeless and bounding sample sites in public settings. See Kim Hopper, *Street Census Project: Final Reports* (New York: Nathan S. Kline Institute for Psychiatric Research, 1991).
 14. Site variation can be extremely complex, especially if one is interested in how homeless people sort themselves out in social space. For instance, Hopper's team in Manhattan observed that some encampments of the homeless were devoted to "party scenes" involving substantial consumption of alcohol and other drugs, whereas others were very quiet and dedicated to getting a night's rest. See Hopper, *Street Census Project*.
 15. John James McCook, "A Tramp Census and Its Revelations," *Forum*, 15 (1893): 753-66; Mary Ann McLaughlin, *Homelessness in Canada: The Report of the National Inquiry* (Ottawa: Canadian Council on Social Development, 1986).
 16. See Richard Fuller, K. K. Lee, and Enoch Gordis, "Validity of Self Report in Alcoholism Research: Results of a Veterans' Administration Study," *Alcoholism: Clinical and Experimental Research*, 12 (1988): 201-5; J. E. Peachey and B. M. Kapur, "Monitoring Drinking Behavior with the Alcohol Dipstick during Treatment," *Alcoholism: Clinical and Experimental Research*, 10 (1986): 663-66.
 17. Institute of Medicine, *Broadening the Base of Treatment for Alcohol Problems* (Washington, DC: National Academy Press, 1990), 263-6. This volume contains an extremely valuable overview of assessment generally; see pp. 242-78.
 18. Pamela J. Fischer and William R. Breakey, "The Epidemiology of Alcoholism in a Homeless Population: Findings from the Baltimore Homeless Study." (Paper presented at the 16th Annual Alcohol Epidemiology Symposium, Kettl Brun Society for Social and Epidemiological Research on Alcohol, Budapest, Hungary, June 3-8, 1990.)
 19. Hopper, *Street Census Project*; Rossi et al., "The Urban Homeless."
 20. Fischer, *Alcohol and Drug Abuse*.
 21. For an explanation of how these estimates were derived, see note 3.
 22. Fischer, *Alcohol and Drug Abuse*, 98,
 23. *Ibid.*, 60-62.

24. Marjorie J. Robertson, Paul Koegel, and Linda Ferguson, "Alcohol Use and Abuse among Homeless Adolescents in Hollywood," *Contemporary Drug Problems*, 16 (1989): 415-52.
25. This is a controversial matter at present. In Philadelphia, the well-respected executive director of a shelter recently called crack abusers "the fastest growing and overwhelming majority [sic] of people on the street." She apparently meant to include "homeless heads of families" in this remark. See Gloria Guard, "It Doesn't Help the Homeless to Simply Do Things for Them," *Philadelphia Inquirer*, April 7, 1991, 7-C. For a very different view based on a study of nearly 500 families applying to New York City's shelters, see Beth C. Weitzman, James R. Knickman, and Marybeth Shinn, "Pathways to Homelessness among New York City Families," *Journal of Social Issues*, 46:4 (1990), 125-40.
26. Fischer, *Alcohol and Drug Abuse*, 50-52.
27. *Ibid.*, 65-67.
28. *Ibid.*, 53-54, 67.
29. Elmer L. Struening and Deborah K. Padgett, "Physical Health Status, Substance Use and Abuse, and Mental Disorders among Homeless Adults," *Journal of Social Issues*, 46:4 (1990): 80.
30. Paul Koegel, M. Audrey Burnam, and Rodger K. Far-r, "Subsistence Adaptation among Homeless Adults in the Inner City of Los Angeles," *Journal of Social Issues*, 46:4 (1990): 101. Although unremarked by epidemiologists, who generally are not versed in welfare and Social Security regulations and their history, this finding probably reflects the Social Security Administration's definition of disability, which until the early 1980s did not recognize alcohol or other drug dependence as an impairment that can be disabling apart from other qualifying conditions. Even now, an impairment deriving from a primary diagnosis of alcohol and/or drug dependence is an ambiguous basis for a Social Security disability claim, and its successful prosecution usually entails a lengthy appeals process. Controversy over the eligibility of alcohol-dependent people for Social Security disability can be traced to the first discussions of such provisions in 1937; discussions cropped up repeatedly during congressional hearings on Title XIV (Aid to the Permanently and Totally Disabled) in 1949 and thereafter. The technical and political-economic issues involved in defining disability are thoughtfully addressed by Deborah Stone, *The Disabled State* (Philadelphia: Temple University Press, 1984). Baumohl is studying the controversy over alcohol dependence in California's Aid to the Disabled program during the 1950s and 1960s. This program was the state-administered forerunner of SSI.
31. For a summary of these findings, see Fischer, *Alcohol and Drug Abuse*, 38,47. The methodologic observations are our own.
32. Koegel and Burnam, *Epidemiology*, 129-37.
33. Koegel et al., "Subsistence Adaptation," 105.
34. See, for example, Keith Lovald, "From Hobohemia to Skid Row: The Changing

Community of the Homeless Man” (Doctoral dissertation, University of Minnesota, 1960); Donald Bogue, *Skid Row in American Cities* (Chicago: Community and Family Study Center, University of Chicago, 1963); Leonard Blumberg, Thomas E. Shipley, Jr., and Irving W. Shandler, *Skid Row and Its Alternatives: Research and Recommendations from Philadelphia* (Philadelphia: Temple University Press, 1973). A useful summary discussion of skid-row housing can be found in Howard M. Bahr, *Skid Row: An Introduction to Disaffiliation* (New York: Oxford University Press, 1973): 123-40. Excellent historical studies of the development of skid row housing can be found in Charles Hoch and Robert A. Slayton, *New Homeless and Old: Community and the Skid Row Hotel* (Philadelphia: Temple University Press, 1989), especially pp. 10-86; and John C. Schneider, “Skid Row as an Urban Neighborhood, 1880-1960,” in *Housing the Homeless*, Jon Erickson and Charles Wilhelm, eds. (New Brunswick, NJ: Center for Urban Policy Research, 1986), 167-89.

35. Many scattered examples illustrate the point. In California, state hospital superintendents attributed the remarkable decline in inebriety commitments during World War I not to wartime Prohibition, which was illusory, but to “increased occupational opportunities and higher wages.” Members of “the inebriety class” joined the armed forces and otherwise went to work. See, for instance, “Report of the Medical Superintendent of Mendocino State Hospital,” in *Biennial Report, 1916-1918*, California State Commission on Lunacy (Sacramento: State Printing Office, 1918), 58. During World War I, the state hospitals themselves were forced to hire attendants of dubious sobriety, and it was during this time, in California at least, that committed inebriates first were used as attendants. World War II virtually emptied skid row of anyone who could show up for work even occasionally. See Lovald, *From Hobohemia to Skid Row*, 213-18. For examples of World War II’s impact on opiate addicts, see David Courtwright, Herman Joseph, and Don Des Jarlais, *Addicts Who Survived: An Oral History of Narcotic Use in America, 1923-1965* (Knoxville: University of Tennessee Press, 1989), 211-12, 221.
36. See Ian Tyrrell, *Sobering Up: From Temperance to Prohibition in Antebellum America, 1800-1860* (Westport, CT: Greenwood Press, 1979), 167-71.
37. John James McCook, “The Tramp Problem: What It Is and What to Do About It,” *Proceedings of the Conference of Charities and Corrections, 1895*, 288-302.
38. There is a huge literature in this area. The *locus classicus* is Barry Bluestone and Bennett Harrison, *The Deindustrialization of America: Plant Closings, Community Abandonment, and the Dismantling of Basic Industry* (New York: Basic Books, 1983); idem, *The Great American Job Machine: The Proliferation of Low Wage Employment in the U.S. Economy* (Washington, DC: Joint Economic Committee, 1986). With specific reference to homelessness, see Rim Hopper and Jill Hamberg, *The Making of America’s Homeless: From Skid Row to New Poor* (New York: Community Service Society of New York, 1984).

Important temporal and regional variations in economic conditions probably have shaped the social production of homelessness and the characteristics of the homeless population. For instance, in Canada, the collapse of the Alberta “oil patch” in the early 1980s inundated Ontario shelters with migrating families unable to pay the high rents prevailing in the Toronto area. Similarly, a study of homeless people in Austin, Texas, conducted in 1984, found that three-quarters of the predominantly single, white, male sample had migrated from other Sunbelt states, 58 percent within the previous six months. The

authors attribute this to Austin's economic boom. See Charles Grigsby et al., "Disaffiliation to Entrenchment," 145. At present, no studies systematically link individual experiences to such larger processes.

39. Nationally, between 1981 and 1988, contract rents rose 16.6 percent faster than general inflation. See William C. Apgar, Jr., "Which Housing Policy is Best?" *Housing Policy Debate*, 1(1990): 11. For a good summary of the erosion of such welfare and social insurance benefits, see Peter H. Rossi, *Down and Out in America: The Origins of Homelessness* (Chicago: University of Chicago Press, 1989), 190-94.

Recently, the Pennsylvania Department of Public Welfare proposed regulations to restrict benefits available to those who share living expenses with other household members. Advocates for homeless people feared that this change would disqualify or reduce benefits to many doubled-up recipients of general assistance, and reduce the purchasing power of people who cope with displacement or leave the shelter system by pooling resources. They speculated that the new regulations would have a particular impact on battered women, pregnant teenagers, and people with alcohol and other drug problems. See Jodi Enda, "Tighter Welfare Rules Take Effect Tomorrow, to Fear and Loathing," *Philadelphia Inquirer*, April 30, 1991, 4-B. Amidst such criticism, the new regulations were put on hold at the eleventh hour.

40. Mary Jo Bane and David T. Ellwood, "Slipping Into and Out of Poverty: The Dynamics of Spells" (Working paper no. 1199, National Bureau of Economic Research, Cambridge, MA, 1983). See also David T. Ellwood, *Poor Support: Poverty in the American Family* (New York: Basic Books, 1988).
41. See Julie Thompson, "How Should Shelters Respond to Alcohol-Related Violence?" *Alcohol Health and Research World*, 11 (1987): 60-61.
42. See Louise Fournier and Celine Mercier, *Étude Spéciale sur Dernier Recours Montréal*, 2 vols. (Montreal: Douglas Hospital, 1989).
43. See Jim Baumohl, "Inebriate Institutions in North America, 1840-1920," *British Journal of addiction*, 85 (1990): 1187-1204.
44. For a sharp debate about the location of services for alcohol-dependent homeless people, see K. Kaufman and S. Walfish, "Improving the Cost Efficiency of Services to the Chronic Inebriate: An Unexpected Paradox," *International Journal of the Addictions*, 20 (1985): 1567-74; and the response by Richard Speigman, Jim Baumohl, and Friedner D. Wittman, "Cutting Services to Chronic Inebriates Represents No Paradox of Accessibility: A Response to Kaufman and Walfish," *International Journal of the Addictions*, 21(1986): 843-46.
45. The antagonism between homeless people and their would-be benefactors is a very old one. The classic modern study of this process of manipulation and counter-manipulation is Wiseman, *Stations of the Lost*. See also James P. Spradley, *You Owe Yourself a Drunk: An Ethnography of Urban Nomads* (Boston: Little, Brown, 1970); and a marvelous piece called "Social Workers Mean Well," in Nels Anderson's pseudonymously published *The Milk and Honey Route: A Handbook for Hoboes* (New York: Vanguard Press, 1934).

46. For a thorough discussion of the project and preliminary outcomes, see Gordon Scott Bonham et al., "Louisville's Project Connect for the Homeless Alcohol and Drug Abuser," *Alcoholism Treatment Quarterly*, 7 (1990), 57-78.
47. See Leonard I. Stein and Mary Ann Test, "Alternative to Mental Hospital Treatment, I: Conceptual Model, Treatment Program, and Clinical Evaluation," *Archives of General Psychiatry*, 37 (1980): 392-97.
48. For details on the Minneapolis project, see Mark L. Willenbring, Joseph A. Whelan, James S. Dahlquist, and Michael E. O'Neal, "Community Treatment of the Chronic Public Inebriate: Implementation," *Alcoholism Treatment Quarterly*, 7(1990): 79-97.
49. For a description of the Women in Need project, see Sylvia Ridlen, Yvonne Asamoah, Helen G. Edwards, and Rita Zimmer, "Outreach and Engagement for Homeless Women at Risk of Alcoholism," *Alcoholism Treatment Quarterly*, 7 (1990), 99-109. The role of the housing specialist is discussed in National Institute on Alcohol Abuse and Alcoholism, *Annual Znterim Process Evaluation Report: First Year (1989)* (Rockville, MD: National Institute on Alcohol Abuse and Alcoholism, 1990).
50. For a recent recapitulation of the debate about supply and demand-side strategies, see William C. Apgar, Jr., "Which Housing Policy is Best?" and comments on Apgar's essay by John C. Weicher and Raymond J. Struyk, *Housing Policy Debate*, 1 (1990): 33-51. For a less technical, political-economic consideration of housing policy that is focused on homelessness, see Michael H. Lang, *Homelessness Amid Affluence: Structure and Paradox in the American Political Economy* (New York: Praeger, 1989).
51. For information on these and other housing programs, see Jim Curtiss et al., *A Guide to Housing for Low-Zncome People Recovering from Alcohol and Other Drug Problems* (Rockville, MD: National Institute on Alcohol Abuse and Alcoholism, 1991).
52. A trenchant observation of Thomas F. Shipley, Jr., on the tendencies inherent in programs serving skid-row men.
53. For a review of the Oxford House program, see Friedner D. Wittman, "Housing Models for Alcohol Programs Serving Homeless People," *Contemporary Drug Problems*, 16 (1989): 483-504. See also John V. O'Neill's contribution to Curtis et al., *A Guide to Housing*, 101-9.
54. The Boston stabilization program is described in Dennis McCarty, Milton Argeriou, Milly Krakow, and Kevin Mulvey, "Stabilization Services for Homeless Alcoholics and Drug Addicts," *Alcoholism Treatment Quarterly*, 7 (1990): 31-45.
55. For details, see Robert C. Robbins, Anne Tate, and Milton Argeriou, *Alcohol and Drug-Free Housing Guide* (Boston: Alcohol and Drug Abuse Association of Massachusetts and the Stabilization Services Project, 1990).
56. See Michael Sosin, Irving Piliavin, and Herb Westerfelt, "Toward a Longitudinal Analysis of Homelessness," *Journal of Social Issues*, 46:4 (1990): 157-74.

57. For such effects to be assessed properly, programs must survive and develop. They must have the opportunity to achieve the stability and face the problems that come with routinization within a customary system of local services. The demonstration projects to which this paper has referred are creatures of a time-limited federal initiative. Although funded as experiments in service provision, it was hoped that they would be maintained by the states and localities involved. In fact, as federal support for these programs ends, many, if not most, appear to be in jeopardy of suspension or major cutbacks, victims of the rising public expenses and declining revenues characteristic of recession. Whatever good they have done for their clients, these projects have failed to make the transition from exceptional to customary institutional status. Thus, they have fallen like seed on hard ground. Arguably, this is a predictable outcome of policy that treats persistent social problems as if they were passing emergencies. On this matter, see Michael Lipsky and Stephen Rathgeb Smith, "When Social Problems Are Treated as Emergencies," *Social Service Review*, 63 (1989): 5-25.
58. For an important appreciation of this point, see Leona Bachrach, "Deinstitutionalization: A Semantic Analysis," *Journal of Social Issues*, 45:3 (1989): 161-71.
59. "Wet" hotels or group residences permit drinking on the premises in the same manner as any commercial hostelry. "Damp" residences permit drinking only in the privacy of a tenant's personal quarters. "Moist" hotels permit no drinking on the premises but tolerate the extramural drinking of residents. Whether or not treatment systems should support such programs is a vexing question that revolves around the extent to which such environments undermine abstinence or the process of "hitting bottom." So far as is known, the terminology was invented by Friedner D. Wittman.

- Wiseman, *Stations of the Lost*, 165-6. In 1960, a decade before deinstitutionalization began in earnest, 36 states had provisions specifically for the involuntary hospitalization of "alcoholics," "habitual drunkards," and "inebriates";³⁴ had such provisions for "drug addicts." A total of 39 states had specific provisions for one group or both groups. In addition, many states had voluntary admission provisions for these groups. The use of existing laws varied regionally, of course, but states entirely without them were concentrated in the temperance belt extending through the Great Plains and Rocky Mountains. See Frank T. Lindman and Donald M. McIntyre, Jr., eds., *The Mentally Disabled and the Law* (Chicago: University of Chicago Press, 1961): 17-8, 82-6, 107-8.
7. Kim Hopper's historical analysis of the public shelters of New York and Chicago suggests that they have always been of a "hybrid" character; that is, they were charged simultaneously with providing custodial care for the disabled and intimidating short-term shelter for the able-bodied based on the principle of less eligibility. See Kim Hopper, "Public Shelter as a 'Hybrid Institution': Homeless Men in Historical Perspective," *Journal of Social Issues*, 46:4 (1990): 13-29. Hopper's discerning analysis is restricted to shelters for men, however. Very likely, the state hospital played a far more important role than municipal shelters in the lives of lower-class and working-class women who were a burden to their families. For suggestive studies, see Constance M. McGovern, "The Community, the Hospital, and the Working-Class Patient: The Multiple Uses of the Asylum in Nineteenth Century America," *Pennsylvania History*, 54 (1987): 17-33; and Richard W. Fox, *So Far Disordered in Mind: Insanity in California, 1870-1930* (Berkeley: University of California Press, 1978). For a fine study of the commitment of redundant and deviant middle-class women (including inebriates) to a proprietary hospital, see Cheryl Krasnick Warsh, *Moments of Unreason: The Practice of Canadian Psychiatry and the Homewood Retreat, 1883-1923* (Montreal: McGill-Queen's University Press, 1989).
 8. "Vagabond" and "vagrant" are among the oldest generic terms for a homeless person, later supplemented by "tramp" (which, like "bum," often connoted alcohol dependence) or "hobo," the more neutral "transient" or "migrant," and later, "disaffiliate" or "unattached person." For a thoughtful consideration of the cultural referents of homelessness, see Kim Hopper, "Homelessness Old and New: The Matter of Definitions," this journal.
 9. This important if obvious understanding about socialization is traceable to Victorian and, subsequently, Progressive ideas about the basis of social control. It has always been prominent in explanations of so-called "deviant subcultures," and has long figured in subcultural explanations of homelessness. A good example is Samuel E. Wallace, *Skid Row as a Way of Life* (Totowa, NJ: The Bedminster Press, 1965). For its most recent application to the homeless, see Charles Grigsby et al., "Disaffiliation to Entrenchment: A Model for Understanding Homelessness," *Journal of Social Issues*, 46:4 (1990): 141-56.
 10. An astute and oft-neglected critique of the received wisdom about "natural areas" is Leonard U. Blumberg, Thomas E. Shipley, Jr., and Joseph O. Moor, Jr., "The Skid Row Man and the Skid Row Status Community," *Quarterly Journal of Studies on Alcohol*, 32 (1971): 909-41. The ideas in this article are developed more fully in Leonard U. Blumberg, Thomas F. Shipley, Jr., and Stephen F. Barsky, *Liquor and Poverty: Skid Row as a Human Condition* (New Brunswick, NJ: Rutgers Center of Alcohol Studies, 1978). This analysis, which emphasizes the continuity of skid row conditions and other manifestations of

- poverty, has proved prophetic in many respects. For a very early study of the "new homeless" that was influenced by this work, see Jim Baumohl and Henry Miller, *Down and Out in Berkeley* (Berkeley: City of Berkeley-University of California Community Affairs Committee, 1974); or the summary of its findings in Henry Miller, *On the Fringe: The Dispossessed in America* (Lexington, MA: D.C. Heath and Company, 1991), 109-37.
11. Peter H. Rossi et al., "The Urban Homeless: Estimating Composition and Size," *Science*, 235 (1987): 1336-41.
 12. Kim Hopper, "The Public Response to Homelessness in New York City: The Last Hundred Years," in *On Being Homeless: Historical Perspectives*, ed. Rick Beard (New York: Museum of the City of New York, 1987): 97.
 13. For example, Kim Hopper and his associates in New York City have illuminated the problems of identifying the homeless and bounding sample sites in public settings. See Kim Hopper, *Street Census Project: Final Reports* (New York: Nathan S. Kline Institute for Psychiatric Research, 1991).
 14. Site variation can be extremely complex, especially if one is interested in how homeless people sort themselves out in social space. For instance, Hopper's team in Manhattan observed that some encampments of the homeless were devoted to "party scenes" involving substantial consumption of alcohol and other drugs, whereas others were very quiet and dedicated to getting a night's rest. See Hopper, *Street Census Project*.
 15. John James McCook, "A Tramp Census and Its Revelations," *Forum*, 15 (1893): 753-66; Mary Ann McLaughlin, *Homelessness in Canada: The Report of the National Inquiry* (Ottawa: Canadian Council on Social Development, 1986).
 16. See Richard Fuller, K. K. Lee, and Enoch Gordis, "Validity of Self Report in Alcoholism Research: Results of a Veterans' Administration Study," *Alcoholism: Clinical and Experimental Research*, 12 (1988): 201-5; J. E. Peachey and B. M. Kapur, "Monitoring Drinking Behavior with the Alcohol Dipstick during Treatment," *Alcoholism: Clinical and Experimental Research*, 10 (1986): 663-66.
 17. Institute of Medicine, *Broadening the Base of Treatment for Alcohol Problems* (Washington, DC: National Academy Press, 1990), 263-6. This volume contains an extremely valuable overview of assessment generally; see pp. 242-78.
 18. Pamela J. Fischer and William R. Breakey, "The Epidemiology of Alcoholism in a Homeless Population: Findings from the Baltimore Homeless Study." (Paper presented at the 16th Annual Alcohol Epidemiology Symposium, Kettl Brun Society for Social and Epidemiological Research on Alcohol, Budapest, Hungary, June 3-8, 1990.)
 19. Hopper, *Street Census Project*; Rossi et al., "The Urban Homeless."
 20. Fischer, *Alcohol and Drug Abuse*.
 21. For an explanation of how these estimates were derived, see note 3.
 22. Fischer, *Alcohol and Drug Abuse*, 98.
 23. *Ibid.*, 60-62.

24. Marjorie J. Robertson, Paul Koegel, and Linda Ferguson, "Alcohol Use and Abuse among Homeless Adolescents in Hollywood," *Contemporary Drug Problems*, 16 (1989): 415-52.
25. This is a controversial matter at present. In Philadelphia, the well-respected executive director of a shelter recently called crack abusers "the fastest growing and overwhelming majority [sic] of people on the street." She apparently meant to include "homeless heads of families" in this remark. See Gloria Guard, "It Doesn't Help the Homeless to Simply Do Things for Them," *Philadelphia Inquirer*, April 7, 1991, 7-C. For a very different view based on a study of nearly 500 families applying to New York City's shelters, see Beth C. Weitzman, James R. Knickman, and Marybeth Shinn, "Pathways to Homelessness among New York City Families," *Journal of Social Issues*, 46:4 (1990), 125-40.
26. Fischer, *Alcohol and Drug Abuse*, 50-52.
27. *Ibid.*, 65-67.
28. *Ibid.*, 53-54, 67.
29. Elmer L. Struening and Deborah K. Padgett, "Physical Health Status, Substance Use and Abuse, and Mental Disorders among Homeless Adults," *Journal of Social Issues*, 46:4 (1990): 80.
30. Paul Koegel, M. Audrey Burnam, and Rodger K. Farr, "Subsistence Adaptation among Homeless Adults in the Inner City of Los Angeles," *Journal of Social Issues*, 46:4 (1990): 101. Although unremarked by epidemiologists, who generally are not versed in welfare and Social Security regulations and their history, this finding probably reflects the Social Security Administration's definition of disability, which until the early 1980s did not recognize alcohol or other drug dependence as an impairment that can be disabling apart from other qualifying conditions. Even now, an impairment deriving from a primary diagnosis of alcohol and/or drug dependence is an ambiguous basis for a Social Security disability claim, and its successful prosecution usually entails a lengthy appeals process. Controversy over the eligibility of alcohol-dependent people for Social Security disability can be traced to the first discussions of such provisions in 1937; discussions cropped up repeatedly during congressional hearings on Title XIV (Aid to the Permanently and Totally Disabled) in 1949 and thereafter. The technical and political-economic issues involved in defining disability are thoughtfully addressed by Deborah Stone, *The Disabled State* (Philadelphia: Temple University Press, 1984). Baumohl is studying the controversy over alcohol dependence in California's Aid to the Disabled program during the 1950s and 1960s. This program was the state-administered forerunner of SSI.
31. For a summary of these findings, see Fischer, *Alcohol and Drug Abuse*, 38,47. The methodologic observations are our own.
32. Koegel and Burnam, *Epidemiology*, 129-37.
33. Koegel et al., "Subsistence Adaptation," 105.
34. See, for example, Keith Lovald, "From Hobohemia to Skid Row: The Changing

Community of the Homeless Man" (Doctoral dissertation, University of Minnesota, 1960); Donald Bogue, *Skid Row in American Cities* (Chicago: Community and Family Study Center, University of Chicago, 1963); Leonard Blumberg, Thomas E. Shipley, Jr., and Irving W. Shandler, *Skid Row and Its Alternatives: Research and Recommendations from Philadelphia* (Philadelphia: Temple University Press, 1973). A useful summary discussion of skid-row housing can be found in Howard M. Bahr, *Skid Row: An Introduction to Disaffiliation* (New York: Oxford University Press, 1973): 123-40. Excellent historical studies of the development of skid row housing can be found in Charles Hoch and Robert A. Slayton, *New Homeless and Old: Community and the Skid Row Hotel* (Philadelphia: Temple University Press, 1989), especially pp. 10-86; and John C. Schneider, "Skid Row as an Urban Neighborhood, 1880-1960," in *Housing the Homeless*, Jon Erickson and Charles Wilhelm, eds. (New Brunswick, NJ: Center for Urban Policy Research, 1986), 167-89.

35. Many scattered examples illustrate the point. In California, state hospital superintendents attributed the remarkable decline in inebriety commitments during World War I not to wartime Prohibition, which was illusory, but to "increased occupational opportunities and higher wages." Members of "the inebriety class" joined the armed forces and otherwise went to work. See, for instance, "Report of the Medical Superintendent of Mendocino State Hospital," in *Biennial Report, 1916-1918*, California State Commission on Lunacy (Sacramento: State Printing Office, 1918), 58. During World War I, the state hospitals themselves were forced to hire attendants of dubious sobriety, and it was during this time, in California at least, that committed inebriates first were used as attendants. World War II virtually emptied skid row of anyone who could show up for work even occasionally. See Lovald, *From Hobohemia to Skid Row*, 213-18. For examples of World War II's impact on opiate addicts, see David Courtwright, Herman Joseph, and Don Des Jarlais, *Addicts Who Survived: An Oral History of Narcotic Use in America, 1923-1965* (Knoxville: University of Tennessee Press, 1989), 211-12, 221.
36. See Ian Tyrrell, *Sobering Up: From Temperance to Prohibition in Antebellum America, 1800-1860* (Westport, CT: Greenwood Press, 1979), 167-71.
37. John James McCook, "The Tramp Problem: What It Is and What to Do About It," *Proceedings of the Conference of Charities and Corrections, 1895*, 288-302.
38. There is a huge literature in this area. The *locus classicus* is Barry Bluestone and Bennett Harrison, *The Deindustrialization of America: Plant Closings, Community Abandonment, and the Dismantling of Basic Industry* (New York: Basic Books, 1983); idem, *The Great American Job Machine: The Proliferation of Low Wage Employment in the U.S. Economy* (Washington, DC: Joint Economic Committee, 1986). With specific reference to homelessness, see Kim Hopper and Jill Hamberg, *The Making of America's Homeless: From Skid Row to New Poor* (New York: Community Service Society of New York, 1984).

Important temporal and regional variations in economic conditions probably have shaped the social production of homelessness and the characteristics of the homeless population. For instance, in Canada, the collapse of the Alberta "oil patch" in the early 1980s inundated Ontario shelters with migrating families unable to pay the high rents prevailing in the Toronto area. Similarly, a study of homeless people in Austin, Texas, conducted in 1984, found that three-quarters of the predominantly single, white, male sample had migrated from other Sunbelt states, 58 percent within the previous six months. The

authors attribute this to Austin's economic boom. See Charles Grigsby et al., "Disaffiliation to Entrenchment," 145. At present, no studies systematically link individual experiences to such larger processes.

39. Nationally, between 1981 and 1988, contract rents rose 16.6 percent faster than general inflation. See William C. Apgar, Jr., "Which Housing Policy is Best?" *Housing Policy Debate*, 1(1990): 11. For a good summary of the erosion of such welfare and social insurance benefits, see Peter H. Rossi, *Down and Out in America: The Origins of Homelessness* (Chicago: University of Chicago Press, 1989), 190–94.

Recently, the Pennsylvania Department of Public Welfare proposed regulations to restrict benefits available to those who share living expenses with other household members. Advocates for homeless people feared that this change would disqualify or reduce benefits to many doubled-up recipients of general assistance, and reduce the purchasing power of people who cope with displacement or leave the shelter system by pooling resources. They speculated that the new regulations would have a particular impact on battered women, pregnant teenagers, and people with alcohol and other drug problems. See Jodi Enda, "Tighter Welfare Rules Take Effect Tomorrow, to Fear and Loathing," *Philadelphia Inquirer*, April 30, 1991, 4-B. Amidst such criticism, the new regulations were put on hold at the eleventh hour.

40. Mary Jo Bane and David T. Ellwood, "Slipping Into and Out of Poverty: The Dynamics of Spells" (Working paper no. 1199, National Bureau of Economic Research, Cambridge, MA, 1983). See also David T. Ellwood, *Poor Support: Poverty in the American Family* (New York: Basic Books, 1988).
41. See Julie Thompson, "How Should Shelters Respond to Alcohol-Related Violence?" *Alcohol Health and Research World*, 11 (1987): 60–61.
42. See Louise Fournier and Celine Mercier, *Étude Spéciale sur Dernier Recours Montréal*, 2 vols. (Montreal: Douglas Hospital, 1989).
43. See Jim Baumohl, "Inebriate Institutions in North America, 1840–1920," *British Journal of Addiction*, 85 (1990): 1187–1204.
44. For a sharp debate about the location of services for alcohol-dependent homeless people, see K. Kaufman and S. Walfish, "Improving the Cost Efficiency of Services to the Chronic Inebriate: An Unexpected Paradox," *International Journal of the Addictions*, 20 (1985): 1567–74; and the response by Richard Speiglmán, Jim Baumohl, and Friedner D. Wittman, "Cutting Services to Chronic Inebriates Represents No Paradox of Accessibility: A Response to Kaufman and Walfish," *International Journal of the Addictions*, 21(1986): 843–46.
45. The antagonism between homeless people and their would-be benefactors is a very old one. The classic modern study of this process of manipulation and counter-manipulation is Wiseman, *Stations of the Lost*. See also James P. Spradley, *You Owe Yourself a Drunk: An Ethnography of Urban Nomads* (Boston: Little, Brown, 1970); and a marvelous piece called "Social Workers Mean Well," in Nels Anderson's pseudonymously published *The Milk and Honey Route: A Handbook for Hoboes* (New York: Vanguard Press, 1934).

46. For a thorough discussion of the project and preliminary outcomes, see Gordon Scott Bonham et al., "Louisville's Project Connect for the Homeless Alcohol and Drug Abuser," *Alcoholism Treatment Quarterly*, 7 (1990): 57-78.
47. See Leonard I. Stein and Mary Ann Test, "Alternative to Mental Hospital Treatment, I: Conceptual Model, Treatment Program, and Clinical Evaluation," *Archives of General Psychiatry*, 37 (1980): 392-97.
48. For details on the Minneapolis project, see Mark L. Willenbring, Joseph A. Whelan, James S. Dahlquist, and Michael E. O'Neal, "Community Treatment of the Chronic Public Inebriate: Implementation," *Alcoholism Treatment Quarterly*, 7 (1990): 79-97.
49. For a description of the Women in Need project, see Sylvia Ridlen, Yvonne Asamoah, Helen G. Edwards, and Rita Zimmer, "Outreach and Engagement for Homeless Women at Risk of Alcoholism," *Alcoholism Treatment Quarterly*, 7 (1990): 99-109. The role of the housing specialist is discussed in National Institute on Alcohol Abuse and Alcoholism, *Annual Znterim Process Evaluation Report: First Year (1989)* (Rockville, MD: National Institute on Alcohol Abuse and Alcoholism, 1990).
50. For a recent recapitulation of the debate about supply and demand-side strategies, see William C. Apgar, Jr., "Which Housing Policy is Best?" and comments on Apgar's essay by John C. Weicher and Raymond J. Struyk, *Housing Policy Debate*, 1 (1990): 33-51. For a less technical, political-economic consideration of housing policy that is focused on homelessness, see Michael H. Lang, *Homelessness Amid Affluence: Structure and Paradox in the American Political Economy* (New York: Praeger, 1989).
51. For information on these and other housing programs, see Jim Curtiss et al., *A Guide to Housing for Low-Zncome People Recovering from Alcohol and Other Drug Problems* (Rockville, MD: National Institute on Alcohol Abuse and Alcoholism, 1991).
52. A trenchant observation of Thomas F. Shipley, Jr., on the tendencies inherent in programs serving skid-row men.
53. For a review of the Oxford House program, see Friedner D. Wittman, "Housing Models for Alcohol Programs Serving Homeless People," *Contemporary Drug Problems*, 16 (1989): 483-504. See also John V. O'Neill's contribution to Curtis et al., *A Guide to Housing*, 101-9.
54. The Boston stabilization program is described in Dennis McCarty, Milton Argeriou, Milly Krakow, and Kevin Mulvey, "Stabilization Services for Homeless Alcoholics and Drug Addicts," *Alcoholism Treatment Quarterly*, 7 (1990): 31-45.
55. For details, see Robert C. Robbins, Anne Tate, and Milton Argeriou, *Alcohol and Drug-Free Housing Guide* (Boston: Alcohol and Drug Abuse Association of Massachusetts and the Stabilization Services Project, 1990).
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