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This article examines the extent to which psychiatric classification in public policy research contributes to the equation of homelessness and mental illness. Surveys that measure psychiatric status of homeless persons are reviewed to understand whether they contribute to biased rates of mental illness among homeless persons. The relationship between psychiatric classification and the concept of need is examined and alternatives to current classification are proposed. Classification is discussed particularly in relation to policies of segmentation for "single" homeless adults.

Homeless? I guess that's the category that's left over in this age of specialization.
— Resident of a municipal women's shelter, Queens, New York, 1987

The people are absolutely incapable of classifying themselves without assistance.
— G.V. Maxwell, a colonial administrator in Fiji, 1915

Injurious social phenomena exist and are even noticed without being perceived as a social problems.[1] In fact, some may even be periodically "rediscovered."[2] Yet once they emerge as a public problem to be managed, classification becomes an issue. For within the rationality of the modern welfare state (and of earlier systems of charity), redistributive politics require some system of classification to indicate eligibility for such resources as cash payments, privileges, access to services and goods. This is the meritocratic process also known as separating the "deserving" from the "undeserving" poor.

By now, the phenomenon of thousands of homeless men, women, and children in the United States has gained legitimacy as a social problem.[3] And as the numbers of persons without stable, permanent places to live have risen, so have the classifications that separate them multiplied. In fact, concern with establishing whether the magnitude of homelessness justifies a federal response has given way to "intelligent segmentation"[4] — the classification of homeless individuals into policy-relevant groups, each of which calls for a specific service response.

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New York City already provides a window on this process: more than any other American city, it has been forced, in large part through adversarial legal processes, to provide an extensive, if ad hoc, system of social and housing services for homeless persons. One response to the increase in "single" adults[5] seeking shelter — New York City's municipal shelters have increased from three a decade ago to between twenty and twenty-five today, serving up to seven thousand residents nightly — has been to further classify shelter residents. Formally and informally, shelters are divided along lines of age, employability, sexual preference, disability, and so forth. Recommendations of a recent mayoral commission, aiming to revamp the city's costly shelter policy, in fact reinforced the already existing practice of segmentation by recommending that the large municipal shelters be replaced by smaller ones, targeting specific "problem" groups (substance users, the able unemployed, the mentally ill, and so forth).[6] While the importance of services cannot be overemphasized, segmentation policy's emphasis on targeting specific problems and refining categories among the homeless fails to address the underlying causes of the homelessness itself. As we shall see, this classificatory practice tends to identify causes of homelessness as well as the needs it generates with a single, salient characteristic.

Classification can thus be thought of as characterizing a second stage in the emergence of homelessness as a social problem. The first stage was exemplified by the "numbers game," in which advocates and conservative policymakers struggled over the recognition of homelessness as a legitimate public problem. The second stage, not unrelated to the earlier mobilization of advocates, is the plan of action for managing the problem; here the larger tensions of the welfare state, between meeting need on the one hand and disciplining, deterring, and (more recently) cutting back costs, are expressed. The current refinement of categories of homelessness represents attempts to provide categorical resolutions to these welfare dilemmas.

In shaping homelessness as a major social problem of the 1980s and 1990s, both public policy and popular opinion often identify the phenomenon with mental illness. Unquestionably, in the race for scarce housing, extremely vulnerable persons who suffer from ongoing psychiatric disorders have fallen through the cracks more easily than those who can better negotiate access to resources. Thus, they appear in disproportionate numbers on the streets and in shelters. However, the shift in the hegemonic view of homeless persons as shiftless, often intoxicated, vagrants (the stereotype of post–World War II) to disorderly mentally ill cannot be explained solely by "facts" and the characteristics of homeless persons themselves.

Some psychiatrists were aware of the appearance of psychiatrically disturbed individuals among homeless persons as far back as the seventies.[7] For years, the prototypical homeless person was the shopping bag lady, whose image of physical deterioration and bizarre behavior blended with a folk notion of mental illness. Subsequently, the homeless label came to group many types of poverty, whose common denominator was a lack of housing. Yet despite clear evidence of an association between the rise of homelessness and such economic changes as the restructuring of the job market and the disappearance of low-income housing,[8] popular representations often identify homelessness with mental illness.[9] While homeless families dominate media attention, homelessness as a social problem continues to be constructed around the idea of the "impaired capacity" of individuals, with mental illness the central characteristic.[10] Among homeless who are mentally ill, it is often the illness that is considered the cause of homelessness.[11]

This article, organized in three parts, is concerned with the extent to which psychiatric classification in public policy research contributes to the equation of homelessness and mental illness. The first part discusses how studies that assess psychiatric status of homeless persons contribute to biased rates of mental illness among homeless persons. Next, the relationship between psychiatric classification and the concept of need in public policy research about homelessness is examined. Finally, from an applied research perspective, alternatives to classification by psychiatric status are suggested. Similar issues of classification apply to substance abuse and other characteristics being targeted by research and policy on homelessness, and to other groups, such as homeless families. However, this article focuses on mental illness and "single" homeless adults.

Does Classification Overdetermine Mental Illness?

Central to numerous government-funded surveys that count and characterize homeless persons in the United States has been the assessment of psychiatric disorders. Despite the range in the rates they report for mental illness, these studies present clear evidence of considerable mental illness among homeless persons. Yet problems in the way assessments are carried out have allowed generalizing from those studies that show *high* rates of disorder to all homeless. And they have lent themselves to the blurring of distinctions between homeless persons with severe psychiatric disorders and those who are either temporarily distressed or psychologically "well."

In the last decade of research, sociologists and mental health professionals alike, struggling to establish a "true" rate of mental illness among homeless populations, used standards quite different from those accepted as scientifically solid in current psychiatric and epidemiological research. For example, in the absence of mental health assessments generated through the use of standardized instruments, they often relied on records or the expert judgment of mental health workers, but without the explicit, or standard, data-collection procedures, much like earlier generations of now critiqued psychiatric epidemiology investigations.[12]

A good example of the standards these researchers and professionals used is found in a series of published exchanges concerning whether or not mental illness among the homeless is a myth. Snow et al. first published an article estimating an extremely low rate among the homeless of Austin, Texas.[13] They defined people as mentally ill if they met two of three criteria for mental illness: (1) a history of psychiatric hospitalization, (2) reports by other homeless of extremely bizarre or "crazy" behavior, and (3) observation by the fieldworker of behavior grossly incongruent with context. (The second and third criteria have grounding in an interactionist approach to the definition of mental illness, found in anthropology and sociology).[14] Another sociologist, Wright, correctly asserted that the Texas rates are probably lower boundaries.[15] But along with his critique, he produced another measure of mental illness that could be considered weak: an assessment based on one contact by a trained (but unspecified) health professional. A third group of social scientists[16] then critiqued Wright's self-selected sample — homeless persons who come to health clinics — but also pointed out that consensus on mental illness certainly does not exist even among mental health specialists and researchers, a fact that can be gleaned from the psychiatric literature on diagnoses that precedes every revision of the American Psychiatric Association diagnostic manual.[17]

Among the other major types of psychiatric status indicators commonly employed in studies of the past decade have been (1) scores on scales that measures symptoms and/or impairment in functioning, (2) diagnoses generated from clinical evaluations by mental health professionals, and (3) diagnoses generated from standardized clinical instruments. A review of these studies[18] suggests at least three problems of assessment that contribute to erroneous conclusions about homelessness and psychiatric status. These methods include how the homeless group was sampled and where the study took place (site); the diachronic dimensions of psychiatric conditions; and environmental contamination of measures.

In general, studies that used small, nonrandom samples at specific sites, such as shelters for persons with psychiatric problems, reported higher rates of psychiatric disorder. Service sites and other locales differ as to who frequent or use them, and this "selection factor" in turn affects reported rates of mental illness. Examination of who uses certain shelters or is to be found at a given site may explain why rates differ. For example, schizophrenia is reported to be almost five times as high among men[19] and older female shelter residents[20] than among young homeless mothers.[21]

Only a truly representative sample could overcome these problems of selection. But representativenes of all types of homeless persons is difficult to achieve, given the high mobility of many homeless, the difficulties in identifying "street" dwellers, and the illusion created by one-day (or -night) cross-sectional "snapshots," and so forth.[22] For example, one study came close to being representative of all homeless, sheltered and unsheltered, in a given city. However, not all shelters agreed to participate in this survey.[23] Furthermore, the methodology for contacting nonsheltered persons consisted of targeting blocks designated by police and service providers and approaching homeless persons in the dead of night, and in the company of police officers. This methodology has been critiqued as undercounting the nonsheltered homeless, especially those who might have been scared off by police or slept in areas not identified to the researchers.[24]

Other large surveys reach but a segment of the homeless population. The surveys of New York City's municipal shelters exclude, by definition, persons staying in family shelters, private shelters, or on the streets at the time of interview.[25] A major Los Angeles study was limited to that city's skid row,[26] another to selected sites in two areas of Los Angeles county.[27]

The problem with biases due to site or sampling difference lies as much in the interpretation of the study results as in the methodology chosen by the researcher. As noted above, findings from sites with high rates of disorder have tended to fuel the media. For example, a few years ago a *New York Times* article cited a local study that showed most homeless people to be severely mentally ill. It did not point out that the site of the study, a psychiatric emergency room,[28] would obviously draw only people with psychiatric emergencies.

The second problem of assessment stems from the use of symptom scales and psychiatric treatment histories as indicators of mental illness. When scales that measure symptoms or distress have been used instead of psychiatric diagnoses, the rates of distress turn out to be very high.[29] Almost half the homeless persons across all studies of the last decade score above cutoff points for "normal" populations, though the sites are different and the instruments used vary.

One reason for such high rates involves temporality. Whereas diagnostic systems generally build in specific duration criteria — for example, according to criteria in

the official manual of the American Psychiatric Association, *DSM III*-R,[30] the symptoms of schizophrenia must have lasted at least six months for a diagnosis to be made — symptom scales are often anchored on the past week or some unspecified "present." This creates confusion as to exactly what is being measured. Many scales are measuring something very nonspecific and transitory, such as distress or demoralization. This interpretation contrasts with the conclusion, based on scores from these scales, that almost half of homeless persons are mentally ill.

Demoralization, "a condition that is likely to be experienced in association with a variety of problems . . . and perhaps conditions of social marginality as experienced by minority groups and persons such as housewives and the poor whose social positions block them from mainstream strivings"[31] can affect all sorts of people in the same situation — flood victims, residents of poor neighborhoods, and certainly men and women living in crowded, unsafe shelters. Like distress, demoralization is affected by the dimension of time in two ways. First, the symptoms can be reactive, disappearing once someone leaves the noxious environment. Second, because the scales themselves use differing, usually short time frames (for example, the last week, for the widely used Center for Epidemiological Studies — Depression Scale, or CES-D), ongoing symptoms cannot be differentiated from transient ones.

The CES-D illustrates this problem of cross-sectional versus longitudinal time frames. The CES-D score above which subjects are considered to be "clinically" depressed was established through epidemiological and psychiatric research because it distinguished persons who were somewhat distressed from those who were "normal." It may be that when applied to homeless persons, high scores on these scales measure a reaction to the homeless situation more often than symptoms of an illness. For example, the 1985 survey of New York City's municipal shelters showed that first-time users of the shelter, on the average, had higher CES-D scores than men who had been in the shelters for long periods of time.[32] This could be interpreted in a couple of ways. First-timers could still be suffering acute distress from recently becoming homeless. (This interpretation is consistent with the literature on the psychological consequences of losing a home or moving.)[33] Alternately, they could be in "shelter shock" from the first encounter with the violent and unhealthy environment of a city shelter. Other researchers who found very high CES-D scores among the homeless have also interpreted these scores as signs of demoralization.[34] Of course, in all these studies, persons with severe psychiatric disorders may also score high on the CES-D.

Another temporal issue is the assumption that past characteristics are present. This can be a problem when information on treatment history is used. Only one indicator of psychiatric status, history of psychiatric hospitalization, is comparable across studies, although it is probably underreported by homeless persons, especially when they fear coercion into treatment. However, having been in treatment in the past is not an indication of whether one is currently disturbed. An Ohio survey illustrated this quite well.[35] One thousand homeless persons from twenty randomly selected counties were interviewed. Almost half of those who had been hospitalized in the past did not report experiencing *any* psychiatric symptoms at the time of interview.[36] Hospitalization history does not tell us much about *current* psychiatric status.

The last assessment problem concerns both diagnoses and symptoms. This confounding has been termed "the contaminating effects of external contingencies."[37] The concept can be applied to conditions of homelessness that may inflate rates of

disorder. Some aspects of a homeless person's life, like not having a regular place to live or not holding a regular job, are part of the official psychiatric definition of certain diagnoses such as antisocial personality disorder. Thus, simply being homeless could increase the likelihood of receiving a diagnosis of a psychiatric disorder.

For example, the *DSM III-R* criteria for antisocial personality disorder could easily describe a lifestyle that represents structured arrangements in a context of economic and other constraints, rather than reflecting the conscious violation of others' rights. The criteria which must have been met in adulthood also appear class bound or at least partly environmentally determined. In fact, they describe events or reactions to conditions of the lives of many homeless — for example, significant unemployment, repeated thefts, irritability or aggressiveness (anger), failure to plan ahead "as indicated by travelling from place to place without a prearranged job or clear goal for the period of travel or clear idea about when the travel could terminate or lack of a fixed address for a month or more."[38]

The hypothesis that rates of antisocial personality disorder are inflated by environmental factors in the lives of homeless persons was tested empirically in the Los Angeles skid row study.[39] When criteria that described characteristics more common among the homeless than among a nonhomeless comparison group — not having a regular place to live, not working for six months or more, having held more than three jobs in the past five years — were eliminated from the definition, the percentage of homeless with antisocial personality disorder decreased. Lifetime prevalence of antisocial personality disorder dropped by one-third, from 31 to 21 percent. Current prevalence also dropped one-third, from 25 to 17 percent.

A second example of such environmental contamination concerns both diagnosis of depressive disorders and symptoms of depression. Having sleep disorders, not being able to concentrate, and losing weight are symptoms of major depressive disorders. They are also common among people who must sleep in dangerous or uncomfortable places and depend on scavenging or handouts for food. The Los Angeles study just cited actually found that these symptoms were not more common among depressed homeless than in domiciled comparison groups. In another study, however, in a factor analysis of the symptom scales administered to homeless persons with serious psychiatric disorders, symptoms of dysphoria (feeling blue, depressed) did not correlate with sleep and appetite disturbances.[40] A correlation was expected because the latter symptoms constitute a dimension of the diagnosis of major depression in various nosological systems.

In this section, it has been argued that surveys measuring psychiatric status among the homeless tend to inflate rates of mental illness among them. The way study subjects are sampled and the sites where the study is carried out create differences in rates. The validity of the measures — whether they are measuring what researchers intend them to measure — are affected by both temporality and environmental contingencies. Is the validity problem inherent in the research, or does it lie in the process by which nonresearchers interpret results? In some cases, researchers have fallen prey to generalizing findings based on studies of specific sites to most homeless people. Other researchers are more conservative in interpreting their measures. Still others use a combination of measures to indicate psychiatric status, such as a composite of symptom scale scores, interviewer ratings, and psychiatric hospital history. However, media reports tend to concentrate on high rates with little interpreta-

tion. In this perhaps unintended sense, psychiatric classification in surveys of the mentally ill overdetermines mental illness among the homeless.

Psychiatric Status as a Construction of Need

Earlier, it was suggested that classification takes on importance when the emergence of a social problem reaches the stage where discussion, advocacy, and other tactics force action. The action can be seen in the ensemble of policies, plans, and programs that develop around homelessness. How does psychiatric classification of homeless persons affect these actions?

A rational assumption might be that such classification provides a database for active policy. In this process, psychiatric status comes to stand for the need for mental health services. Then, if psychiatric classification has inflated rates of psychiatric disorder among the homeless, public policy must concern itself with managing large numbers of psychiatrically disabled persons. This view can be challenged on both an empirical and a conceptual basis.

Mental health policy for homeless persons in New York State over the past decade and a half belies a one-to-one relationship between psychiatric status as an indicator of need and the development and provision of services. Hopper has shown how data concerning the presence of psychiatrically disturbed individuals among homeless persons existed prior to any official responses to the problem.[41] In the early 1980s, although State Office of Mental Health bulletins reported a high number of shelter residents assessed as needing mental health services, state officials publicly disavowed high rates of psychiatric disorders among the homeless.[42] As Hopper explains, any acceptance of such a rate would have been tantamount to acknowledging the failure of deinstitutionalization. When a state-commissioned random study of shelter residents found 33 percent to have histories of previous psychiatric hospitalization, it argued that, given the time lag between change in hospital policy and the appearance of homelessness, deinstitutionalization could not explain the presence of mentally ill homeless persons.[43] A similar argument was presented in studies commissioned by state offices of mental health in Ohio[44] and Michigan.[45] In New York, the Office of Mental Health also refused a primary responsibility for basic material needs of homeless mentally ill in its 1981 five-year plan, although subsequently it went on to provide some housing for them.[46]

In the late 1980s, New York City's roundup of mentally ill homeless from the streets provided another illustration of the distance between research findings and policy. This action, the so-called Koch Plan, was carried forth even though, from the very beginning, city as well as state mental health officials declared that the mental health system did not have the beds to accommodate more patients. In fact, the heart of the plan — an extension of the state mental hygiene law to allow, as grounds for involuntary hospitalization, behavior patterns suggesting that persons might harm themselves in a foreseeable future — was articulated by the mayor as early as 1981, when the city administration attempted to absolve itself of responsibility for sheltering the homeless. The plan itself affected only a small number of people and is focused on emergency and acute services, not long-term supports. The plan also aimed to pressure the state into providing more facilities for the mentally ill homeless, perpetuating the old state-city struggle over responsibility for the homeless that began in 1980.[47]

If a major goal lay behind the policy, it may have been linked more to the economics of postindustrial cities than to psychiatric problems conceived of as needs. The plan targeted Manhattan from 110th Street on the Upper West Side and 96th Street on the Upper East Side to downtown Manhattan, although there is no hard evidence that the most severely mentally ill frequent only those areas. These are, however, prime areas for real estate and tourism. The tension between ejecting disturbing individuals from public space, or treatment for the sake of "aesthetics," and legitimate treatment for a psychiatric disorder runs through the court case of Joyce Brown, the homeless woman forcibly removed, under the policy, from the East Side sidewalk where she resided. Alternately described as dirty, disheveled, malodorous, delusional, acutely psychotic, possibly suffering from lupus cerebritis (a degenerative disease that can affect brain functioning), possibly suffering from schizophrenia or a severe affective disorder, and, in her words, "a professional street person, though not a career street person,"[48] Brown's psychiatric classification was never clear. If she is a symbol of the policy by which she was hospitalized involuntarily, then her case suggests that psychiatric classification bears little direct relation to policy. The "aesthetic" approach, a reflection of land value and transformation,[49] characterized earlier practices of hospitalizing homeless mentally ill individuals.[50] It was also a major reason for funding many skid row studies in the fifties and sixties. At that time, though, alcoholism, not mental illness, provided a rationale for treatment, which often amounted to removal of skid row men from urban renewal areas and central business districts.

In social policy research, the concept of need takes on a universal quality, as if it were a clear, objective phenomenon that could be attributed to the individual recipient or potential recipient of services. An alternative approach interprets need as a socially constructed reality that, in policy research, serves as a guide for designing and planning services and for the functioning of organization. In his analysis of British social welfare research, which is applicable to the United States as well, Smith identified numerous variables that are represented by "needs," such as agency-determined eligibility for resources, expressed need of individuals for a resource, needs assessed by researchers.[51] What concept then, lies behind using mental health status as a major variable in surveys of the homeless?

The studies reviewed earlier suggest a multiplicity of constructed needs, as we will see. In fact, the needs assumed by using rates of psychiatric disorder or distress do not coincide with the needs expressed by homeless persons themselves. By now, enough surveys have established the consistent finding that homeless persons do not necessarily express a need for the mental health resources service providers and researchers assess them as needing. They also order their needs quite differently from the way professionals do.

The 1985 survey of New York City municipal shelters illustrates this point.[52] Both clients and interviewers were asked to rate needs for services in twenty different areas of living. The largest discrepancy between client and interviewer judgment was in need for help with health and emotional problems. Interviewers judged that 52 percent of the clients needed these services, yet less than half (23%) of the clients reported that this type of service could improve their quality of life. Other large discrepancies were found in the areas of getting along with family, improving job skills, health and medical problems, drinking problems, drug problems, and improving interpersonal relations.

These findings are in keeping with the observations in a San Francisco study.[53] It found that the hierarchy of needs expressed by homeless users of psychiatric services in the downtown area did not correspond to the services that mental health professionals made available to them. Although the homeless persons interviewed had two or more voluntary contacts with acute or emergency psychiatric services in the two months preceding the interviews, the frequency with which they rated mental health resources as a need was much lower than those for housing, entitlements, or employment.

A study of service utilization and preference patterns of homeless persons at three sites in Boston — a shelter and treatment program for homeless persons who are also mentally ill and two publicly funded shelters — came to similar conclusions.[54] Help with housing, food or food stamps, job seeking, obtaining clothing, and benefits applications were needs homeless persons cited most frequently. The majority of the homeless persons interviewed had not sought mental health services in the six months preceding the interview, nor did they cite a need for such services. The authors state that "this is interesting in light of the fact that the interviewers, all of whom were experienced mental health workers, rated the majority of respondents from all groups as being in need of mental health services."[55]

Other studies illustrate the priority homeless persons give to material needs and the differences between goals set by social workers and those acceptable to homeless persons with psychiatric disorders.[56] One of the first evaluations of innovative service programs for homeless mentally ill individuals found that client disagreement over housing goals had a significant negative effect on the likelihood that the client would remain in housing once it was obtained. The authors write that "housing 'placements' sometimes came undone if programs did not ensure that the process of setting and pursuing service goals incorporated clients' own perspectives on their needs and options."[57]

What accounts for such wide discrepancies between the need constructed by homeless persons and need constructed by researchers and service providers? Mulkern and Bradley point out that those homeless persons who attempted to obtain mental health services were by and large able to, "suggesting that accessibility to mental health care may not be a barrier for homeless persons, but acceptability may be."[58] Public psychiatric services, of course, are not readily accessible in New York City and other areas of the United States for all who desire them, judging by the long waits in emergency rooms. However, regardless of supply, many former and occasional patients who have not consistently been part of the mental health "system" and who are not necessarily homeless express a similar reluctance to accept treatment.[59] Others desire treatment, but not the medication and constraints offered.[60] Fifteen years after mental illness was "discovered" among homeless persons, this response continues to be one of the most persistent themes in services for mentally ill homeless.

Relative disinterest in mental health services may reflect the greater need for material resources or prior negative treatment experiences. It may also reveal a lack of insight or awareness of a mental health problem. However, rather than interpreting homeless persons' reluctance in seeking or accepting mental health services on the basis of a universal notion of need, we might do well to view such expression of autonomy as a critical consciousness of the situation. The low priority they give to psychiatric care may reflect conflicts between the value systems of two worlds[61] or

dislike or inability to tolerate the rigidity of organizational structure and time,[62] as well as the centrality of basic needs for shelter, food, and so forth. Refusing to "hear" such needs has adverse effects on service planning and may lead to extreme consequences, such as creating absolute and meaningless (as suggested above) categories of mentally ill homeless. Rather than interpreting the expression of non–mental health needs as resistance, the context in which they are voiced should be examined. This points to the way mental health services are organized, the multiplicity of agencies a homeless person must deal with, and the continual shrinking of resources. Furthermore, programs that meet homeless persons at the point where they are do exist; examples include "low-demand, no-questions-asked" approaches, as well as services that emphasize engagement and trust building as precedents to intervention or involve clients in management,[63] such as the Heights Residence in New York City, Women of Hope in Philadelphia, and a number of consumer-run alternatives, such as the Independence Support Center in Oakland.

On empirical grounds, then, we can question that the mental health needs identified in surveys affect policy directly. However, the very concept of need that underlies this policy research can also be challenged. Using psychiatric status as an indicator of need presents a further danger. It promotes a circularity by which the supply defines the demand. That is, by defining the needs of homeless persons in terms of psychiatric dimensions and symptoms, the service itself — hospitalization or treatment — becomes the social goal. This circularity in turn legitimates and reinforces the existing system (or nonsystem) of services[64] while preempting the possibility of other types of responses. It also removes from the universe of discourse (social policy) any indication of the macro-level changes that create and affect the day-to-day situation of homeless persons.

Alternative Classifications and Alternatives to Classification

The circularity created by constructing need through psychiatric status parallels the equation of homelessness and mental illness. In fact, it amounts to a "psychiatrization" of a social problem. Using single signifiers to cover the multiple problems of poor people is, of course, not new in American welfare history. In the two earlier major crises of the United States in this century, the thirties and the sixties, the pattern of intervention was similar: individualizing cases, categorizing and isolating the poor, multiplying the agencies distributing aid, with the effect of denying that poverty is a social and political problem. In this approach, social problems are increasingly turned into psychological ones, by redefining them as problems of individual pathology and deflecting attention from their fundamental social, economic, and political causes.[65] While psychiatry plays a role in this process, it takes place regardless of the formal involvement of psychiatrists, as some concurrence exists between the culture of psychiatric professionals and the hegemonic values of American culture.

Is there an alternative to classification by psychiatric status that might break the circularity described? The question begs consideration both because classification is inevitable at this stage in the emergence of homelessness as a social problem and because the fact that some homeless persons suffer from severe psychiatric

conditions requires responses as immediate as that of housing for homeless persons in general.

A first suggestion would involve shifting emphasis from a static characteristic to the resources one has for negotiating the experiences of everyday living, or survival. For some time now, psychiatrists and researchers have been questioning the usefulness of a psychiatric diagnosis for treatment purposes. Diagnosis neither provides knowledge of the context of distress or illness nor suggests which types of treatment are preferable.[66] Perhaps the one exception to this statement is a primary diagnosis of substance abuse or a dual diagnosis of substance abuse and psychiatric disorder. In fact, such diagnoses make getting into treatment harder, because the individuals fall between two treatment systems and bodies of knowledge. The substance-abuse label also makes it less likely to obtain other resources, such as housing.

Psychiatric research suggests that symptoms and diagnosis may not be the most useful predictor of who will be referred to what service or of who does best where. Instead, both stressful experiences in an individual's life and how well he or she had been able to negotiate everyday life (for example, work, social relations) may be more useful in suggesting the intervention that should be made available and the results that could be expected.

Among persons with schizophrenic disorders, for example, future behavior has been shown to be predicted best not by symptoms but by past behavior in the same outcome domain, such as employment.[67] A study that examined a wide range of psychiatric disorders found that the decision to hospitalize rather than refer to outpatient treatment is most highly correlated with current adaptive functioning.[68]

These study results confirm what clinicians have long observed — in their language, that stress and level of functioning are important predictors of a need for treatment. In what is almost a research cliché, two leading researchers who are attempting to unravel the "nature" of the course of schizophrenia showed that the social competence a person diagnosed as schizophrenic demonstrates before onset of the illness is his or her best prognostic indicator.[69] People may be impaired in some areas (symptoms) but not others (ability to work). These researchers also conceptualize separate systems of functioning. We might reinterpret these as domains of everyday life which one is able to negotiate: treatment, social relations with others, obtaining and retaining resources, and so on. While these are clearly interrelated in an individual's concrete lived reality, past performance predicts future performance in the same domain: past hospitalization predicts future hospitalization, past employment predicts future employment, and so forth.

In an attempt to clarify the concept of chronicity in mental illness, Bachrach raised the question of whether it refers to active symptoms or to functional disabilities.[70] This clarification is important given the assumption that it is chronically mentally ill homeless persons who are most in need of services.[71] Symptoms of illness may be present without disability, as we saw above. Similarly, difficulty in day-to-day functioning may persist long after primary symptoms of the illness have disappeared. Some aspects of that disability, as Estroff's ethnography of patients living in community-based settings suggests,[72] are produced by social interaction with people and organizations, as well as by the experience of illness, and may persist without the illness.

Evidence from research concerning homeless persons with psychiatric problems adds further grist in suggesting that competence in everyday life, or so-called level of

functioning, is more predictive than symptoms or diagnosis — with the exception, again, of substance abuse. In an evaluation of programs for mentally ill homeless, two aspects of competence — personal care and community skills — predicted who got into housing within a six-month period. In the 1987 New York City municipal shelter survey, level of functioning also predicted the interviewers' rating of type of housing a homeless client needed.[73] These ratings were part of a needs assessment made by the interviewers after they had spent, on the average, an hour and twenty minutes asking questions about demographic background, residential history, mental health, health, substance abuse, and other client characteristics. Interviewers were asked to place clients' housing needs on a continuum, ranging from independent housing to partly supervised housing to inpatient treatment. An interviewer's evaluation of client's competence, a client's ability to function, contributed more to the rating than did such mental health indicators as client's self-reported depressed mood and psychotic ideation, interviewer's rating of psychotic behavior, or history of psychiatric hospitalization.

Although measures of adaptive functioning may be preferable to measures of psychiatric status for social policy research, level of functioning presents its own sets of problems. First, level of functioning does not escape thorny issues of validity. A major problem in using level-of-functioning rating scales concerns the contaminating effects of environmental contingencies, which were discussed in relation to psychiatric symptoms. Several studies of homeless persons have noted the confounding of poor functioning with adaptation to a hostile or resourceless environment.[74] Among the direct effects of environment are dangerous or noisome conditions that affect sleep and concentration; food retrieved from garbage, or donated or routinized meals that affect ability to eat nutritiously; overcrowded and violent shelter conditions; and danger of physical or sexual assault or theft in the streets, which affect interpersonal relations.

Finally, level of functioning resembles too closely another administrative category, disability, that plays a large role in the distributive politics mentioned earlier.[75] As Stone later demonstrated for categories of policy research, the level-of-functioning measures, when isolated, emphasize one characteristic at the exclusion of others that may be equally as important.[76] In this metaphorical process, level of functioning, or its inverse, disability, becomes a symbol, as does psychiatric status. As such, it is both ambiguous and elastic, shaped by political agendas and economic priorities. In the Social Security Administration's recertification policy in the early 1980s, thousands of individuals were thrown off the Supplementary Security Income rolls as the incapacity to work was narrowly defined by the presence of symptoms.

To these elements of classification should be added two other types of indicators. A truly social, rather than psychiatric, "diagnosis" should include some signs of the community or network to which an individual has been attached. Becoming homeless happens in a social context, and disaffiliation from major social institutions does not necessarily mean detachment from other human beings.[77] Second, needs articulated by homeless persons themselves must be incorporated into their classification. Many surveys, as was shown above, contain this information. However, in diffusing findings, each element is broken up and isolated from the other, thus reflecting only a fragment of the lived experience of the individuals described. In this process psychiatric status tends to take on disproportionate importance.

An alternate to classification can take place to the stage of developing a plan of action. Needs can be articulated at several levels. The examples presented thus far focused on the individual level. Collective expressions of needs can emerge in a dialogue among potential clients, on the one hand, and advocates, service providers, and planners, on the other. In the field of mental health, some examples exist of the organization of services and resources that evolve as needs are brought to awareness, are redefined, or change. Bachrach described this process in idiosyncratic programs for new types of mental health consumers.[78] Other examples are evident in the democratic psychiatry movement in Italy[79] and in recent experiences such as psychiatric consumer-run housing and drop-in centers. The action-research of European poverty programs and of earlier periods in the United States formalize some of these practices.

Finally, needs may be articulated through collective actions. This is the case with Union of the Homeless's taking over of empty public housing and with the homesteading movement in New York City and elsewhere. Psychiatrically vulnerable homeless persons, while not figuring prominently, have nevertheless been involved in collective ventures such as living in abandoned buildings or shantytowns.

Whether an alternative classification or an alternative to classification is developed, we can conclude that psychiatric classification is overinterpreted. As shown, classification efforts too often serve the desire of administrations to define homelessness as someone else's problem or to meet the needs of other interest groups. These same measures and categorical schemes will not allow us to answer disparate but crucial questions about whether homelessness is due to personal or societal failings, which governmental agencies contribute to it, what agencies are responsible for responding to it, and what specific approaches are needed to change the situation, regardless of its causes. ❧

I would like to thank Susan Makiesky Barrow, Elmer L. Struening, and Fredric Hellman for their thoughtful readings of earlier versions of this article, and Kostas Gounis for calling my attention to the Fiji quotation.

Notes

1. Herbert Blumer, "Social Problems as Collective Behavior," *Social Problems* 18 (1971): 298–306. Blumer's conceptual scheme is applied specifically to contemporary homelessness by Mark J. Stern in "The Emergence of the Homeless as a Public Problem," *Social Services Review* 58 (1984): 291–301.
2. Michael Harrington, *The New American Poverty* (New York: Penguin, 1984).
3. Stern, "Emergence of the Homeless."
4. This term was suggested as a conceptual framework for developing programs by HUD assistant secretary Anna Kondratas (U.S. Department of Commerce, Bureau of the Census, *Enumerating Homeless Persons: Methods and Data Needs,* Washington D.C., 1991), 13.
5. The administrative category "single adults" actually includes many people who are married and/or have children, according to representative surveys of the New York City municipal shelter system (Elmer L. Streuning, "A Study of Residents of the New York City Shelter System" [New York: New York State Psychiatric Institute, 1986, revised 1987]).
6. Celia W. Dugger, "Panel Report on Homeless Is Criticized by Dinkins' Staff," *New York Times*, February 1, 1992, 1,26.

7. Robert R. Reich and Loren Siegel, "The Emergence of the Bowery as a Psychiatric Dumping Ground," *Psychiatric Quarterly* 50 (1978): 191–201.

8. Kim Hopper and Jill Hamburg, "The Making of America's Homeless: From Skid Row to New Poor, 1945–1984," in R. Bratt, C. Hartman, and A. Meyerson, eds., *Critical Perspectives on Housing* (Philadelphia: Temple University Press, 1986).

9. Examples abound, from articles in the widely diffused weeklies (*People*, *Newsweek*, and others) to films such as Terry Gilliam's *The Fisher King*.

10. Kim Hopper, "More Than Passing Strange: Homelessness and Mental Illness in New York City," *American Ethnologist* 15 (1988): 155–67.

11. Carl I. Cohen and Kenneth S. Thompson, "Homeless Mentally Ill or Mentally Ill Homeless?" *American Journal of Psychiatry*. In press.

12. The methodological problems with these earlier studies were critiqued in Bruce P. Dohrenwend and Barbara S. Dohrenwend, "Social and Cultural Differences in Psychopathology," *Annual Review of Psychology* 25 (1974): 417–52.

13. David A. Snow, Susan G. Baker, Leon Anderson, and Michael Martin, "The Myth of Pervasive Mental Illness Among the Homeless," *Social Problems* 33 (1986):301–17.

14. James D. Wright, "The Mentally Ill Homeless: What Is Fact and What Is Myth?" *Social Problems* 35 (1988): 182–91.

15. See, for example, Sue E. Estroff, *Making It Crazy: An Ethnography of Psychiatric Clients in an American Community* (Berkeley: University of California Press, 1981), and Erving Goffman, "The Insanity of Place," his appendix to *Relations in Public* (New York: Harper & Row, 1971).

16. Irving O. Piliavin, Herb Westerfelt, and Elsa Elliott, "Estimating Mental Illness Among the Homeless: The Effects of Choice-Based Sampling," *Social Problems* 36 (1989): 525–31.

17. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, (3rd ed.) (Washington, D.C.: American Psychiatric Press, 1980, revised 1987). Hereinafter cited as *DSM III*-R.

18. All the studies discussed in this section are reviewed in tables by and available from me (Anne M. Lovell, New York State Office of Mental Health, 75 Morton Street, 7B14, New York, NY 10014). Two types of psychiatric indicators — the homeless person's self-report of treatment history or need for mental health services and a service provider's brief assessment of psychiatric status — are less commonly used today and methodologically less sound than the other three indicators. They are discussed in Anne M. Lovell, Sue Barrow, and Elmer Struening, "Between Relevance and Rigor: Methodological Issues in Studying Mental Illness and Homelessness," in René Jahiel, ed., *Homelessness: A Prevention-Oriented Approach* (Baltimore: Johns Hopkins University Press). In press.

19. Paul Koegel and Audrey Burnam, "The Prevalence of Specific Psychiatric Disorders Among Homeless Individuals in the Inner City of Los Angeles," *Archives of General Psychiatry* 45 (1988): 1085–92.

20. William R. Breakey, Pamela J. Fisher, Morton Kramer, et al., "Health and Mental Health Problems of Homeless Men and Women in Baltimore," *Journal of the American Medical Association* 262 (1989): 1352–57.

21. Ellen L. Bassuk, Leonore Rubin, and Laurel Alison Lauriat, "Characteristics of Sheltered Homeless Families," *American Journal of Public Health* 76 (1986): 1098–1100. Another possible reason for differing rates is the definition of homelessness that is used. The definitions chosen are value laden and as much a political as a research decision. In applied research, who is called homeless depends on the prevailing "ceiling of decency" in housing, as Peter Rossi calls it, and varies from residents in emergency shelters, to the precariously housed or doubled up, to people staying in flophouses or welfare hotels.

22. Anne M. Lovell, Sue Barrow, and Elmer L. Streuning, "Measurement Issues in Services Research on the Homeless Mentally Ill," in J. Franks and M. S. Levine, eds., *Proceedings of the Eighth Annual MSIS National Users Group Conference* (Orangeburg, N.Y.: Nathan S. Kline Institute, 1984). See also the selections in U.S. Department of Commerce, *Enumerating Homeless Persons*.

23. Peter H. Rossi, Gene A. Fisher, and G. Willis, *The Condition of the Homeless in Chicago* (Amherst: Social and Demographic Research Institute, University of Massachusetts, and Chicago: NORC, A Social Science Research Center, University of Chicago, 1986).

24. Peter H. Rossi, "Lessons from the 1985–1986 Chicago Homeless Study," in U.S. Department of Commerce, *Enumerating Homeless Persons.*

25. See, for example, Struening, "A Study of Residents."

26. Koegel and Burnam, "The Prevalence of Specific Psychiatric Disorders."

27. Marjorie J. Robertson, Richard I. Ropers, and Richard Boyer, *The Homeless of Los Angeles County: An Empirical Evaluation* (Los Angeles: Basic Shelter Research Project, University of California School of Public Health, 1985).

28. Frank R. Lipton, Albert Sabatini, and Stephen A. Katz, "Down and Out in the City: The Homeless Mentally Ill," *Hospital and Community Psychiatry* 34 (1983): 817–21.

29. Diagnoses usually involve a group of symptoms that cluster together in time, severity of symptoms, and a certain duration.

30. American Psychiatric Association, *DSM III*-R.

31. Bruce G. Link and Bruce P. Dohrenwend, "Formulation of Hypotheses about the True Prevalence of Demoralization in the United States," in B. P. Dohrenwend, B. S. Dohrenwend, M. S. Gould, B. Link, R. Neugebauer, and R. Wuntsch-Hittig, eds., *Mental Illness in the United States* (New York: Praeger, 1990).

32. Ezra Susser, Elmer L. Struening, and Sarah Conover, "Psychiatric Problems in Homeless Men: Lifetime Psychosis, Substance Use, and Current Distress in New Arrivals at New York City Shelters," *Archives of General Psychiatry* 46 (1989): 845–50.

33. For example, Mark Fried, "Grieving for a Lost Home," in W. Duhl, ed., *The Urban Condition* (New York: Basic Books, 1963).

34. Rossi et al., *The Condition of the Homeless*.

35. Dee Roth, Jerry Bean, N. Lust, and T. Saveaunu, *Homelessness in Ohio: A Study of People in Need*, Ohio Department of Mental Health, 1985.

36. Ibid., 119. The study does not correlate symptoms with length of time since last psychiatric hospitalization.

37. Dwight Frankfather, S. Rick, and Frank Caro, *Residential and Service Configurations for the Chronically Mentally Ill*, unpublished manuscript.

38. American Psychiatric Association, *DSM III*-R, 36.

39. Paul Koegel and Audrey A. Burnam, "Problems in the Assessment of Mental Illness Among the Homeless: An Empirical Approach," in M. J. Robertson and M. Greenblatt, eds., *Homelessness: A National Perspective*. In press.

40. Unpublished data from the study "Evaluation of Programs for the Mentally Ill Homeless," Community Support Systems Evaluation Program, New York State Psychiatric Institute.

41. Hopper, "More Than Passing Strangers."

42. Ibid., 157–58.

43. Stanley P. Hoffman, "Psychiatric Assessment of Homeless Men." Paper presented to the 136th Meeting of the American Psychiatric Association, New York City, 1983.

44. Roth et al., *Homeless in Ohio*.

45. Carol Mowbray, V. Johnson, Andrea Solarz, and C. Combs, "Mental Health and Homelessness in Detroit: A Research Study" (Lansing: Michigan Department of Mental Health, 1986).

46. See also Ann Braden Johnson's discussion of these state-local conflicts over responsibility for homeless mentally ill (*Out of Bedlam: The Truth About Deinstitutionalization* [New York: Basic Books, 1990]). New York has resolved the conflict somewhat through a formal agreement between the city and the state to provide over 5,000 units of housing for mentally ill homeless.

47. Bruce Lambert, "Koch Says He Saw Hospital Plan for the Homeless as a Spur for the State," *New York Times*, September 4, 1987, A-1, B-4.

48. Josh Barbanel, "Woman Battles Koch's Program for Mentally Ill," *New York Times*, November 2, 1987, B-3; Josh Barbanel, "Hospitalization of Homeless Challenged," *New York Times*, November 3, 1987, B-2; Josh Barbanel, "Koch Foe Agrees to Live in Group Home," *New York Times*, November 24, 1987, B-1, B-3.

49. Anne M. Lovell, "Nomadic Thought, Disorder, and the State: An Analysis of Post-Industrial Homelessness." Paper presented to the American Ethnological Society, St. Louis, Mo., 1988.

50. Hopper, "More Than Passing Strange."

51. G. Smith, *Social Need* (London: Routledge and Kegan Paul, 1980).

52. Struening, "A Study of Residents."

53. F. L. J. Ball and B. E. Havassy, "A Survey of the Problems and Needs of Homeless Consumers of Acute Psychiatric Services," *Hospital and Community Psychiatry* 359 (1984): 917–21.

54. Virginia Mulkern and V. J. Bradley, "Service Utilization and Service Practices of Homeless Persons," *Psychosocial Rehabilitation Journal* 10 (1986): 23–30.

55. Ibid., 28.

56. Jane Plapinger, *Program Service Goals: Service Needs, Service Feasibility, and Obstacles to Providing Services to the Mentally Ill Homeless* (New York: Community Support Systems Evaluation Program, New York State Psychiatric Institute, 1988); Paula Goering, D. Paduchak, and J. Durbin, "Housing Homeless Women: A Consumer Preference Study," *Hospital and Community Psychiatry* 41 (1990): 790–94.

57. Susan M. Barrow, Frederic Hellman, Anne M. Lovell, Jane D. Plapinger, and Elmer L. Struening, "Evaluating Outreach Services: Lessons from a Study of Five Programs," *New Directions in Mental Health*. In press.

58. Mulkern and Bradley, "Service Utilization," 28.

59. Stephen M. Goldfinger, J. T. Hopkin, and R. W. Surber, "Treatment Resisters or System Resisters? Toward a Better Service System for Acute Care Recidivists," *New Directions in Mental Health Services* 21 (1984): 17–27.

60. Anne M. Lovell, "Marginal Arrangements: Homelessness, Mental Illness, and Social Relations," Ph.D. diss., Columbia University, 1992.

61. Steven P. Segal and Jim Baumohl, "Engaging the Disengaged: Proposals on Madness and Vagrancy," *Social Work* 25 (1980): 358–65.

62. Harry Murray, "Time in the Streets," *Human Organization* 43 (1984): 154–61.

63. Barrow et al., "Evaluating Outreach Services."

64. Daniel Cooper and Marine Zecca, *Recherche-intervention sur l'auto-definition des besoins socio-sanitaires par la population* (Paris: Centre pour la Recherche Scientifique ATP 5004, 1982).

65. Robert Castel, "La guerre a la pauvreté aux Etats-Unis: le statut de la misère dans une société d'abondance," *Actes de la Recherche en Sciences Sociales* 31 (1978): 47–60. See also Robert Castel, Françoise Castel, and Anne M. Lovell, *The Psychiatric Society* (New York: Columbia University Press, 1982).

66. This is not the place to enter into a debate over the advantages or disadvantages of a tight nosological system such as *DSM III*. Clearly, explicit, discrete, and reliable criteria are essential for advancing etiological knowledge, for example, in genetics, psychopharmacological clinical trials, and so forth.

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69. John S. Strauss and William T. Carpenter, "The Prediction of Outcome in Schizophrenia II Relationships Between Predictor and Outcome Variables: A Report from the WHO International Pilot Study of Schizophrenia," *Archives of General Psychiatry* 31 (1974): 37–42.

70. Leona L. Bachrach, "Defining Chronic Mental Illness: A Concept Paper," *Hospital and Community Psychiatry* 34 (1988): 812–17.

71. H. Richard Lamb, ed., *The Homeless Mentally Ill: A Task Force Report of the American Psychiatric Association* (Washington, D.C.: American Psychiatric Association, 1984).

72. Estroff, *Making It Crazy*.

73. E. L. Streuning, unpublished data, 1987.

74. See the discussion in Lovell et al., *Homelessness*.

75. Deborah A. Stone, "Diagnosis and the Dole: The Function of Illness in American Distributive Politics," *Journal of Health Politics, Policy and Law* 4 (1979): 507–21.

76. Deborah A. Stone, *Policy, Paradox and Political Reason* (Glenview, Ill.: Scott, Foresman, 1988).

77. Lovell, "Marginal Arrangements."

78. Leona L. Bachrach, "Overview: Model Programs for Chronic Mental Patients," *American Journal of Psychiatry* 137 (1980): 1023–31."

79. Nancy Scheper-Hughes and Anne M. Lovell, *Psychiatry Inside Out: Selected Writings of Franco Basaglia* (New York: Columbia University Press, 1987).