
The Homeless Mentally Ill

The homeless mentally ill in the United States endure two immediate problems: the manifestation of their illness and their state of homelessness. What is increasingly unclear is which precedes the other. It is generally accepted, however, that the depopulation of mental institutions has resulted in a number of patients becoming homeless (Dear and Wolch 1987) and that homelessness is, in part, symptomatic of the chronic nature of mental illness (Talbot and Lamb 1984; Lipton, Sabatini, and Micheels 1986). Others argue that the rigors of life on the street—the constant stress and personal trauma of daily existence—contribute substantially to mental illness among the homeless (Bassuk and Lauriot 1984; Hope and Young 1986b; Wright 1987; Burns 1988; Daly 1989). Although the implications of homelessness as a causative factor in mental illness are far-reaching, little research has been conducted in this area. As our knowledge of the subject expands, no doubt, so will the debate. In any case, the multifarious problems of homelessness are being borne by individuals who have trouble coping with everyday life—the least able are required to weather some of life's worst conditions. To be without a home is to be without privacy, dignity, and sanctuary (Jaheil 1987). Commonplace activities such as bathing are complicated tenfold (Culhane and Fried 1988), and the absence of sanctuary leaves a person vulnerable to crime, a common occurrence among the homeless (Lamb 1984; Jaheil 1987). Yet the homeless mentally ill not only are victimized but are also often themselves treated as criminals, spending time not in treatment centers but in jails (Lamb 1984).

The homeless mentally ill are exposed to prejudice both from the general populace as well as from the professionals charged with their care and treatment. Bachrach (1984) and Bassuk and Lauriot (1984) suggest that the chronic nature of mental illness, coupled with its low cure rate, deters many professionals from treating the homeless mentally ill. According to Bachrach (1984), professionals concentrate their time and resources on those who "best respond to their efforts" (p. 32). Thus those among the homeless mentally ill who resist assis-

tance are more likely to be overlooked by community mental health professionals (Miller and Fiddleman 1984).

Unfortunately, planners and policymakers, for similar reasons, also tend to relegate the homeless mentally ill to last place on their list of social causes (Goldfinger and Chafetz 1984; Bassuk 1986). A comparison of government expenditures and programs designed to aid the developmentally disabled and the mentally ill indicates a wide discrepancy in favor of the developmentally disabled (Lamb 1984; Hope and Young 1986a). Hope and Young (1986a) submit that, in many states, programs once combined to serve both populations have now been split, with programs for the developmentally disabled experiencing greater success. Recognizing the complexity of the problems of the homeless mentally ill, this note surveys current literature in an attempt to delineate the dimensions of the problem, to examine the role of deinstitutionalization in adding to the numbers of homeless mentally ill, and to review current policies and programs intended to mitigate the problem of homelessness among this group.

A PROBLEM OF DEFINITION

Researchers are hampered in their investigations of homelessness by a number of factors, including the absence of a standard definition of homelessness, the dispersed nature of the homeless population, and the often cyclic nature of homelessness (Advisory Commission on Intergovernmental Relations [ACIR] 1989). Most important among these factors is the lack of a clear definition. Definitions of homelessness are as varied as existing studies and range from the very narrow to the broad and inclusive (Steffl 1987). For example, a study of homelessness in Alabama included only those who spent their nights in shelters, on the streets, or in public areas such as parks (LaGory et al. 1989). Researchers in Richmond, Virginia, defined a homeless person as "one who has no shelter or stays in cheap hotels, rooming houses, or adult homes" (Benda and Dattalo 1988, 884). Finally, a study conducted in Columbus, Ohio, added to the tally those who temporarily reside with families or friends (Toomey and Belcher 1987; Belcher 1988).

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The variety of definitions employed by researchers clearly is in direct relationship to their differing estimates of homelessness at local, state, and national levels (Santiago et al. 1988).

Also associated with variations in definition is research bias, which consequently is linked to the choice of definition. The goals, political positions, and professional traditions of the investigator may ultimately affect how homelessness is defined in a particular study (Bahr 1989). In other words, the background of the investigator has a significant impact on study results. Some researchers focus on homelessness as a housing problem precipitated by changing national economic and social factors that have resulted in a shortage of affordable housing (Greer 1986; The Partnership for the Homeless [The Partnership] 1987; Wright and Lam 1987; Huttman 1988; Hayes 1989). For example, Hayes (1989) contends that the loss of approximately one million low-income housing units over the last ten years is the primary cause of homelessness in the United States. Hoch and Slayton (1988) maintain that the near decimation of the nation's single-room occupancy (SRO) housing stock has stimulated the growth of homelessness. Others suggest that homelessness, although associated with the concurrent housing crisis, is the end-state of familial, social, and political disaffiliation (Bahr 1989) or the culmination of a series of life crises faced by the homeless individual (Benda and Dattalo 1988; Culhane and Fried 1988; Wolch, Dear, and Akita 1988; LaGory et al. 1989). On a philosophical level, homelessness is viewed as a natural consequence of governmental bias toward capitalist interests. According to this argument, "homelessness becomes a repository for those who are judged expendable" (Belcher and Singer 1988, 46).

As a function of research orientation and resources, many studies on homelessness are location- or program-specific: they concentrate on the population of a designated shelter or service. Stefl (1987) points out that such research frequently fails to enumerate the homeless who are transient or are unable to utilize existing programs; the often fearful, disillusioned, or incapacitated mentally ill can be included in the latter category (Lipton, Sabatini, and Micheels 1986; Ridgway, Spaniol, and Zippel 1986). On the other hand, Hoch and Slayton (1988), citing state and regional homelessness studies, contend that research focusing on specific shelters or locations may lead to an overestimation of the homeless mentally ill.

The study of the mentally ill as a subgroup of the homeless is hindered by additional definitional problems. For example, though substance abuse is thought to be prevalent among the homeless, it remains unclear whether substance abusers should be counted as mentally ill (Sachs, Phillips, and Cappelletty 1987). Lipton, Sabatini, and Micheels (1986) argue they should, along with those who suffer from "schizophrenia, major affective disorders, alcoholism, mental retardation, and organic brain disorders" (p. 36). However, some studies differentiate between substance abusers and the mentally ill, and programs designed to aid the homeless may also differentiate between the two groups (see the Stewart B. McKinney Act, P.L. 100-77). Aside from problems of definition, the difficulty of assessing the number of homeless mentally ill is compounded because many among this population, like homeless people in general, suffer from episodic homelessness (Arce et al. 1983). This phenomenon was documented in a

1985 study that monitored the status of 154 patients newly discharged from psychiatric facilities; during the six-month study period, thirty percent of those discharged were homeless for the entire period, and six percent were intermittently homeless (Toomey and Belcher 1987). Often, homeless individuals tied to social services or cash-grant aid can afford housing for only a limited time and become homeless again when these resources are exhausted (Steff 1987). In addition, some homeless mentally ill people are hospitalized, jailed, or temporarily sheltered by friends or family, thus interrupting their time on the street (Lamb 1984; Toomey and Belcher 1987). All of these problems—varied definitions, transiency, episodic homelessness—contribute to the debate and the confusion over the demographic characteristics of the homeless, especially the homeless mentally ill. Yet some data are available, though unreliable, and a brief examination of them appears below.

THE DEMOGRAPHICS OF HOMELESSNESS

"Homelessness has historically reflected the interaction between the most vulnerable of our population and the scarcity or plenty of our resources" (Talbot and Lamb 1984, 2). Indeed, successful reallocation of finite resources to combat homelessness—cash assistance, housing, professional commitment, health and psychiatric services—depends on the quality of available data. Only when the dimensions of the problem are fully understood can comprehensive, lasting solutions be devised. Yet there is general agreement that such data on homelessness are not available and that existing data are often fragmented, biased, or simply too location-specific to be useful in the formulation of comprehensive programs (Hopper 1986; Levine and Stockdill 1986; Stefl 1987; Sachs, Phillips, and Cappelletty 1987; Culhane and Fried 1988; ACIR 1989).

Estimates of the homeless population range from 350,000 to 3 million persons (Levine and Stockdill 1986; Wright and Lam 1987; ACIR 1989). The percentage of mentally ill persons among this population has been variably estimated at thirty-three percent (Hope and Young 1986; ACIR 1989), twenty-five percent (Wolch, Dear, and Akita 1988), and twenty-three percent (Reyes and Waxman 1987).

In 1987, in order to understand the dimensions of homelessness in the United States, the U.S. Conference of Mayors commissioned a twenty-six-city survey (Reyes and Waxman 1987). The findings indicate that the percentage of mentally ill homeless ranges from

50 percent in San Juan, 45 percent in San Francisco, 40 percent in Louisville, Minneapolis, and Seattle, 25 percent in Charleston, Phoenix, Philadelphia, and Providence, and 9 percent in Detroit. (Reyes and Waxman 1987, 22)

Lamb (1984), commenting on the unreliability of existing data, submits that the homeless mentally ill population may number in the tens of thousands. The extreme variation in available data on homelessness and the homeless mentally ill is clearly illustrated in the above interpretations of the data. It is this variation that increasingly generates skepticism regarding how much is known about homelessness in the United States (Burns 1988; Culhane and Fried 1988; Santiago et al. 1988; Bahr 1989; LaGory et al. 1989). Yet the consensus is that the ranks of the homeless are growing, that homeless people

are on the average younger, and that the number of homeless who are mentally ill is increasing (Bachrach 1984).

DEINSTITUTIONALIZATION

The deinstitutionalization movement, which began in the 1950s, has been identified as a significant contributor to the numbers of homeless mentally ill (Vergare and Arce 1986). The premise underlying deinstitutionalization—the release and treatment of the mentally ill within a community setting—was the culmination of medical, social, and legal processes (Dear and Wolch 1987). Specifically, the move to free residents of mental institutions evolved from the development of a new treatment philosophy focused on providing treatment outside institutional walls, from the discovery of medicines (psychotropic drugs) that ameliorate the symptoms of mental illness, from a new locus within the legal community emphasizing the rights of patients to receive care outside institutions, and from the widely held perception that patient abuse and neglect were rampant in the nation's mental institutions (Hope and Young 1986a; Dear and Wolch 1987). Dear and Wolch (1987) contend that the evolution of this new treatment philosophy began in England, where the concept of treatment and integration within community settings was developed. Lipton, Sabatini, and Katz (1983) and Arce and Vergare (1987) maintain that this community-based philosophy also stemmed, in part, from the belief that institutionalization fostered dependency among patients, exacerbating their illness and isolating them from the world. Concurrently, breakthroughs in the medical treatment of mental illness came about with the advent of drugs used to treat anxiety, addiction, and psychotic disorders (Dear and Wolch 1987). No longer was confinement considered absolutely necessary in the treatment of psychiatric patients.

Influenced by the civil rights movement of the early 1960s, and reacting to the issue of involuntary commitment of patients, the legal community also became a catalyst for deinstitutionalization (Birnbaum 1960). Focusing on a least restrictive environment doctrine, based on ensuring the civil liberties of patients involuntarily confined to mental facilities, the legal system championed the rights of patients to be treated in a community setting. This legal activism led to changes in state commitment laws, in many cases making involuntary commitment more difficult (Lerman 1982). In addition, public perceptions about the usefulness of institutions began to change. Outcries against physical abuse and neglect within institutions grew louder and began to pervade the media and society (Dear and Wolch 1987). The Congress, for its part, stimulated the process of deinstitutionalization by enacting the 1963 Community Mental Health Centers Act. Its mandate, within the purview of this legislation, was to encourage local communities to care for their own mentally ill populations. The act allocated federal funds for the construction of community mental health centers (CMHCs), thereby cementing the concept of community-based treatment (Dear and Wolch 1987; Schwartz, Ferlauto, and Hoffman 1988). The legislation did not, however, provide for residential services, and CMHCs supplied mainly outpatient and referral services (Randolph, Lindeberg, and Menn 1986). The need for housing alternatives for the mentally ill was not addressed, and perhaps not even foreseen

(Lamb 1984; Stefl 1987). Cash-grant programs were also made available to the mentally ill. These included the Supplemental Security Income (SSI) program, a federal program established under Title XVI of the Social Security Act, which provides monthly payments to recipients eligible on the basis of old age, blindness, or other disabilities (Newman and Schnare 1988). The SSI program has become the mainstay of the deinstitutionalized person (Dear and Wolch 1987).

Spurred by the fervor of the federal government and facing major expenditures for repairing and expanding existing mental facilities, state governments, as the administrative and financial guardians of the mental institutions, were glad to relinquish their responsibility for the mentally ill (Dear and Wolch 1987). Thus the stage was set for deinstitutionalization. Federal monies were promised, states willingly gave up their role as keeper, and the establishment of CMHCs, key to the integration of mental patients into the community, was under way.

FAILURES OF DEINSTITUTIONALIZATION

Deinstitutionalization did not pan out as planned. The mentally ill, some of whom had been institutionalized the majority of their lives, were released without sufficient national policy direction, support services, or financial assistance. Many agree that while deinstitutionalization was conceptually noble, its implementation was problematic. Talbott and Lamb (1984, 3) state that although the premise of deinstitutionalization was "clinically sound and economically feasible . . . the way deinstitutionalization was originally carried out, through poorly planned discharge of thousands of mentally ill residents into inadequately prepared or programatically deficient communities, was another thing altogether."

Levine and Stockdill (1986) reminded us that deinstitutionalization is not synonymous with homelessness and that, indeed, many deinstitutionalized patients succeeded in making the transition from the institution to the community. Many were placed with families or in boarding facilities (Lamb 1984). Disparities between the ages of the deinstitutionalized and the mentally ill homeless are used by Kiesler and Sibulkin (1987) to support their contention that the proportion of deinstitutionalized individuals among the homeless is nominal. Hope and Young (1986a) suggest, however, that the process of deinstitutionalization failed most often for those patients who belonged to the low- or moderate-income groups.

Between 1955 and 1985 the population of psychiatric facilities dropped from 559,000 to 138,000 patients (Greer 1986). Yet, between 1963, when the Community Mental Health Centers Act was legislated, and 1986, only 717 of the proposed 2,000 CMHCs were constructed (Hope and Young 1986a). Similarly, cash-assistance and health programs either failed to materialize or were curtailed. Thus, even as the population needing community services grew, resources needed to facilitate these services shrank.

The federal funds essential to cash assistance, human services, and health care programs were cut during the 1980s. Eligibility requirements were tightened for income-maintenance programs, thereby limiting access to SSI and Title XX monies—the federal funds, allocated by the Social Security Act, that supplement the provision of social service and local welfare

programs (Hope and Young 1986a; Kiesler and Sibulkin 1987). In 1985, for example, on average the monthly benefits received by an individual SSI recipient totaled \$325. If, however, that beneficiary received shelter from family or friends at no cost, the SSI benefit was reduced by one-third (Newman and Schnare 1988). Funding was not targeted at community mental health services (Flynn 1985), and states continued to funnel monies into institutions rapidly emptying of patients (Lipton, Sabatini, and Katz 1983; Schwartz, Ferlauto, and Hoffman 1988). Indeed, Schwartz, Ferlauto, and Hoffman (1988) contend that "the patient-to-staff ratio in state mental hospitals has dropped from 50:1 in the 1960s to something approaching 1:1 now; yet state mental health budgets are still disproportionately hospital, not community care budgets" (p. 205). Lipton, Sabatini, and Katz (1983) further illustrate this point. They maintain that between 1978 and 1982, the New York State Office of Mental Health spent \$4.5 billion on its mental institutions, while allocating only \$450 million to community mental health programs. State governments failed to adjust their budgets to support deinstitutionalized patients and, instead, chose to fund the depopulated institutions.

Health insurance, crucial in meeting the financial costs of ongoing treatment (Lipton, Sabatini, and Micheels 1986; Kiesler and Sibulkin 1987), has historically been provided to the poor through Medicaid, a federal-state partnership program, and General Relief, a state-funded, county-administered program (Waxman 1986). Yet the federal expenditure reductions of the 1980s resulted in cutbacks of Medicaid benefits at the state level. Fewer people were eligible for the program, and those who were found that Medicaid paid less on their claims (Waxman 1986; Wolch and Akita 1989). In addition, according to Hope and Young (1986a), Medicaid and related programs have been prone to a pro-institutionalization bias, paying more often for services in long-term, inpatient settings than for residence in foster homes, shelters, or halfway houses. Rehabilitation and socialization programs are also not eligible for reimbursement by Medicaid (Hope and Young 1986a). Local hospitals, faced with Medicaid cuts and uncompensated treatment, have reexamined their position on the provision of health care to those without private health insurance (Waxman 1986). This has limited the treatment they have frequently been called upon to provide to the poor, among whom are the homeless mentally ill.

Persons who are both homeless and mentally ill face additional problems in accessing federal and state programs. Eligibility requirements stipulate that those applying for assistance have an address, a requirement that precludes many homeless mentally ill individuals from benefiting from these programs (Lipton, Sabatini, and Micheels 1986). For the most part, potential beneficiaries are assumed to be literate, to be capable of dealing with existing bureaucratic processes, and to have transportation (Bachrach 1984). Often these expectations also deny the mentally ill access to services. Inherent in the failure of deinstitutionalization to integrate patients into the community was the lack of understanding of what community-based therapy entails (Talbot and Lamb 1984; Stefl 1987). Aside from concerns about treatment and income maintenance, Talbot and Lamb (1984) suggest that the need of the mentally ill for supportive housing was not addressed during implementation

of deinstitutionalization. It is only now, faced with the crisis of the homeless mentally ill, that the need for housing and the lack of available housing alternatives are being analyzed.

In response to the inadequacy of housing options for the mentally ill, a growth in the number of private and partially subsidized nursing homes and proprietary shelter facilities occurred during the early years of deinstitutionalization (Lerman 1982). This was offset, however, by the rapid decline in the availability of low-cost housing units, including SRO units, the traditional domain of the low-income mentally ill (Lipton, Sabatini, and Katz 1983; Greer 1986; Fabricant 1988, Fodor and Grossman 1988). By no means was this solely due to the deinstitutionalization movement. This was a concurrent phenomenon that limited placement options for deinstitutionalized individuals. The number of group homes and halfway houses established was far below the number needed (Schwartz, Ferlauto, and Hoffman 1988), and federal housing assistance in the form of loans or grants, income supplements, and tax assistance declined (Carliner 1987; Schwartz, Ferlauto, and Hoffman 1988). Displacement (Hope and Young 1986b) and gentrification (Greer 1986; Kasinitz 1986; Wolch, Dear, and Akita 1988) have also been cited as compounding the housing problem of deinstitutionalized individuals. The point, then, is that patients on fixed incomes, who were once housed, fed, and clothed within institutions, were released into communities where low-cost housing was at a premium and alternate forms of housing simply did not exist. The result, according to Flynn (1985) and Dear and Wolch (1987), was that many of these individuals congregated in city slums or ultimately lived out on the street.

The failure of deinstitutionalization, however, was not simply a failure of programs or funding. It was a failure of government, at every level, to assume responsibility and provide policy direction for the community-based care of the mentally ill. Indeed, the federal government's most severe failure revolved around its inability to provide a national policy direction for deinstitutionalization, forfeiting its leadership role. For instance, the National Institute of Mental Health, the federal watchdog of mental health service agencies, "contributed only a small portion of funds needed to develop support systems and had no authority to operate ongoing programs, set nationwide policy, or even monitor and enforce standards of mental health programs" (Hope and Young 1986a, 177).

In the case of the homeless mentally ill, states were reticent to reassume the burden, and local governments initially relied heavily on private sector organizations to serve the growing ranks of the homeless. These nonprofit groups resisted this service obligation, viewing provision of services to such an extensive population as a municipal or state responsibility (Bassuk and Lauriot 1984).

Coordination of funding and service provision was also lacking not only between different governmental levels but between service agencies as well. Mental health and social service programs were often isolated, and neither one complemented the services of the other. Service program offices were even spatially separated, requiring the homeless mentally ill beneficiary to travel from one agency to another. According to Hope and Young (1986a), "No one agency at any state or local level has been clearly charged with the responsibility for com-

prehensive appraisal of mental health and community support needs of the mentally disabled, for planning and implementing a system to assure those needs are met, and for monitoring the quality of both institutional and community support programs" (p. 178).

Little coordination exists within specific programs, moreover, and different programs exercise different eligibility criteria, admissions policies, and treatment philosophies (Goldfinger and Chafetz 1984; Hope and Young 1986a). Community services, hidden behind bureaucracies and fragmented at different governmental levels, are of little use to many of the mentally ill homeless who are too disillusioned, frustrated, or distrustful to take advantage of them (Hope and Young 1986b; Lipton, Sabatini, and Katz 1983). Although homelessness was recognized as a legitimate problem in 1983 when the Federal Task Force on Homelessness was established, the Task Force was deemed a mere coordination and information resource (Vieth 1988). Local and state governments were left to their own devices to deal with the issue of homelessness.

POLICY AND PROGRAMMATIC RESPONSES

Emergency shelters for the homeless are one response to the problem. Increasing the number of available emergency shelters provides, at best, a short-term solution to a long-term problem (Bassuk and Lauriot 1984; Talbott and Lamb 1984; Galbreath 1986; Greer 1986; Baxter and Hopper 1984; The Urban Institute 1988). This is especially true for the homeless mentally ill. Shelters are often understaffed and staff members are not trained to deal with the unique problems of the mentally ill. Behavioral rules enforced by shelters also often lead to the expulsion of the mentally ill (Levine and Stockdill 1986). However, support services, including psychiatric treatment and financial assistance, mean little to a person without a home (Baxter and Hopper 1984; Lamb 1984). In addition, Lamb (1981) and Hope and Young (1986a) contend that it is essential to recognize that some of the homeless mentally ill are unable, because of the chronic nature or severity of their illness, to be fully integrated into society. They must be provided with a supervised, safe environment.

It is evident that a wide variety of needs exists among the homeless mentally ill. Creation of a network of services for these individuals above and beyond simple shelter is thus imperative. This network must be comprehensive, with designated responsibilities and channels of accountability assigned to service providers (Talbott and Lamb 1984; Lipton, Sabatini, and Micheels 1986). In recent years, municipalities have attempted to respond to the growth in the number of homeless mentally ill within their boundaries. New York City, for example, has devised a service network, administered through its Department of Mental Health, Mental Retardation, and Alcoholism, which consists of a three-tiered system of programs (Kellerman et al. 1985; Blau 1988). This includes an outreach program designed to locate and establish a rapport with mentally ill individuals on the street. A second program provides assessment by mental health professionals once shelter has been established; employment and semi-permanent residential options are considered. A final program links the client to a social service program dedicated to the integration of such

persons into the community; treatment, financial aid, and housing are also provided at this stage (Kellerman et al. 1985).

Critical to service networks similar to New York City's is the availability of residential facilities with differing levels of supervision and structure. A distinction between emergency and transitional shelter emerges. Transitional facilities give a more structured environment and often offer support services (Schwartz, Ferlauto, and Hoffman 1988; National Coalition for the Homeless 1988). Philadelphia, with its community rehabilitation residences (CRRs), provides such transitional housing. The CRRs are supervised facilities, providing access to needed mental health services through a contractual agreement with area CMHCs (Arce and Vergare 1987). Not surprisingly, however, many municipalities do not have the funds or the staff to support service networks. In fact, many cities not only face a shortage of emergency shelters but also have no transitional housing whatsoever (The Partnership 1987; Reyes and Waxman 1987).

Until recently local governments have been the most responsive to the homeless. In 1987, however, amid growing political and public pressure, the U.S. Congress enacted the Stewart B. McKinney Homeless Assistance Act (P.L. 100-77). This act created the Interagency Council on the Homeless in an attempt to encourage a national policy stance on homelessness (Schwartz, Ferlauto, and Hoffman 1988; U.S. Department of Housing and Urban Development [HUD] 1987; National Coalition 1988; Wolch and Akita 1989). Under this act, Congress initially authorized \$442.7 million for twenty homelessness programs to be administered by seven federal departments: the Federal Emergency Management Agency (FEMA), the Veterans Administration (VA), and the Departments of Health and Human Services (HHS), Housing and Urban Development (HUD), Agriculture (DOA), Education (DOE), and Labor (DOL). Of the funds originally authorized in 1987, only \$355 million was actually appropriated for use (National Coalition 1988; Daly 1989; Wolch and Akita 1989).

Three of the twenty McKinney programs were specifically targeted at the homeless mentally ill. The Transitional Housing Demonstration program, administered by HUD, was designed to aid local governments in providing housing and support services that focus on moving the homeless off the streets permanently (U.S. HUD 1987; National Coalition 1988). A second McKinney program developed under the auspices of the HHS, and implemented by the National Institute of Mental Health, was the Mental Health Block Grant program. Under this program, grant money is appropriated to the states to fund the development and enhancement of community mental health care services for the homeless (National Coalition 1988). The third program, the Mental Health Demonstration program, also administered by the HHS, was established to stimulate innovation in community mental health care programs. Funding for this program, however, was not renewed in the 1988 congressional appropriations (National Coalition 1988). In addition to the programs specifically targeted at them, the homeless mentally ill are also among those aided by other McKinney programs including the Emergency Food and Shelter program (administered by FEMA) and the Emergency Shelter Grant program (the largest of the McKinney programs, administered by HUD).

The network of McKinney programs represents the federal government's recognition, however belated, of the need for federal direction and support in the effort to eradicate homelessness. Yet many homeless persons fail to benefit from available programs (ACIR 1989), and although the McKinney Act does supplement state and local resources and programs, it fails to provide enough support to meet the needs of the growing homeless population (National Coalition 1988; Wolch and Akita 1989). Specifically, Wolch and Akita (1989) contend that the McKinney appropriations do not make up for the federal cuts in income assistance, housing subsidy, and health care programs instituted during the early years of the Reagan administration. In addition, the low appropriation-to-authorization ratio of McKinney funds and the emphasis on emergency intervention instead of permanent solutions have also been cited as criticisms of the act (National Coalition 1988; Wolch and Akita 1989). Finally, the Interagency Council, the federal agency charged with the interagency coordination of programs and the formulation of national policy, has been accused of negligence in the performance of its duties (National Coalition 1988). Considering these criticisms, it seems appropriate to question just how far the federal government has gone, and will go, in assuming its leadership role.

THE ROLE OF PLANNERS

Wolch, Dear, and Akita (1988) argue that planners can play an important role in aiding the homeless and, consequently, the homeless mentally ill. Historically, many community residents have resisted attempts to locate mental health facilities, including shelters and group homes, in their neighborhoods. Fears of declining property values and questions about personal safety and changing neighborhood character have all been cited as reasons for this (Applebaum 1983; Randolph, Lindeberg, and Menn 1986; Greer 1986; Dear and Wolch 1987). Although public concern about homelessness has generally increased, so has community resistance to mental health facilities (Cutler 1986). But combating community resistance through education and negotiation is not new to planners. Indeed, planners possess the expertise required for siting facilities in accessible locations, including service hubs essential to the functioning of a service network. Planners can also aid in the siting of emergency shelters, advocate fair share programs in which facilities and service hubs are dispersed throughout the city, and educate the community about the specialized needs of the homeless (Wolch, Dear, and Akita 1988).

On a larger scale, planners can use their knowledge of and participation in comprehensive planning and zoning to help formulate long-range solutions to the problem of homelessness. For example, Dear and Wolch (1987) suggest that a portion of a community's general plan should be dedicated to the needs of its dependent populations, especially the homeless and the homeless mentally ill. Greer (1986) maintains that inclusionary zoning may aid in the provision of low-cost housing. She cites a program in San Francisco that requires replacement of destroyed or converted SRO units on a one-to-one basis. Thus planning tools such as linkages and exactions may be used to facilitate the provision of housing for the

homeless. Finally, at the policy level, Wolch, Dear, and Akita (1988) discuss the need for the union of social and physical planning. They suggest that if such a union had occurred, the problems associated with deinstitutionalization might have been ameliorated.

It becomes clear, then, that planners are challenged to become actively involved in aiding not only the homeless but also the homeless mentally ill. The planner's expertise in facility siting, negotiation, zoning, comprehensive planning, and policy formulation is vital to the establishment of facilities, programs, and policies that will end the widespread homelessness in this country. Only time will tell, however, whether the planning profession, along with the government and society, will accept this challenge.

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