Homelessness, Severe Mental Illness, and the Institutional Circuit

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Objective: **Research on homelessness among persons with severe mental illness tends to focus on aspects of demand, such as risk factors or structural and economic forces. The authors address the complementary role of supply factors, arguing that "solutions" to residential instability—typically, a series of institutional placements alternating with shelter stays—effectively perpetuate homelessness among some persons with severe mental illness.** ***Methods:*** **Thirty-six consecutive applicants for shelter in Westchester County, New York, in the first half of 1995 who were judged to be severely mentally ill by intake workers were interviewed using a modified life chart format. Detailed narrative histories were constructed and reviewed with the subjects.** ***Results:*** **Twenty of the 36 subjects had spent a mean of 59 percent of the last five years in institutions and shelters. Analysis of the residential histories of the 36 subjects revealed that shelters functioned in four distinctive ways in their lives: as part of a more extended institutional circuit, as a temporary source of transitional housing, as a surrogate for exhausted support from kin, and as a haphazard resource in essentially nomadic lives. The first pattern dominated in this group.** ***Conclusions:*** **Shelters and other custodial institutions have acquired hybrid functions that effectively substitute for more stable and appropriate housing for some persons with severe mental illness. (*Psychiatric Services* 48:659–665, 1997)**

Inquiry into the nexus of homelessness and severe mental illness has moved away from the concerns of the early and mid-1980s—how many and how bad—to closer examinations of "what went wrong" and "how it might be fixed." Depictions of the longitudinal course of homelessness aside, much of the descriptive task has been accomplished. Meta-analyses have narrowed the range of estimates of prevalence of severe mental illness among homeless people, drawn useful distinctions among subpopulations of that group, and recognized that, despite methodological caveats, different contexts are likely to produce different rates of disorder (1,2).

Ethnographic studies have yielded fine-grained descriptions of street and shelter life (3,4), supplemented by comparative inventories of victimization and hardship (5,6). To be sure, "base rates" research on homelessness and mental illness continues in circumscribed pockets of inquiry—among veterans, prisoners, and forensic patients (7–10); in less heavily urbanized areas (11); and as they relate to risk of HIV infection (12). But the bulk of the research effort has shifted to more sophisticated analyses of the causes of (or pathways to) homelessness for persons with severe mental illness, and to careful evaluations of programs and housing models designed to arrest and prevent the recurrence of homelessness among them (13–15).

This paper takes a different approach. It argues that de facto "solutions" to precarious housing—shelters and custodial facilities linked in haphazard chains of time-limited occupancy—should be considered among the inertial forces that sustain homelessness among persons with severe mental illness.

Causal analyses of homelessness have become progressively more refined. Nonetheless, the tendency is still for explanations to migrate, at least in relative emphasis, toward polar extremes—one stressing vulnerability and pathology, and the other stressing underlying social structure (16). The first of these is best exemplified by the burgeoning of "risk factor" analyses in studies of homeless individuals and, to a lesser extent, homeless families. Diagnostic assessments, life history interviews, and inventories of recent stressful events have all been used to identify factors disproportionately found among homeless populations that are likely to be causally related to the occurrence of homeless "episodes."

Statistical techniques (multivariate analyses, regression models, and survival analysis), along with computations of relative risk and odds ratios, are then used to take the measure of the factors' differential contributions to such episodes. Male gender,

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African-American ethnicity, long-standing psychiatric disorder (especially when coupled with substance abuse), childhood out-of-home placements, and disruptive life events have all been shown to increase the risk of homelessness among single adults (17,18).

Structural analyses, undertaken in part as a corrective to the focus on individual disability, shift the focus to "fundamental causes," understood as the unequal distribution of resources (material and social) that limit one's exposure to risks and enhance one's ability to deal with misfortunes (19). Inventories typically include persistent poverty, dearth of affordable housing, injurious social and economic policies, and depleted social networks (20,21). Lately, attempts have been made to synthesize the two approaches (22,23).

These approaches to the "etiology" of homelessness share the epidemiological premise that homelessness is a condition akin to a disease or disorder. They further assume that methods for mapping the distribution and determinants of affliction in human populations can be usefully applied to instances of "social pathology" as well. Accordingly, even those with a structural bent tend to ignore the institutional mechanics of shelters, what might be called the supply side of relief, except insofar as such places provide convenient sampling sites. To extend the disease analogy, homelessness is what shelters "treat"; there is little reason to inquire into the intentions or routines of deliberating agents, whether clients or keepers.

Etiologic analyses seek to disentangle the bundles of early trauma, rigged life chances, bad habits, threadbare supports, co-existing ailments, and external forces that propel persons with severe mental illness into homelessness, sometimes repeatedly. No one disputes the productivity of such analyses, but their limits concern us. By ignoring the actions of shelter users and street-level bureaucrats (24), they miss ingredients that may be central to "making it crazy" (25) on the margins today.

This paper argues that, in addition to personal "risk factors" and structural "root causes," homeless service systems should be viewed as independent agents shaping the course of homelessness. It offers provisional evidence that these and allied systems may have the perverse institutional effect of perpetuating rather than arresting the "residential instability" that is the underlying dynamic of recurring literal homelessness (26) and that so often harries the lives of persons with severe mental illness. It concludes that any attempt to "unravel" the causes of homelessness and its association with mental illness (27) must seek not only to plumb the backgrounds of shelter users and street dwellers but also to take account of the institutions that serve them.

Methods

Setting

Narrative histories for this project were collected as part of a feasibility study of methods for tracking homeless individuals over time. Interviews were conducted in the first half of 1995 at the shelter adjoining the Single Homeless Assessment Center, the central intake site for single adults seeking shelter in Westchester County, New York. The intake process includes a clinical assessment of psychiatric history and current diagnoses. For this study, shelter applicants were considered severely mentally ill if they were already receiving Supplemental Security Income (SSI) for psychiatric reasons or if intake workers referred them for SSI evaluation. That is, for purposes of tracking the fate of homeless people thought to be severely mentally ill, we accepted the classification itself as ethnographic fact.

The original intent was to compile histories of residential instability that would refine the risk profile of the cohort to be followed. A close reading of these histories, however, has enabled us to describe how shelters and allied facilities have functioned over time in managing the basic needs of a population no single system seems prepared to claim.

Procedure

Sixty-two consecutive applicants for shelter who were also considered mentally ill were approached for participation in the study; 36 consented to participate. Refusers did not differ significantly from consenters in demographic characteristics; consenters were younger and had more foster care history than comparable subjects recruited from the same site a year earlier (28).

Subjects' whereabouts and support for the preceding five years were mapped using a version of the life chart pioneered by Harding and colleagues (29), as modified by World Health Organization researchers in a long-term study of schizophrenia (30). The three fieldworkers who conducted the interviews were college graduates recruited for the study. One was enrolled in a doctoral research program. They were trained in field methods and interview technique by the first author. Twelve pilot interviews using the life chart schedule were conducted before the study began.

Subjects were guided through a reconstruction of places of residence, treatment experiences, family relations, and sources of income for the past five years, beginning with the circumstances leading them to request shelter. Anchor points—incidents clearly fixed in the subject's memory—were used to prompt and order other recollections. Special attention was paid to reasons for changes in residence. Inconsistencies were flagged and resolved later in the interview.

The process could be painstaking. Each interview lasted from 45 minutes to two and a half hours. A second fieldworker was on hand to take notes during the process. The raw data of the life chart were reviewed by both workers, assembled the same night into coherent narratives, and then read by the first author. Gaps or contradictions in the account were highlighted. The next day, the interviewer reviewed the narrative with the subject, making emendations as needed. In several cases, further corrections were made as new material surfaced in the course of follow-up interviews. These narratives, data from a brief structured interview, and the official intake record of the Single Homeless Assessment Center formed the basis for the analysis.

Analysis

Narratives were independently reviewed by the fieldworkers and by the first author to identify and measure periods of past homelessness, institutional stays, and other placements. In this way, a complete inventory of residence was compiled for each subject. Time the subject was literally homeless was computed, both for the entire five years and for the noninstitutionalized portions of those years—the time effectively at risk of homelessness. For purposes of this analysis, persons were considered to be institutionalized, and thus not substantially at risk of becoming homeless, while residing in jails or prisons, hospitals, detoxification and rehabilitation facilities, and segregated housing located on the grounds of psychiatric hospitals.

The narratives were detailed enough with respect to the circumstances leading to past episodes of homelessness to enable us to identify a provisional list of functions played by shelters in these lives. Armed with that list, investigators rereviewed the narratives, amended the list of functions, and classified each five-year history by the dominant pattern of shelter use exemplified. These patterns were then compared with the officially recorded reason for homelessness in the intake record.

Table 1

Characteristics of 36 homeless adults eligible for Supplemental Security Income who sought shelter at the Single Homeless Assessment Center in Westchester County, New York

Characteristic	Total (N=36)		Males (N=26)		Females (N=10)	
	N	%	N	%	N	%
Age						
17 to 29 years	15	42	12	46	3	30
30 to 39 years	10	28	7	27	3	30
40 to 49 years	7	19	5	19	2	20
50 years or older	4	11	2	8	2	20
Ethnicity						
Black	23	64	15	58	8	80
White	11	31	9	35	2	20
Hispanic	2	6	2	8	0	0
Education						
Less than high school	16	44	13	50	3	30
High school or general equivalency diploma	9	25	5	19	4	40
Some college	11	31	8	31	3	30
Psychiatric history						
Previously hospitalized	36	100	26	100	10	100
Taking psychiatric medications	34	94	24	92	10	100
Foster care	8	22	7	27	1	10

Results

As Table 1 indicates, the 36 subjects did not differ markedly from cohorts in other studies of single homeless adults with severe mental illness. They were predominantly young, of minority status, not well educated, and with substantial foster care experience. As Table 2 shows, their residential histories reveal that women were more successful in negotiating doubled-up arrangements (staying with kin whether rent was contributed or not; staying with nonkin, or with someone not a romantic partner, for less than one week without making a rent contribution). However, the histories are chiefly notable for the amount of time spent literally homeless; on average, subjects spent

Table 2

Five-year residential histories of 36 homeless adults, by months in various settings and percentage of the five years in each setting[1]

Group	Own or shared housing[2]		Doubled up[3]		Institutionalized[4]		Literally homeless[5]		
	Mean months	% of five years	Mean months	% of five years	Mean months	% of five years	Mean months	% of five years	% of five years at risk[6]
Total sample (N=36)	19.7	33	6.9	11	17.1	29	12.0	20	29
Male (N=26)	20.5	34	5.5	9	16.8	28	12.6	21	29
Female (N=10)	17.6	29	9.7	16	17.7	29	12.8	21	30
First time homeless (N=5)	18.7	31	17.0	28	15.2	25	0	0	0

[1] Not included in the total were community mental health housing and time spent in the Job Corps, foster care, a state-affiliated group home, or residential school. Periods when subjects could not recall their housing status were not counted.

[2] Making a rent contribution to obtain regular access to housing; staying for one week or more with a partner in a "romantic relationship" whether rent was contributed or not; or staying overnight in a motel paid out of pocket (when not accounted for on a shelter or mental health housing roster)

[3] Staying with kin whether rent was contributed or not; staying with nonkin or with someone not a romantic partner for less than one week without making a rent contribution

[4] Psychiatric hospitalization, prison or jail, detoxification facility, rehabilitation, or mental health housing on the grounds of state psychiatric facilities

[5] A shelter, motel, or drop-in center; living on the street; or living in a nomadic manner

[6] Time literally homeless/(60 months–time institutionalized)

Table 3

Official reasons for homelessness noted in the intake records of 36 homeless adults

Reason	Total subjects N	%
Evicted		
By landlord for nonpayment of rent	2	6
By landlord for behavior problems	2	6
Because dwelling was a fire hazard or conditions were untenable	3	8
By family for behavior problems	3	8
Institutional discharge		
From prison or jail	7	19
From a psychiatric hospital	3	8
Other		
Lost job or was relocated	2	6
Unspecified	14	39

20 percent of the past five years on the street or in shelters and 29 percent of the time at risk—that is, not in institutions. (These figures rise to 23 percent and 33 percent, respectively, if five persons who had never been previously homeless are excluded.)

Table 3 shows the reasons for the subject's current homelessness. Subjects' intake records either resorted to using the category of "other" or identified eviction (formal or informal) and institutional discharge as the chief reasons for homelessness. Strikingly, nearly a third (32 percent) of the 22 shelter seekers for whom a reason was listed had come directly from jail or prison.

Table 4 presents four patterns of how shelters have functioned in the lives of these individuals—patterns that reveal further institutional linkages. For many subjects, shelters repeatedly provided the bridgework from confinement to community, and back again. At first glance the shelters seem to be functioning as discharge planning units for people who are otherwise difficult to place. However, for 20 subjects, shelter stays appeared to be part of a more durable pattern, of a life lived on the "institutional circuit" with occasional breaks for temporary housing on their own. Persons in this group had spent on average of 40 percent of the last five years in institutions; shelters accounted for an additional 19 percent of those years. Thus, if we ignore time spent in a place of one's own (alone or shared), as well as time doubled-up with others, in specialized community-based housing, and on the street, we can still account for 59 percent of the last five years in these persons' lives.

"Release from institution" cited as a reason for homelessness often simply marked a transition from one institution to another. For some young adults in this group, the latest shelter stay coincided with a bid for independence as they negotiated the transition from foster care or emergency housing placements with their parents.

Other shelter functions were also apparent in the subjects' histories. For some, the shelter functioned as a time-limited resource, a way station en route to another habitat of often tenuous stability. For others, it served as a surrogate for informal (usually kin-based) assistance that had either been exhausted or for other reasons was no longer available. For still others, it provided fleeting refuge for nomadic souls who nowhere put down roots, let alone engaged in rehabilitation or treatment.

The cases of those who had never before been homeless offer telling counterpoints to the institutional circuit pattern. Two of the five were young men who had only recently left foster care settings; the other three were middle-aged men and women whose kin-based sources of assistance had, for the first time, failed them. For the younger group, the shelter system both extended the institutional apparatus that had largely defined their life to date and broke with it at a crucial transitional point, the passage to adulthood. For the middle-aged individuals, it substituted for informal supports.

In all these cases, shelter proved a transitory resource; the stays of all five were relatively brief, and once they left, they did not return in the next year. Three found independent housing on their own, one was placed in supportive housing for persons with mental illness, and one returned home to Alabama.

Discussion

An alternative approach to the causation (or, better, the perpetuation) of homelessness takes its lead from historical accounts of the manifold "uses of charity" (31) and looks at how institutional resources are actually deployed. It observes, for example, that the function of confinement for disabled persons is not fixed but variable, subject to the needs and capacities of households, demands of seasonal labor, and exigencies of wartime (32–34). Problem-oriented, suspicious of bureaucratic boundaries, and careful not to confuse site of custody with category of need met, this approach asks how dilemmas of subsistence and housing (compounded by individual disability) are solved in everyday practice over time.

The old notion of the "latent" function of institutions (35,36) resurfaces, now put to the mundane task of accounting for the whereabouts of those formerly housed in special-purpose quarters. For example, Rochefort and Mechanic (37) remarked on the variety of "nontraditional institutions" that were pressed into service as functional equivalents of asylum in the wake of widespread deinstitutionalization, itself a hodgepodge of what they termed "design and inadvertence." Dear and Wolch (38) decried the growth of "service-dependent ghettoes" where legions of the formerly hospitalized were exiled. This fresh (and often short-lived) profusion of reclaimed rooming houses, board-and-care facilities, and single-room-occupancy hotels, in turn, represented the rediscovery of the value of cheap marginal housing for the unstable or misfit (39,40). But when the capacity of such alternatives is exhausted, or access to them is foreclosed, other arrangements must be made.

Sosin and Grossman (41) found that homeless clients of residential treatment facilities and shelters were distinguished from their housed, poor, and mentally ill counterparts chiefly by the latter's access to such "tangible resources" as a steady income. (Members of both groups made frequent use of soup kitchens.) That is, shelters and treatment beds served as in-kind surrogates for a commodity others could afford to purchase. Obviously, persons

Table 4

Four patterns of shelter function among 36 homeless adults who were interviewed about their five-year residential histories

Pattern of function	Mean months in institutions	% of five years in institutions	Mean months literally homeless	% of five years literally homeless	Mean months in shelters	% of five years in shelters	Excerpts from narrative of interview
Institutional circuit (N=20)	24.2	40.4	14.0	23.3	11.2	18.7	Has lived virtually an institutionalized life Institutionalized since age eight; jailed after flare-up at residential work program Succession of residences: jail, parents' home, own place, retreat for alcoholics, shelter, rehabilitation facility, hospital Has never lived in a place of his own Used the hospitals as an alternative to the shelter system but also would occasionally stay at shelters when he was between treatment facilities
Surrogate for informal assistance (N=5)	7.6	12.6	1.8	2.8	.6	1.0	Long-standing structure of support (kin and friends) collapsed after subject's injury and convalescence After lengthy prison term, moved with daughter to mother and aunt's apartment; wore out welcome and moved on, leaving daughter behind Long psychiatric history; sister intervened recently to prevent subject from moving back with his elderly father After long absence, moved back to New York City, but funds gave out, as well as support from friends and kin (sister recovering from surgery)
Crisis and temporary housing (N=6)	15.3	25.6	6.3	10.4	6.0	10.0	Usually on own in marginal housing, but evicted from unsuitable dwelling Usually in shared housing, but after brief jail term came to shelter Burned out of apartment with wife and later separated after she was hospitalized Moved a lot in last five years, occasionally resorting to shelters when out of work and without income
Nomadic (N=5)	5.6	9.3	25.8	42.9	9.7	16.1	Wandering for a long time; homeless most of the time since 1970 Haphazard ill-planned bus trip to New York City area, footloose (mostly in California) Confirmed nomad, with stays at monasteries, retreats, missions, on the road, in a tent, and in abandoned houses; even worked for a time as a nanny

with severe mental illness are not the only group to suffer income shortages, but they may find it more difficult to arrange informal makeshifts, especially when psychiatric problems are compounded with substance use (42).

In implicit recognition of their multipurpose nature, contemporary shelters have been compared not to the missions or flophouses of skid row but to 19th century police station lodgings and almshouses (43,44), to total institutions (45,46), to refugee camps for the American poor (47), and, pointedly, to "open asylums" (48). Four decades after the first stirrings of deinstitutionalization, attempts to locate the enduring but reconfigured functions of "custody and asylum" (49) must, it seems, take public shelters into account.

This argument rests on a simple logic of displacement: if persons with severe mental illness are moved from hospitals, and kin-based alternatives prove unavailable or unequal to the task, they must be relocated somewhere, no matter what the classification or official provenance of that place is. As certain institutional resources dry up, others—market-based, informal, or bureaucratic—are cobbled together to provide some semblance of the ordered subsistence that encompassing institutions like asylums once ensured. Especially when disreputable populations are involved—for example, the indigent chronic inebriate at the turn of the century (34), resistance may be expected from institutional quarters unused to catering to such a clientele and eager to dispose of them elsewhere ("not in my back ward"). In other cases, bureaucratic niceties of design and classification grudgingly give way in the face of the de facto "hybridization" of institutional function (50,51).

Unplanned, accidental, or haphazard as such accretions of function may be, they not uncommonly acquire inertial forces of their own. Over time, accommodating "inappropriate referrals" can become routinized, even accepted practice. Consider the designation of shelters as legitimate "housing placements" in some hospital discharge plans. Neither the utilities nor the clientele of facilities serving as the functional equivalents of hospitals or halfway houses is adequately captured by the conventional names for such places.

Studies explicitly located in this tradition first reframe the immediate issue of sheltering the homeless, mentally ill or not, as part of the more durable problem of holding surplus and potentially troublesome populations in "abeyance" (52). They then attempt to describe how contemporary shelters actually work in this respect (43,53,54). Homelessness is treated less as social pathology than as a variable state that is defined by degrees of "regular access to a conventional dwelling" (55).

Just as labor economists have learned to examine alternative employments in military service, prisons, hospitals, and the informal economy in accounting for the officially unemployed, so students of abeyance are learning to seek out alternative residences for erstwhile (and would-be) patients who in times past would have been hospitalized. Just as alternative sources of work can lure and harbor people who are ill suited for conventional jobs, or barred for various reasons from attaining them, so alternative dwellings can work to keep difficult people out of conventional housing.

This report reflects that tradition. Prudence dictates caution in interpreting these results; the numbers are not large, "heavy users" may be overrepresented, and other uncontrolled sources of bias may have gone undetected. Nevertheless, the continuing dominance of institutional stays in the lives of the 36 subjects is impressive. Solomon (56) has written about the imitative couplings that increasingly join clinical and criminal justice systems in the handling of difficult patients, such that the jobs of case managers and parole officers begin to resemble one another. Less formal modes of institutional articulation are apparent here. The couplings at work in these histories are not extended versions of coercive surveillance, but largely haphazard and uncoordinated transfers across institutional domains.

In this respect, today's homeless poor people with psychiatric disabilities strongly resemble their skid-row counterparts of the 1960s. That kinship was apparent to some early analysts (57,58), but with few exceptions (39,40) it has been ignored or denied since. Marginal lives spent on the institutional circuit today are not much different from those played out on "the loop" (jails, detoxification facilities, missions, and flophouses) in the skid rows of the 1960s (59); nor, indeed, are they much different from the shuttle round of saloons, fleabag hotels, missions, jails, almshouses, hospitals, and asylums that turn-of-the-century homeless drunks navigated (60).

Not that there aren't "good reasons" for any one facility refusing the long-term view. Displacement of problems and the timeworn desire to run an establishment unencumbered by the demands of people whose needs do not fit neatly into prescribed niches and whose eagerness to get with the program is suspect no doubt explain much of the mobility of the subjects in this study. Whether such reasons justify the hidden costs of disheveled systems is another question.

Public mental health care in the U.S. may have once represented, in Dowdall's words (61), "an unusually clear example of a highly institutionalized organizational field," but only irony salvages that characterization for the population studied here. When the locus of extended care was disaggregated, traditional lines of bureaucratic responsibility were disrupted. Recreating them outside the hospitals through networks of coordinated care has proven difficult, in part because the relevant agencies tend to have parochial ideas about their proper domains of work. Community-based systems of care were supposed to counter and correct for that tendency, but have manifestly fallen short of that goal. When sufficient resources are dedicated, the premise of flexible, coordinated care has proven sound, even for homeless persons with severe mental illnesses (13).

Thus one solution to the disarray depicted in this report would be to establish a special-purpose "alternative system" for this population. But the costs of such a parallel system are likely to be prohibitive. More feasible options, such as mobile relocation and stabilization units designed for "critical time intervention" (62) or modified assertive community treatment teams (14), also recommend themselves as interim measures.

However, in the face of a severe shortage of affordable housing for income-constrained households in Westchester County that shows no sign of lifting soon (63), stepped-up efforts to serve the needs of a relative few amount to little more than queue-jumping. Service providers have little choice but to advocate for the special needs of their clients, but that ought not to be mistaken for a solution to homelessness. ♦

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