DESCRIPTING THE PROCESS OF HOMELESSNESS AMONG FORMER STATE HOSPITAL PATIENTS

DISSERTATION

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By

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* * * * *

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CHAPTER I
INTRODUCTION

Statement of the Problem

News reports and scholarly publications have made Americans painfully aware that there are growing numbers of homeless persons living in the streets and alleys of this country. The exact number of homeless persons has been estimated to be as many as two million to as few as 350,000 (Hirsch, 1986). Estimating the numbers of homeless persons has been referred to as a "demographer's nightmare" (Hirsch, 1986). Controversy about the numbers of homeless persons and the specific causes of the condition have created little consensus.

Nevertheless, Bachrach (1984) points out that professional and popular sources appear to agree on three points concerning the homeless in America today: that their numbers are growing steadily, that their average age is dropping precipitously and that the percentage who are chronically mentally ill, by any definition, is increasing rapidly.

Homeless persons come from a wide variety of situations with different reasons for being homeless and different problems associated with their homeless existence. Researchers agree that several factors contribute to a homeless existence, such as lack of housing, unemployment and poverty, deinstitutionalization, and domestic violence and
abuse (Stoner, 1983). These factors often interact with one another in such a way that it is very difficult to determine which factor began the chain of events that culminated in the person becoming homeless. The issue of which came first, the "chicken or the egg," is particularly a problem when examining the problem of homelessness among mentally ill persons.

Numerous studies have been conducted to determine the extent of mental illness among homeless persons. Bassuk (1983) studied the psychiatric status of 78 shelter residents in a facility that was determined to be representative of shelters in the Boston-Cambridge area. Psychiatric evaluations determined that 40 percent of the residents had major mental disorders (Lamb, 1984). A study conducted in Phoenix in 1983 determined that about 30 percent of the homeless people had spent some time in mental institutions (Lamb, 1984). Another study of shelter residents in Baltimore, Maryland revealed that 31 percent had psychiatric histories (Lamb, 1984).

These studies point out that there are documented cases of mental illness in the homeless population, but all these studies caution the reader about the generalizability of their findings. There are numerous difficulties in counting both the numbers of homeless people and determining the existence of psychopathology among the people counted. One significant difficulty lies in the definition of homelessness. This is problematic because some persons are obviously homeless, while other persons appear to be living in homes but are actually homeless.
Bachrach (1984) elaborates further about problems in counting by pointing out that:

there are obvious difficulties in confirming the presence of psychopathology among individuals who are often shy and frightened, who frequently use alcohol and drugs, and who are likely to have a subculture encompassing different values and normative expressions from those of most mental health workers and researchers (p. 20).

Once the psychopathology is established there remains an argument as to whether the mental illness caused the homelessness or the homelessness caused the mental illness.

Lamb (1984) has pointed out other problems in studying homeless persons:

1. Overlap with Other Populations

The characteristics of the homeless mentally ill as a group are not readily distinguishable from those of other chronically mentally ill groups such as 'revolving door' patients (p.22).

2. Heterogeneity

The homeless mentally ill are also frequently difficult to define and count out because of their extreme diversity a blind-man-and-elephant kind of methodological limitation (p.23).

3. Geographic Variability

This is difficult because the homeless mentally ill are hard to locate. They may migrate to another city or state (p.24).

These various problems make any study of homelessness among mentally ill persons difficult. Past studies have documented the presence of current psychopathology and a record of psychiatric hospitalization, but the life situations of homeless mentally ill persons remain relatively misunderstood. Examining the process that
led to a person becoming homeless can begin to unravel clues as to how and why a person became homeless.

The process of becoming homeless for mentally ill persons may be particularly complex. They have specific needs, which are the result of problems in cognition, personality disturbances and mood disturbances. These factors can make the achievement of traditional goals such as employment difficult to accomplish. This creates a greater vulnerability to poverty and in order to prevent mental and social decompensation, a system of care that responds to mentally ill persons needs to reflect these concerns.

It has been argued that both the formulation and implementation of deinstitutionalization has contributed to homelessness among mentally ill persons (Appleby, 1985; Treffert, 1985). Many mental health professionals argue that deinstitutionalization has created a nonsystem of care and lack of a holistic responsibility which is specific to the needs of chronically mentally ill persons (Appleby, 1985; Gralnick, 1985). Other mental health professionals have argued that the formulation of deinstitutionalization philosophy is not flawed; instead the problem is with the implementation of this philosophy (Okin, 1985). Disagreement and ideological constraints have prevented the interface of this philosophy with the creation of homelessness among mentally ill persons from being adequately explored. This research will explore the process of how mentally ill persons become homeless. The interface between deinstitutionalization
philosophy and policy, and this process will receive specific attention.

**Definition of Homelessness**

One of the greatest difficulties in studying homeless persons is the conceptualization of a definition of what constitutes homelessness. A study done in Ohio in 1984 conceptualized homelessness as "existing on a continuum" (Roth et al, 1985). The resulting definition of that study will be utilized in this study as well.

A person is homeless if he/she lives in:

1. Limited or no shelter for any length of time. (Examples include: under bridges, inside door stoops, in cars, in abandoned buildings, in a bus station or all-night care, or in any public facility.) (Roth et al, 1985, p.5).

2. Shelters or missions run by religious organizations or public agencies for any length of time. These facilities are specifically for homeless people, are run on a drop-in basis, and charge no fee or a minimal fee. (Examples include: Salvation Army, Volunteers of America, Open Shelter of Columbus.) (Roth et al, 1985, p.5).

3. Cheap hotels or motels when actual length of stay, or intent to stay, 45 days or less (Roth et al, 1985, p.5).

4. Other unique situations that do not fall into categories 1-3 and the actual length of stay, or the intent to stay, is 45 days or less. (Examples include: staying with family and friends, tent cities and having spent a night in jail.) (Roth et al, 1985, p.5).

This definition is meant to include as many different types of homelessness as possible. The continuum definition approach suggests that types of homelessness situations can change over time.
Significance for Social Work

The profession of social work has a long tradition of involvement with the mental health system. The Community Mental Health Centers (CMHC) legislation of 1961 and 1963 offered a unique role for social workers as service providers. As a profession, social work is committed to promoting self-worth and an environment conducive to growth. Homelessness among mentally ill persons is of particular importance to social work because deinstitutionalization of persons from mental hospitals was designed to provide an improved opportunity that was conducive to the self-actualization of the former patient.

The existence of homelessness among mentally ill persons suggests that a problem exists. Whether the source of the problem lies in the conceptualization of deinstitutionalization philosophy, or is the result of poor implementation of that policy, or lies in a combination of the two, the problem needs to be examined by the profession of social work. New aftercare services may be needed; changes in commitment laws, an improvement in the continuity of care, or other relevant issues in care may need to be addressed. The study of the process of how and why a former patient of a state mental hospital becomes homeless is one method of determining what changes need to be addressed in order to establish a system of mental health care in which homelessness for mentally ill persons is a rarity.

Social work as a profession also has the responsibility to improve upon past tracking studies of former clients. In order to deliver effective services to clients, an evaluation of those services
is necessary. Problems in past studies can be noted and solutions proposed. Unfortunately, past aftercare studies of state hospital patients have not accounted for all those persons who did not return to the hospital (Rosenblatt et al, 1974; Soloman et al, 1984). Those persons who did not return to the hospital were assumed to be successful in their community adaptation, yet they could have died, become homeless or incarcerated. By suggesting improved methods of evaluation, social workers can help to facilitate the best fit between the person and the environment. Without improved methods of evaluation, service delivery systems will function with misinformation and potentially damage clients.

Unresolved Issues

Addressing the needs of homeless mentally ill persons demands that policymakers examine the purposes of public policy. An important question for consideration is whether public policy should be constructed for the majority or the minority. This researcher believes that public policy in a capitalistic society will need to be constructed for the majority. Public support for policies that only serve the needs of the less fortunate minority have never faired well in an economic system devoted to individualism and self-sufficiency. Homeless mentally ill persons represent both a minority among homeless persons and a minority among mentally ill persons. Any policy that addresses their needs would be one that serves the needs of a minority.
Public policies reflect the needs of the majority, but they also need to be aware of the humanitarian needs of the minority. Awareness means that public policymakers need to be educated about these needs and how existing public policies may exacerbate human misery. Otherwise, public policies will continue to ignore the humanitarian needs of minorities within a larger target population.

Martin Rein (1976) points out that research needs to expose contradictions and paradoxes in existing social policies. This dissertation examines a group of people who represent a contradiction or paradox in a society where persons are supposed to have a home. Not only are homeless mentally ill persons a minority within both the homeless population and the mentally ill population, they are also a hard-to-treat population that is often ignored by politicians, researchers and mental health professionals. Factors that contribute to the homeless condition can be revealed, but the actual cause of homelessness among mentally ill persons will always remain elusive.
CHAPTER II
LITERATURE REVIEW

An examination of the problems of homeless mentally ill persons demands an understanding of the mental health system which often affects their daily lives. The persons in this study are all former clients of a state mental hospital. The public policies that led to their admissions and discharges are directly related to their particular life stories. This review of literature will outline the conceptualization, development and implementation of deinstitutionalization policies. A review of the literature surrounding the philosophy of deinstitutionalization is subject to interpretation. When reviewing the literature, the author attempted to remain aware of how various legislative reforms have served the needs of chronically mentally ill persons. The criticisms raised about deinstitutionalization will address how this public policy has met the needs of chronically mentally ill persons. This overview will help to provide a context for the study of the persons who became homeless during this research project.
Overview

In most states, deinstitutionalization is the philosophy or theoretical framework which "drives" the mental health system (Beis, 1983). While the outcomes of this philosophy are debated, the fact of its influence on the lives of mentally ill persons in many communities is significant (Bachrach, 1983). Bachrach (1983) points out that "the very word deinstitutionalization is itself surrounded by uncertainty and a basic absence of consensus" (p.9). Terms such as "least restrictive alternative" and "community success," which are closely associated with this philosophy, are clouded by vague definitions (Mechanic, 1980). Nevertheless, there are three points that have been associated with this philosophy:

1. Community-based care is preferable to institutional care for most, if not all, mental patients (p.13).

2. Communities not only can, but are also willing to, assume some responsibility and leadership in the care of the most seriously ill (p.13).

3. The functions performed by mental hospitals can be equally well, if not better performed by community-based facilities (Bachrach, 1983, p.13).

Early History

These three points emerged over a period of years as new ideas were conceptualized about the state hospital and the treatment of mental illness. Some of the new ideas had a basis in reality; others were more representative of social ideology. Morrissey and Goldman (1984) point out that "the first major effort to improve the care of the mentally ill in America occurred in the early 19th century as part
of a broad-based social reform movement aimed at bettering the condition of the less fortunate members of society" (p.786). This reform movement came to be known as "moral treatment" and was characterized by a "set of beliefs and practices akin to today's concepts of milieu therapy" (Dain, 1980). The assumption was that mentally ill persons should be separated from their environment and placed in an asylum where they would receive "humane" treatment.

The early asylums had no real treatment for mental illness and by the mid-19th century the asylums were fast becoming vast warehouses. America was changing as a nation and with the influx of immigrants and the increase in poor persons, legislators became concerned that there be some place to house these unfortunate persons and keep them out of sight. Research of the history of asylums reveals that a two-class system of mental health care was slowly emerging. Lower class persons and incurables were overtaking the public asylums and middle class patients were utilizing private care (Morrissey, Goldman and Klerman, 1980).

By the 1870s, an atmosphere of pessimism had overtaken state hospital care. State hospitals were overcrowded, suffered from acute staff shortages, and no real treatment for mental illness existed. In 1908, Clifford Beers, himself a former patient in a state mental hospital, wrote a book which exposed the conditions of mental hospitals (Beers, 1925). Beers found the state hospital to be a vast warehousing operation where treatment was limited and custody was the norm. His former patient status added to the credibility of his
findings. It is interesting to note that, although he pointed out the failures of the hospital, he said he would seek rehospitalization if necessary (Siegler and Osmond, 1974). At the same time, he recognized the failures of the hospital, Beers implied that he received benefits from its limited treatment.

Beers has been observed as "adding a note of optimism to the prevailing criticisms of the time" (Dain, 1980). This optimism surrounded new-found successes in treating acute episodes of mental illness, but "these new facilities were unable to eliminate chronic mental illness" (Deutsch, 1944; Morrissey and Goldman, 1984). Beers founded the National Committee for Mental Hygiene. This reform movement, along with other professionals and former patients interested in changing state hospital care, thought that hospitals were stagnant, repressive and monolithic (Grob, 1983). Unfortunately, these reformers overlooked significant changes that were taking place that affected the role of hospitals.

It was true that between 1890 and 1950 psychiatrists began to "push the boundaries of their specialty outward into the community and attempted to broaden its functions and roles under the ageism of the mental hygiene movement" (Morrissey and Goldman, 1984, p.788). However, changes were also taking place in the hospital. In 1890, the New York State Care Act was passed. This was a landmark piece of legislation that required New York to assume full financial responsibility for the care and treatment of mentally ill persons. Other states began to pass similar legislation, and local communities saw
this as an opportunity to shift the financial burden of caring for senile persons from county homes to state hospitals (Grob, 1983).

Between 1903 and 1950, state hospitals became overburdened with a large group of individuals who were in need of custodial care. Morrissey and Goldman (1984) make the point that "in the absence of specific treatments, mental illnesses remained chronic illnesses and state hospitals remained predominantly chronic care facilities providing long-term care for poor and disabled persons" (p.788). Knowledge about how to effectively treat mental illness was basically nonexistent, perhaps because of the lack of scientific inquiry and discovery related to this problem.

Economic factors were important in helping to make state mental hospitals between 1903 and 1950 vast warehouses. The residents of these warehouses were poor and dependent. Persons with these characteristics do not generally elicit the kind of investment by government that persons of more "worth" in a capitalistic society can demand. Institutional reform was needed to relieve some severe overcrowding and introduce a greater sense of humanity to this vast warehousing operation. Yet as Grob points out, despite their very real shortcomings and failures, "state hospitals did provide minimum levels of care not otherwise available for individuals unable to survive for themselves" (Grob, 1983, p.788). A sense of hopelessness and pessimism continued to surround hospital care, yet the real shortcoming was medicine's inability to cure mental illness.
A Change in Conceptualization: A Shift to the Community

Circumstances surrounding World War II introduced greater enlightenment into both the discovery of the incidence of mental illness in the general population and improved treatments. Many of the young men who were examined prior to entering the armed forces were found to be unfit for military service because of mental illness (Morrissey and Goldman, 1984). Psychiatrists at the war-front discovered new-found success in treating cases of "war neurosis" (Spiegel and Grinker, 1945).

Suggested reforms of state hospitals moved rapidly following World War II. Advances with acute mental illness led many mental health professionals and advocates for reform of the mental health system to believe that these same techniques could be transferred to chronic cases of mental illness (Talbott, 1982). Advocates for the rights of mentally ill persons found support in these advances. In the mid-1950s, psychiatrists began to use psychoactive medication and found it effective in reducing the symptoms of mental illness. Researchers began to discuss the idea that living in an institution created the symptoms characteristic of schizophrenia. These symptoms included the apparent apathy and confusion manifested in many of these patients (Wing, 1970). The combination of these factors led to a consensus that early intervention in a community setting could prevent chronicity and long-term disability, rendering the state hospital obsolete (Morrissey and Goldman, 1984).
A conceptual short-cut was taken at this point in the development of mental health philosophy. This conceptual short-cut failed to recognize that persons who develop chronic mental illness are very different from persons who experience an acute episode of mental illness. Blaming the institution for many of the symptoms of mental illness meant treatment in the community would be the logical means of curing these symptoms. This argument failed to recognize the severe debilitation of persons who suffer from long-term mental illness as compared with persons who experience one episode of mental illness, recover and function well. The attribution of chronicity exclusively to institutionalization lacked scientific rigor and was a simplistic explanation to a complex phenomenon. The disease process of mental illness was not thoroughly examined by mental health professionals indicating an anti-disease bias that would characterize mental health research and lead to treatment compromises that lacked scientific support.

Beginning in 1946 with the passage of the National Mental Health Act, a period of significant federal interest and activity into mental health was launched. The Mental Health Study Act of 1955 established the Joint Commission on Mental Illness and Health (Morrissey and Goldman, 1984). This Commission sought to analyze and evaluate the needs and resources of mentally ill persons in the United States and make recommendations for a national mental health program (Morrissey and Goldman, 1984). The commission promoted the concept of community mental health care which led to the passage of the Community Mental
Health Centers (CMHC) Act of 1963. Morrissey (1982) points out that a struggle to shape the federal role in the field of mental health was "sustained by two essentially antagonistic ideologies, one rooted in institutional psychiatry and the other in community mental health."
The community mental health lobby consisted of a collection of citizen advocates, traditional mental health professionals, anti-psychiatry and anti-hospital mental health professionals, and former patients of state mental hospitals. From this struggle emerged the concept of community treatment known as deinstitutionalization. State hospital care was seen as unnecessary by several groups that participated in the struggle to shape federal involvement in mental health services.

Bachrach observes that deinstitutionalization came to be recognized as a protest movement against state hospitals (Bachrach, 1983). This protest movement received support and indirect leadership strength from the National Institute of Mental Health (NIMH) (Foley and Sharfstein, 1984). The director of NIMH, Robert Felix, was key in making the federal government the "prime mover" in research, training, and the development of community-based services (Foley and Sharfstein, 1984). He was active as director from the inception of NIMH in 1946 through the passage of the CMHC legislation in 1963.

Understanding of mental illness at the time can best be described by a statement made by Dr. Overholser of St. Elizabeth's Hospital, "It is not only a question of emptying the hospital or reducing the load, not only restoring the patient to his family, but making him a productive unit in society" (Hearings, 1955, p.12). Newly available
psychoactive drugs and community treatment were believed to have few therapeutic boundaries. It was anticipated that mentally ill persons could become "productive members of society" as they benefited from these new treatments. This optimism reflected an absence of conservatism normally characteristic of the medical community. Rehabilitation was considered to be needed only on a limited basis and direct care was considered unnecessary because persons would quickly recover from their mental illness or through the benefits of psychotropic medication and be able to live a productive life in the community. Some research suggested that some chronically mentally ill persons could develop significant problems in the community but the implications of this research were overlooked by the more apparent emphasis on treatment in the community (Pasamanick et al, 1967).

State hospitals were perceived as being the best that medicine could provide to patients, when in reality the "hospitals" had long since ceased to function as hospitals serving acute illness. In fact, they served as warehouses for long-term patients whose prognosis for immediate recovery was bleak, not only because of their hospital treatment but also due to the nature of their illness.

The struggle to shape federal involvement in mental health care was also being debated in the courts. The "right to treatment" was first mentioned in an article in the American Bar Association Journal in 1960 "stressing the idea that the mentally ill person committed to public institutions had a legal right to be treated so he may regain his health, and therefore his liberty as soon as possible" (Birnbaum,
1960, 1969). Szasz, a noted critic of state hospitals, pointed out that "the abstract definition of 'right' removes the imperative to treat as a justification for confinement" (Toomey, Simonsen, Allen, 1976). Szasz's suggestion that society does not have the responsibility to confine a person to treat them meant that the role of the state hospital in providing care for mentally ill persons was severely limited.

In 1966, Rouse v. Cameron was decided by District Court Judge David Bazelon, Washington, D.C., who pointed out that the purpose of involuntary hospitalization is treatment (Rouse v. Cameron, 1966). This decision upheld the state's right to utilize the parens patriae doctrine to confine for treatment persons not adjudicated criminal or dangerous to society (Toomey, Simonsen, Allen, 1976). Court decisions continued to clarify the issues of a right to treatment and the least restrictive environment. Litigation surrounding the rights of mentally ill persons was a hallmark of the struggle to define the federal role in mental health services. It created an atmosphere in which the interests of patients were considered. An anti-hospital bias was also created by this litigation which stressed community treatment.

In 1961, the Joint Commission on Mental Illness and Health issued the report, Action for Mental Health, which promoted the concept of community mental health care (Joint Commission, 1961). This came to be known as a "bold new approach" which led to the 1963 Community Mental Health Centers legislation. Two factions had emerged on the
commission which competed for federal recognition. One favored the regeneration of state mental hospitals as the center of mental health services, while the other called for the demise of state hospitals to be replaced by a community-based service system (Morrissey and Goldman, 1984).

Some members of the commission wanted to upgrade the hospital system, but economic factors convinced other commission members that funding both a community system and a hospital system would be too expensive. Beginning in 1955, state hospitals were beginning to open their "back doors" and discharging thousands of mentally ill persons into the community (Morrissey and Goldman, 1984). And the community appeared to be successful in absorbing those mentally ill persons. The apparent success of the community as compared with the hospital added credibility to a community-based program. This meant that increased funding for state hospitals would not be forthcoming. Aftercare studies on the success of these former patients were rarely undertaken in the 1950s and 1960s (Morrissey and Goldman, 1984). The community was considered to be successful as evidenced by their apparent absorption of mentally ill persons. Researchers are now, however, concluding that "shifts in the focus of care did not solve the problem of chronic mental illness" (Morrissey and Goldman, 1984, p.790).

Those in favor of a community-based system won support largely by citing the benefits of the new psychoactive drugs (Foley and Sharfstein, 1983). These drugs were supposed to "cure" mental illness and the idea of chronicity was not seriously considered as a reality.
Former officials of NIMH now point out that they "oversold the drugs to President Kennedy and Congress" (Lyons, 1984). Reliance on the wonders of these new drugs played an important part in Kennedy's 1963 message to Congress in which he mapped out his "bold new approach" (Gronfein, 1985; Bachrach, 1976; Bassuk and Gerson, 1978; General Accounting Office, 1977; and Kramer, 1977).

Community mental health centers (CMHC) were gradually "overtaken" by recently released chronically mentally patients. Foley and Sharfstein observe that:

CMHCs were originally intended more to serve new constituencies in their own communities than large numbers of a great under-constituency of patients discharged 'better but not well' from mental institutions to communities (Foley and Sharfstein, 1983, p.98).

The "drive" to deinstitutionalize was fueled by fiscal conservatives, particularly with the passage of Supplemental Social Security Income (SSI) legislation, which allowed states the opportunity to shift the financial burden of care to the federal government (Rose, 1979; Scull, 1979). Consequently, the states failed to adequately fund community-based programs to handle the care of chronically mentally ill persons.

Deinstitutionalization slowly took shape as the philosophy that would guide the CMHC legislation and mental health care for the next 20 years. This was not a particular formal federal policy, in fact authors have shown that such a conceptualization "overstates the connection between changes in policy and inpatient censuses" (Gronfein, 1985, p.439). The CMHC legislation provided a framework or
structure for deinstitutionalization philosophy and this legislation reflects such a philosophy today.

It has, however, been observed that deinstitutionalization was a protest movement and translating this protest movement into a planned series of program initiatives that could be implemented as a public policy has proven difficult. This is particularly true when attempting to understand changes in hospital populations.

The fragmentation of the depopulation of state hospitals was in part the result of President Kennedy's decision to bypass the states and enact the CMHC legislation in such a way that the local community could implement it without consultation with state governments. Consequently when patients left the state hospital, community treatment did not always follow.

Kennedy and other designers of the Great Society wanted to redistribute power to those persons who in the past had been excluded from the power structure (Piven and Cloward, 1971). Efforts to accomplish these goals led federal planners to view state and local governments as impediments. CMHCs were to be locally controlled by nonprofessional citizen boards. Elites in local communities were to be avoided in favor of disadvantaged groups. Planning for patients in the community and evaluating the consequences of releasing large numbers of patients into the community were not priorities of these citizen-controlled boards. This created an atmosphere that often led to hostility and animosity between state hospitals and local communities.
As a result, the depopulation of state hospitals simply occurred with little coordination between the state and new CMHCs (Bassuk and Gerson, 1978; Chu and Trotter, 1974). This created an environment in which many former clients of state hospitals were discharged with no specific agency being responsible for their aftercare.

Continuity of care was built into the CMHC legislation through the use of treatment plans. Patients were to be discharged from mental hospitals under a treatment plan in which the patient had an appointment date with a local community mental health center where they were to receive their aftercare. Community mental health centers would provide aftercare for these patients and help them adjust to community life and maintain themselves in the community. Halleck (1981) pointed out that "even if the community clinic provides a full range of interventions for the psychotic person, the coordination of treatment modalities is fragmented." Patients were expected to follow through with their scheduled appointments but once released from the hospital, the continuity of care concept quickly broke down for many patients (Gralnick, 1985). Patients were sometimes not fully compensated and did not follow through with their prescribed psychoactive medications. This led to loss of functioning and decompensation, which was exacerbated if the patient failed to go in for aftercare. Continuity of care relied upon the assumption that patients would follow through with medication. The demonstrated failure by many mentally ill persons to do so makes this assumption only partially valid.
The 1963 Community Mental Health Centers Act legislation enjoyed compatibility with other legislative initiatives of the Great Society. These initiatives often combined community participation and citizen involvement on the boards of such projects as the CMHCs. The shift away from the state hospital to the community proceeded with great speed up until passage of the Mental Health Systems Act of 1980. This act was the first real pause when policymakers began to assess the effects of deinstitutionalization.

Proponents who supported the shift in treatment emphasis to the community often used as their philosophical basis such authors as Szasz, Scheff and Laing. These authors conceptualized mental illness as a "myth" and a creation by society to serve powerful elites and control disadvantaged persons who did not fit into particular norms. This perspective had limited empirical support. Cummings and Cummings explored the feelings about mental illness among a group of residents in a small northwestern community. They published a report of their findings called Closed Ranks in which they began to sow the seeds of the conspiratorial model of mental illness (Cummings and Cummings, 1957).

The conspiratorial model of mental illness conceptualized no treatment for mental illness; instead it contended that if changes were made in society's social fabric, mental illness would disappear. Proponents of this perspective believed that mental illness is a "label" which is unfortunately pinned upon some people (Siegler and Osmond, 1974). This model is also described as a belief that mental
illness only exists in the eye of the beholder. Cummings and Cummings "tried to convey the message that some of the patients in the hospital (mental hospital) were no more ill than those who remained harmlessly at home" (Siegler and Osmond, 1974, p.161).

This philosophy was incorporated into the CMHC legislation, yet the idea that mental illness also needed to be prevented was a goal of the legislation. Unfortunately, many mental health professionals believed that mental illness was a myth. How could something be prevented that did not exist? This dilemma posed a dichotomous model in which some professionals utilized the medical model while others did not believe their clients were mentally ill and utilized a nonmedical model. When released from the state mental hospital, chronically mentally ill persons who were previously treated under the medical model found many mental health workers pointing out that they were not really ill at all. Eliminating the word illness did not eliminate the suffering of persons who were afflicted by something which often left them disorganized and debilitated.

Many intellectuals also endorsed the belief that mental illness was a myth, but the continued incidence of chronic mental illness indicated otherwise. The dichotomy of beliefs concerning the reality of mental illness often left the deinstitutionalization movement and the CMHC legislation on a conflicted and contradictory philosophical basis. The philosophical basis for treating mentally ill persons remains conflicted today.
Implementation

The implementation of this philosophy has been shown to vary from state to state. With no formal federal policy, states proceeded at their own pace and operated with their own interpretation of deinstitutionalization. In the 1950s and early 1960s, available treatments for mental illness were limited. Chlorpromazine had been introduced into the United States in 1954, and it was being widely used in the community. The short-term effects upon patients appeared to be positive. The positive contribution of psychoactive drugs to long-term recompensation were largely unknown. Nevertheless, treatments in state mental hospitals were not effective. This led many mental health professionals to believe that patients could and should be treated in the community. Morrissey (1982) points out that the back door of state mental hospitals opened first with the discharge of thousands of mentally ill persons into the community.

By 1965, the front door to state mental hospitals was beginning to shut with continued social optimism that all patients could be successfully treated in the community and the development of restrictive admission policies (Bachrach, 1976). Mental illness continued to be viewed as uniform; differing types of mental illness were not easily separated. This created the belief that the needs of all patients in relation to how to best treat their mental illness were somewhat similar. There were treatments for more acute forms of mental illness but subgroups of chronic mental illness such as schizophrenia and affective disorders remained resistant to treatment.
Advocates for mentally ill persons correctly pointed out that mental hospitals had no real treatments. Unfortunately, the community did not have any treatments for subgroups of chronically mentally ill persons.

In 1978, the General Accounting Office observed, "deinstitutionalization of the mentally ill has been plagued by the lack of a planned, well managed, coordinated and systematic approach" (p.13). Another author, writing in 1978, pointed out, "once discharged from the total institution, the asylum, they often arrive in hostile communities with a nonsystem of care supported by a bewildering array of federal, state and local programs making up a confusing, patchwork of services and financing" (Sharfstein et al, 1978, p.413). Because of this lack of responsibility for patients by any specific agency, former patients fell through gaps in the service delivery system. This made them more vulnerable to experience problems in the community and exhibit bizarre behavior. Consequently, reports began to indicate that former patients were being incarcerated in local jails and correctional facilities (Abrahamson, 1972; Stelovich, 1979).

Some homeless mentally ill persons could be seen wandering the streets in the early and mid-1970s but it was not until the late 1970s that it became commonplace to see mentally ill persons flailing their arms or babbling incoherencies on the streets (Hope and Young, 1986). The discharge of mentally ill persons into the community, which had begun in the 1950s, had created a number of problems that were growing in their significance by the late 1970s. Although the CMHC system was
overwhelmed during the 1960s, the problem of a system overload had reached crisis proportions by the late 1970s. From its inception in the 1950s, deinstitutionalization had contributed to some homelessness. But by 1975, voluntary admission of mentally ill persons into state hospitals had become difficult.

The commitment criteria were narrowed in many states to include only persons diagnosed as dangerous to themselves or others. Consequently, state hospitals could no longer serve as a safety valve for mentally ill persons who for whatever reason could not survive in the community. Improvements in the community system were suggested as one way of solving this crisis. It was suggested that more aggressive aftercare and more community support would create an environment more conducive to community success. The debate as to where to best meet the needs of chronically mentally ill persons was never actually settled, yet most states continued to support mental health experts and advocates who acknowledged the benefits of community treatment.

By 1976, researchers observed that the CMHC program was in serious trouble. Fifteen hundred CMHCs were to have been built, but only 600 were actually funded (Foley and Sharfstein, 1983). Original funding had been set up through a complicated system of federal seed-money supports which were now beginning to expire. There was also the growing recognition that the state hospitals had been depopulated too rapidly for available treatments and limited community resources, therefore, many chronically mentally ill individuals were not being adequately served.
These dilemmas prompted President Carter in 1977 to develop solutions to these dilemmas. The proposals called for sweeping reforms including new funding for programs. Out of this recognition for reform came the NIMH's Community Support Program (CSP) with the concept of the Community Support System (CSS). The CSP was designed to improve comprehensiveness and continuity of care within the then fragmented system of care. These initiatives resulted in the Mental Health Systems Act of 1980. This legislation has been characterized as presenting "conflicting directions on community services for the mentally ill" (Foley and Sharfstein, 1984, p.135). It pointed out problems, yet did not adequately propose solutions. The act did stress the active follow-up of persons discharged or diverted from state mental hospitals. This improvement would have provided for an accounting of how well mentally ill persons were "succeeding" in the community. However, the CSP concept assumed that voluntary treatment should continue to be the guiding philosophy behind any mental health system. The active follow-up of persons after they left the hospital would provide effective care for many mentally ill persons, but the issue of leverage for those who would not comply with medication requirements was not provided for by the program.

The CSP reform accepted the premise that chronic mental illness did exist and unlike the CMHC legislation of 1963 it did provide some realistic solutions for addressing the needs of chronically mentally ill persons. However, it ignored some of the research that was beginning to show that mental illnesses such as schizophrenia had a
disease process in which there were periods of recompensation and regression. During periods of regression, hospitalization might be necessary, but one could not predict how much time it would take for a hospitalization to contribute to recompensation (Harrow et al, 1983; Herz, 1984; and Wing, 1970). This meant that the CSP concept was an improvement, but it left unresolved questions as to what to do about those persons who needed structure in order to recompensate.

Unfortunately, the Mental Health Systems Act fell victim to the 1981 Omnibus Budget Reconciliation Act. The major provisions of the Systems Act were eliminated (Tessler and Goldman, 1982). The Community Support Program received limited appropriations for fiscal year 1984, and today it is largely up to states to fund this program (Morrissey and Goldman, 1984). The National Institute of Mental Health does sponsor CSP demonstration projects, but the assumption is that states will eventually assume funding for these demonstration projects.

Since 1946, funding of mental health care has usually begun with the federal government starting a program and eventually asking the state to assume fiscal responsibility for the program. The limitations of the original CSP that was conceptualized at the federal level are seldom corrected by state governments that have limited funding for social programs.

The current status of mental health services varies from state to state and the problems that existed before the passage of the Systems Act have been exacerbated by long years of neglect, fiscal problems
and lack of a consensus of what the problems are and how to correct them. Bachrach observes that deinstitutionalization is a "fact" (Bachrach, 1983). The implementation of this "fact" and the conceptualization of some of its philosophy is now being criticized. In relation to homeless mentally ill persons, the criticisms that are most relevant are the following: the existence of homelessness, criminalization, the need for asylum and sanctuary, and the multiple needs of the chronically mentally ill. These criticisms will be discussed in the next section.

Criticisms

Community-based care and a philosophy of deinstitutionalization are now being questioned by professionals both in practice and policy analysis (Bassuk and Gerson, 1978; Halpern et al, 1978; Langsley 1980; Scherl and Macht 1979). If the assumptions upon which this model is built are flawed, procedures that implement these assumptions will compound errors in conceptualization. Whereas some professionals question the assumptions which have guided community-based care, other professionals only question the procedures which were used to implement the assumptions. Unraveling problems in both the conceptualization and the implementation of deinstitutionalization philosophy become more difficult as a result of the double jeopardy created by implementing programs which may be flawed.
The overview of the conceptualization and implementation of deinstitutionalization shows that with regard to some chronically mentally ill persons, there appears to be some major flaws in the assumptions which have influenced services to this population. The strongest indictment against this philosophy is that there has generally been a failure to recognize the needs and potential outcomes for some chronically mentally ill persons. The needs of chronically mentally ill persons differ according to a multiplicity of variables which include past level of functioning, highest level of past functioning, severity of mental illness, history of response to psychotropic medication, etc. Potential outcomes of what can be realistically expected of chronically mentally ill persons as to prognosis also differ. There is a relationship between the expected needs of a person and the potential social functioning of a person. Any projection of the expected needs of a person must accurately account for the potential social functioning or outcome of a person. For example, a chronically mentally ill person who has shown a poor response to a wide variety of antipsychotic drugs, has a low level of past functioning, and regresses rapidly after only recompensating for brief periods has a much different potential outcome than would a chronically mentally ill person who had a higher level of past functioning, responds well to antipsychotic medication and has extended periods of recompensation and remission of the illness. This means that mental health systems must individualize treatment plans and long range planning must reflect the needs of individuals as well
as groups. Studies point out that 80 percent of persons with schizophrenia need and can benefit from group therapy, yet the specific needs of each individual will be different. Failure to recognize individual needs by the system has meant that mental health policy has been overly optimistic and seldom based upon case studies.

This does not mean that community-based care for the majority of mentally ill persons has not been a positive experience. Whereas this is true for the majority, it has been observed that:

There is a fair degree of consensus that community mental health services tend de facto to be geared toward patients who can, for the most part and most of the time, look after themselves; and the most seriously ill are alleged to have been shortchanged in the deinstitutionalization movement (Bachrach, 1983, p.6).

Chronically mentally ill persons who often cannot look after themselves will be the focus for criticisms of deinstitutionalization. These criticisms contend a failure of this treatment model for this particular client population.

The Existence of Homelessness

The fact that homeless mentally ill persons are wandering the sidewalks of major cities indicates there is a serious gap somewhere within the mental health system. Gralnick points out that "there is no precise measure of the failure of deinstitutionalization, but several facts give us reason to view the situation with pessimism" (Gralnick, 1985). One fact which suggests the failure of this policy for some persons is the growing numbers of mentally ill persons who have become homeless (Appleby et al, 1985; Bassuk, 1984; and Lamb,
Estimating the actual numbers of homeless mentally ill people is difficult because of problems in definition, overlap with other populations, establishing psychopathology, the heterogeneity of the population and its geographic variability (Bachrach, 1984). Although it is difficult to establish precise numbers, there are enough mentally ill persons who have become homeless that further investigation is warranted.

The reasons for their homelessness can often be linked to their premature discharge from the state mental hospital (Hombs and Snyder, 1982). Prior to the advent of restrictive hospital admission policies and discharge by administrative fiat instead of clinical judgment, many of these persons would have been housed in state hospitals (Bachrach, 1984, a,b). They would have received minimum levels of support and possibly some care, but most of all they would not have been homeless. Planners of the CMHC movement believed that when patients returned to the community they would become productive members of that community (Hearings, 1955). The hospital was conceptualized as being the reason that persons were not productive members of society. Their illness was considered inconsequential (Chapman and Chapman, 1973). It has been pointed out that deinstitutionalization philosophy determined the future of the state hospital (Talbot, 1985; Zusman and Bertsch, 1975). That future turned out to be a limited future and those that needed some type of asylum or sanctuary were left without a home.
Throughout the implementation of the policy of deinstitutionalization, dependency was conceptualized as a weakness instead of a possible consequence of a serious illness. Dependency as a consequence of an illness is viewed as natural and not the fault of the person. As a consequence of illness, the needs of these persons are also more legitimate. For example, a person who becomes blind as a result of eye disease is viewed as being more legitimately dependent than a mentally ill person. Persons in society may argue about how best to meet the needs of blind persons, but the blind person's right to having some dependency needs is considered legitimate. A chronically mentally ill person may become dependent, but they are blamed for their dependency, along with the mental health system which is often blamed for creating this dependency. A chronically mentally ill person could also be considered dependent as a result of his or her illness; therefore, instead of viewing dependency as illustrative of personal weakness, it could be viewed as a more legitimate need.

Lamb has pointed out that some chronically mentally ill persons need a structured environment in order to recompensate (Lamb, 1980). Structure is often missing from community-based services because it does not represent a total treatment environment. Structure means providing some controls and life supports for some persons when they exhibit an inability to maintain themselves without such structure. Chronically mentally ill persons who are grossly psychotic, not oriented to time, place or person need some structure. Without
structure they may die because of the inability to provide for their own basic needs.

The original planners of the CMHC movement did not envision the consequences of chronicity and the massive cognitive disorganization that often resulted from this condition (Chapman and Chapman, 1973). Chronically mentally ill individuals were supposed to have been "cured" by the miracle drugs of psychiatry, but decompensation and disorganization often continued in spite of medication (Grahnick, 1985; Gronfein, 1985). The fact that some persons continue to decompensate while regularly taking their psychotropic medication points out that some mentally ill persons cannot be expected to realistically meet community goals, such as living in a nonstructured environment.

Other individuals, when discharged from a structured environment, often decompensate because they fail to take their medication. This represents a major flaw in the original legislation. Some persons may be too ill to be released into a nonstructured environment where their illness is often exacerbated by their failure to continue their psychotropic medication (Linn et al, 1979). The human factor of noncompliance is difficult to separate from persons who may be so cognitively disorganized that they are unable to realize the need to take psychotropic medications.

The Systems Act of 1980 recognized some of these flaws, such as the necessity of improved tracking of patients after discharge, but
restrictive admission policies and a preoccupation with rapid discharge left little promise for homeless mentally ill persons. The Act provided for CSPs, but as a result of the 1981 Omnibus Budget Reconciliation Act meaningful benefits from this program may never be fully realized.

The Systems Act failed to recognize the importance of needing to change the commitment laws. Narrowly defined civil commitment statutes have been cited as an obstacle in providing comprehensive services for some chronically mentally ill persons (Treffert, 1985). Persons are often allowed to decompensate until they are considered dangerous to themselves or others before they can be hospitalized at many state hospitals (Beiss, 1983). Once in the hospital, narrow interpretations of who should remain often means that persons are discharged before they are capable of responding to a community-based system of nonstructured care. The CSP failed to address the issue of outpatient commitment which has led to continuing problems for many homeless mentally ill persons.

Homeless mentally ill persons can often be characterized as system "misfits" who do not fit well into the existing service system (Schwartz et al, 1983). Changing how deinstitutionalization is implemented would not totally eliminate this problem. The necessity for recompensation and the dependency needs of persons while they struggle through that process means that some institutions must provide support in the form of three meals a day and a roof over a person's head. The provision of asylum and sanctuary in a structured
environment is a recent suggestion that could coexist with a community-based system of care. The specifics of how such a facility would operate have not been fully explored because institutional care is not recognized as a necessity for some individuals under deinstitutionalization philosophy.

Another problem facing chronically mentally ill persons that appears to contribute to homelessness is the failure of a community-based system to place responsibility for patients with any specific agency (Langsley, 1980). Consequently, once discharged from the hospital, former patients find that they have no specific place to receive care (Bachrach, 1983). This raises the greatest flaw in the assumptions that have guided community-based care. The system often has unrealistic expectations regarding homeless mentally ill persons (Barrow and Lovell 1983; Bassuk, 1983). Discharge planning does formulate an outpatient treatment plan for the former state hospital patient, but current discharge planning operates under the guiding principle that former patients are willing and able to follow-up with their aftercare appointments. Deinstitutionalization philosophy portrays the image that mental illness is not severe enough to warrant continued supervision by the state, such as through outpatient commitment.

The community-based system assumes that persons are willing and want to consent to treatment (Drake, 1982; Kamer, 1982). The homeless mentally ill are often unwilling or unable to consent to treatment. They may be in need of hospitalization, but they are often unwilling
to admit themselves and do not meet the state criterion of dangerousness. The dilemma of independent living is best illustrated by Ms. Smith, "a bag lady who two months ago died of hypothermia in her home, a cardboard box on the streets of New York City" (Death in a Cardboard Box, 1982). Ms. Smith wanted to be free to enjoy her right to independence, yet the quality of that right varies directly with a person's ability to enjoy it (Stone, 1985). The ability of Ms. Smith to enjoy that right as a result of her mental condition can be seriously questioned. "Freedom" may mean freedom to suffer or possibly die with "their rights on" (Treffert, 1985, p.260).

Community-based care assumes that freedom for mentally ill persons is a goal, yet meeting this goal before persons are ready to enjoy their freedom may mean that persons go without care.

Deinstitutionalization is both a philosophy and a policy. Certain guiding principles in this philosophy, such as a failure to realize the limits of chemotherapy, demonstrate that to only examine the implementation of this policy would fail to illustrate issues that demand further understanding. Evaluating a policy demands that the inputs that helped to create the policy be understood along with the outputs. Deinstitutionalization does provide some hope for a majority of chronically mentally ill persons. But a minority of chronically mentally ill persons have been overlooked in the rush to both conceptualize and implement a far too simple approach to understanding the problems of mentally ill persons. The fact of homelessness among mentally ill persons has already been cited as evidence demanding a
more complete examination of deinstitutionalization. The increasing numbers of mentally ill persons in jails would also indicate that a problem in conceptualization and implementation are present.

Criminalization

Researchers point out that jail and prison populations reflect growing numbers of mentally ill persons (Bonovitz and Bonovitz, 1981). Recent studies of jail populations show that mentally ill persons, particularly homeless mentally ill persons, represent an increasing presence (Lamb and Grant, 1982). Previously, many of these persons would have been housed in state mental hospitals, but due to restrictive hospital admission policies and rapid hospital discharge, these persons often end up in the place of last resort—jail (Teplin, 1983). The CMHC movement was supposed to educate the general public and encourage it to become more tolerant of odd and bizarre behavior. This goal has not been realized (Lagos et al, 1977; Rabkin et al, 1980). Perhaps this goal was too optimistic because the communities' acceptance of odd or bizarre behavior appears to be related to the inability of jails to accommodate large numbers of mentally disturbed persons. Consequently, police must arrest mentally ill persons less frequently because the community has no other choice than to tolerate them or increase budgets to build new and differently designed detention facilities. Most jails are not designed or equipped to handle mentally ill persons. Their needs are different; they may require psychiatric assistance, they may not be able to be housed with
other prisoners because of their bizarre behavior, or they may destroy their cells unless they are constructed properly.

Mentally ill persons were supposed to be discharged from the state hospital in a state of mind in which they were prepared and were able to live in the community. Unfortunately, many mentally ill persons were either not fully recompensated when they were discharged or they dropped out of the mental health aftercare system soon after discharge. Confused and disorganized, many mentally ill persons violated societal norms or acted in a bizarre manner. Unable to be admitted to a state hospital, because they were not suicidal or homicidal, many of these persons ended up in the place of last resort which was the jail.

Improved tracking of former patients as suggested by the Systems Act of 1980 would have kept fewer numbers of persons from becoming lost. But those persons who were not able to care for themselves and were in need of some type of structured environment remained at risk of going to jail. Some chronically mentally ill persons began to decompensate and failed to continue their psychotropic medication. As they become lost to the mental health system and they begin to wander the streets, often times acting in a threatening manner, they are at greater risk of being arrested. The arrest of individuals is the principle means available to the police officer of keeping order in society. Charges common among mentally persons arrested include disorderly conduct, trespassing, indecent exposure and disturbing the peace. The chronically mentally ill person may have urinated in a
public park, and the person is charged with indecent exposure for exposing his genitals in public.

Restrictive hospital admission policies and an inability to set limits on a person's life after discharge suggest that the planners of the mental health system did not fully comprehend what would happen to persons once they left the hospital. The failure to realize that many chronically mentally ill persons would end up in jail was a consideration that the mental health planners of the CMHC movement did not expect. This represents a flawed assumption and also shows how deinstitutionalization was planned for the majority of mentally ill persons and did not reflect the needs of a minority of mentally ill persons who were not able to respond correctly to societal sanctions. The assumption was that all mentally ill persons could positively respond to a community-based system. This proved to be flawed because many could not positively respond and ended up in jail. The assumption was based upon the dominant characteristics of the majority who did not end up in jail. Again the dependency needs of persons were ignored in favor of an overly optimistic belief that all persons could adapt to the community.

The Need for Asylum and Sanctuary

The possibility of persons needing asylum or sanctuary was not acceptable to many of the reformers of the 19th and 20th centuries. Some professionals today continue to seek to hasten the demise of the state hospital apparently feeling that asylum or sanctuary are
unnecessary (Okin, 1985). The unwillingness to visualize the necessity for some type of asylum and sanctuary represents a major flaw in the conceptualization of deinstitutionalization philosophy. The belief that all of the patients in mental hospitals did not actually need to be there, supported by the belief that drugs and the community would cure all mental illness, meant that hospitals were seen as a place to be avoided. Deinstitutionalization operates under the belief that there is a "cure" or "answer" for all persons who suffer from mental illness. The likelihood of persons needing asylum and sanctuary do not coexist well with the optimistic view that there is a "cure" or "answer" for all persons who suffer from mental illness. Asylum and sanctuary are not "cures" or "answers"—they are only stop-gap measures which recognize the limits of current treatment techniques and the resistance to treatment of some types of mental illness.

The present commitment legislation represents this belief. Unable or unwilling to gain access to asylum and sanctuary, some mentally ill persons go without treatment.

Conclusion

Bachrach and Lamb point out that an ability to ask appropriate questions is a necessary step in program planning (Bachrach and Lamb, 1982). The questioning of some of the assumptions that provided the supportive framework for deinstitutionalization philosophy does not mean that the philosophy is ready to be scrapped, but it is in
desperate need of revision. Some authors have called the criticisms "unanticipated problems" that have made the delivery of services to chronic mental patients problematic (Cannon and Kotkin, 1979; Christensen, 1980; Cramer, 1978; Salzman, 1975; Scherl and Macht, 1979).

Homeless mentally ill persons represent one such "unanticipated problem" that needs to be addressed. This overview of deinstitutionalization philosophy and some of the criticisms of this philosophy sets the stage for this qualitative research into the process of becoming homeless among former patients of a state hospital. This research does not seek to prove or disprove particular hypotheses because the specifics of how mentally ill persons become homeless remain largely unexplored. The process demands exploration and documentation. A qualitative research approach can yield working hypotheses which can lead to improved policy analysis. The researcher attempted to understand the needs of chronically mentally ill persons as he sought to understand how these persons become homeless. The hospital was also not visualized as a definite negative. Instead, the hospital was understood as it fit into the lives of mentally ill persons. That interaction could be negative or positive, but it was never assumed that all mentally ill persons are always better off in the community.

The literature review has suggested that asylum and sanctuary were not envisioned by the planners of deinstitutionalization policy. One of the consistent criticisms of state hospitals is the tendency to become vast warehouses for indigent chronically mentally ill persons.
This is a tragedy, yet to ignore the dependency needs of chronically mentally ill persons by failing to recognize that at the present time there is no "treatment" or "cure" for some types of mental illness overlooks a group of persons who are in need of asylum and sanctuary. A more appropriate way to conceptualize the use of asylums and sanctuaries is to view them as a place of rest and comfort for persons who are beyond the current understanding of medical science. Such places would not have to be inhumane; instead they could provide food, clothing, shelter and medical care in a nontargeting fashion. Persons residing in these institutions would need to have the opportunity to leave when their illness began to go into remission or a breakthrough was discovered. This would require close monitoring of the patients and a commitment by society that these persons are not to be forgotten. Medical and social science would need to continue to struggle for an effective treatment for a wide variety of mental illnesses. In order not to repeat the same mistakes of the past, dependency needs of persons must not be overlooked in order to justify the goal of helping the majority; instead the needs of dependent persons must be provided for in a humane environment.
CHAPTER III
RESEARCH METHODOLOGY

Research paradigms provide us with a way to view the world by setting up questions and constructing realities. This research design will utilize a naturalistic or qualitative approach to better understand the process of how mentally ill persons become homeless. There are certain axioms that support a naturalistic or qualitative approach to research.

Axiom 1: The Nature of Reality (Ontology)

There are multiple constructed realities that can be studied only holistically: inquiry into these multiple realities will inevitably diverge so that prediction and control are unlikely outcomes although some level of understanding (verstehen) can be achieved (Lincoln and Guba, 1985, p.37).

Axiom 2: The Relationship of Knower to Known (Epistemology)

The inquirer and the 'object' of inquiry interact to influence one another; knower to known are inseparable (Lincoln and Guba, 1985, p.37).

Axiom 3: The Possibility of Generalization

The aim of inquiry is to develop an idiographic body of knowledge in the form of "working hypotheses" that describe the individual case (Lincoln and Guba, 1985, p.38).
Axiom 4: The Possibility of Causal Linkages

All entities are in a state of mutual simultaneous shaping so that it is impossible to distinguish causes from effects (Lincoln and Guba, 1985, p.38).

Axiom 5: The Role of Values in Inquiry

Inquiry is value-bound (Lincoln and Guba, 1985, p.38).

Certain implications follow from these axioms:

1. A naturalistic setting is to be used. In the case of this research, the streets of Columbus, homeless shelters, soup kitchens, COPH and the jail were used. These settings are natural to the subjects in this study.

2. The human as the instrument of data collection is to be used. In the case of this research, John Belcher is the human instrument. He interviewed the subjects in the study and interacted in their natural setting in such a way that he blended into their setting.

3. In a naturalistic inquiry instead of using the traditional terms of internal and external validity, a more appropriate issue to consider is the trustworthiness of the findings. Trustworthy findings mean that other researchers can utilize the findings from this study with the confidence that they were collected in a consistent and credible fashion.

4. Inductive data analysis is the key to this study. The data was constantly compared until categories began to emerge from the data. No a priori theory or hypothesis was tested; instead the results emerged from the data. The data were analyzed constantly throughout
the life of the project in order to take advantage of intuitive knowledge gained from the natural setting.

5. Subjects emerged as the study progressed. Homeless subjects were not preselected. This resulted in a grounded theory that cannot be generalized, instead it can be transferred to other settings if the contexts of the two settings are similar.

6. In order to transfer the findings, the reader is informed about the context of the study. This is done through thick description and case studies.

Naturalistic research does not rely upon any sociological theory, although it borrows from symbolic interactionism. It seeks discovered reality and, like symbolic interactionism, assumes that any discovered reality is best understood by gaining "intimate familiarity" with the subjects and the setting in which they live (Lofland and Lofland, 1984). This kind of familiarity moves slowly and gradually gains momentum as the researcher becomes more involved in the natural setting of the subjects.

The axioms and implications of naturalistic research have provided a groundwork for a view of reality which must emerge from frequent contact with the subject's reality. The specific methodology of a naturalistic inquiry is best understood as a series of steps which lay the foundation for an intensive exploration of humans in a natural setting. Although the subjects were contacted for consent beginning in March of 1985, the laying of the groundwork began in mid-February 1985 as community contacts were established. The design
emerged as more knowledge about the setting was gathered from these contacts. Community contacts included, but were not limited to, homeless shelter staff, jail staff, soup kitchen staff, police officers and homeless people themselves. As the study progressed more contacts were cultivated and emerged.

The first potential subject was released from COPH in April of 1985 and a design was in place by that time. This design continued to emerge and change according to the discovered reality of homeless persons. For example, if more homeless mentally ill persons were present at The Open Shelter (homeless shelter), then staff at that shelter would be intensively cultivated in order to facilitate closer contact. The activities of persistent observation, prolonged engagement and triangulation helped to build relationships with community contacts and added to the trustworthiness of the project. These activities were developed as the researcher established a working knowledge of the "hangouts" of homeless persons and was perceived as being trustworthy by shelter staff and homeless persons.

Persistent observation and prolonged engagement demanded that the researcher invest sufficient time so that he would blend into the setting and not be seen as a stranger by the subjects. Past studies have indicated that subjects are often more open and truthful with the researcher when a less intrusive relationship can be established (Lofland and Lofland, 1984). A network of contacts was developed and these persons were able to identify subjects who had become homeless. Persistent observation and prolonged engagement helped the researcher better understand the lives of mentally ill persons who became
homeless and because the setting was very familiar to the researcher, data which emerged that did not "fit" with the culture that was emerging could be investigated more carefully.

Triangulation was also developed gradually as more contacts and sources of data collection were established. The purpose behind triangulation was to develop a system of being able to cross-check information in order to verify its trustworthiness. Sources of data collection included, but were not limited to, landlords, community mental health centers (CMHC), jails, relatives, neighbors, other homeless individuals and state hospital staff. These persons and institutions were asked to provide information without violating the confidentiality of the subjects. For example, if a subject had been living at a particular address and the CMHC had reported to the researcher that the subject had moved, a neighbor would be asked if the apartment was now vacant, and if they knew to where the former tenant had moved.

The researcher developed a case record on each hospital releasee. Former patients were tracked by contacting them at one, three and six months after discharge, unless they had a previous record of being homeless, in which case they were contacted soon after their release from Central Ohio Psychiatric Hospital (COPH). Once it was discovered that they had become homeless, the contacts and data collection became more intense. Each time any subject or informant was contacted with reference to a subject a notation of the contact was made in the log. Those subjects who became homeless and were more difficult to find had
more lengthy logs. These logs served as an audit trail. A chronological record of contacts was established and the subject's life during the six months of the study became easier to follow. A graduate social work student audited the logs of the homeless subjects to determine whether the data were collected in a consistent manner and whether the findings were supported by the data.

Working hypotheses began to emerge as more information was gathered about the homeless subjects. These working hypotheses were explored, modified and developed throughout the life of the project. Many working hypotheses were explored with the subjects and were subsequently abandoned because of insufficient data. This method helped the researcher in finding and tracking persons who became homeless.

**Strengths and Limitations**

One of the important strengths of this study is that working hypotheses that were developed in this study can be investigated in other qualitative studies. However, new research into homelessness among mentally ill persons should not be undertaken with the sole intention of evaluating any working hypotheses from this study. The working hypotheses cannot substitute for intuitive knowledge that could be gained in a emergent study design, but they can assist in the development of a constantly changing theory.

Working hypotheses developed in this study are subject to the unique context of Franklin County, Ohio. Franklin County interprets commitment legislation differently than other Ohio counties. Franklin
County determines that persons must be found dangerous to themselves or others in order to be committed to the state mental hospital. Other counties, such as Hamilton, utilize a third commitment criterion (grave disability), as well as dangerousness, to commit persons. Some Ohio counties also use outpatient commitment, but this type of commitment is not often used in Franklin County. Different utilization or interpretation of commitment criteria can make any county or state unique.

These contextual features make this study environment different from states like Wisconsin, which has less restrictive admissions policies and a well implemented outpatient commitment policy. Central Ohio Psychiatric Hospital is different from other state hospitals in Ohio because of differing resources in the community and aftercare placement. Nevertheless, from the perspective of the naturalistic researcher, these are reasonable limitations recognizing relevant differences between settings.

This research is not meant to generate findings which are applicable across all mental hospitals, but rather it will produce "working hypotheses" which are subject to the time and context of this particular study. In order to transfer the findings of this research, the reader must be in a context similar to that of the research setting.

This research documents the lives of those former patients of a state hospital who became homeless. Comparison with those patients who did not become homeless is not the purpose of this research, therefore no specific findings of the group with housing will be
presented. Since this research is not attempting to predict who in the future will become homeless, such a comparison is unwarranted. This research fully and clearly documents the needs of those persons who become homeless. A response to their needs can be based upon the findings of these data.

Past Research Flaws

In a naturalistic inquiry a significant amount of time is invested in learning about the research setting and establishing relationships in the research setting before subjects are ever contacted. Past studies have relied upon traditional research methods which invest less time learning the culture of the research setting before subjects are contacted. This creates less familiarity with subjects, a practice which has tended to oversimplify problems that have been studied concerning mentally ill subjects.

This oversimplification and greater distancing from subjects has resulted in problems in research design. Braun et al (1981) found that, historically, aftercare studies have not attempted to evaluate the effect of discharging large numbers of chronically mentally ill persons from state hospitals. The multiplicity of interacting and intervening variables was largely ignored and linear models of analysis attempted to isolate such variables as aftercare compliance and to predict "success" in the community (Paolillo and Moore, 1984; Solomon, Gordon and Davis, 1984).

This oversimplification of data analysis has been compounded by an overreliance on secondary sources of data. In one such study, very
few former patients were interviewed and hospital or community social workers were asked to "talk" for their patients (Solomon, et al, 1984).

One of the most potentially damaging problems in aftercare studies is the tendency to not account for all subjects in a given patient cohort (Goering et al, 1984; Ben'e-Kociemba, Cotton and Frank, 1979). This tends to overpredict successful community tenure. Those subjects who do not maintain a permanent address, die, become homeless, move from the area or go to jail are often counted as being successful in the community because they did not return to the hospital.

The majority of aftercare studies have been quantitatively based. Whereas these studies can provide some useful information, there has been a general failure of these studies to adequately account for the research context. A research context where the mental health system utilized outpatient commitment and stressed longer hospital stays would be qualitatively different from a research setting where aggressive deinstitutionalization was taking place.

This study improved upon these past errors by not attempting to make statistical predictions on the basis of linear data analysis. Instead, variables were not isolated but a holistic understanding which assumes complexity was sought. Secondary sources of data collection were not the major means of collecting data; instead, repeated interviews with the subjects over a six-month period were conducted. Most important, all subjects within a particular patient cohort were accounted for by the researcher. If someone was not
found, relatives or friends were contacted. Lastly, the context of the research setting is described so the user of the research can feel comfortable in transferring the findings to his/her particular setting, if comparable.

**Sampling**

Sampling in this naturalistic inquiry was purposive. The exact number of homeless persons who would emerge was not known beforehand. The actual size that emerged is inconsequential because whatever size emerges, the findings are important because they are the discovered reality of that group.

Beginning in March 1985, all patients at the Central Ohio Psychiatric Hospital Franklin County Admission Wards were approached about participating in a six-month follow-up study. Nursing staff on the COPH admissions wards determined that patients were "cleared" enough to be contacted by the researcher, staff of the research department at COPH or a Ph.D. psychology intern from The Ohio State University. Hospital policy did not "spell" out what was meant by the patient being "cleared." After watching and listening to how individual nurses would make a decision as to how they determined that a patient was "cleared", it was determined by the author that "cleared" meant the patient was no longer grossly psychotic and was somewhat oriented. Since there were no specific criteria, the degree of psychosis and orientation varied from patient to patient. However, there was consensus among the nursing staff that the patient would
have to understand something of what was being said to them. This did not always mean complete comprehension.

Patients were told about the nature of the study and asked if the researcher could try to keep in touch with them throughout the six months, with a final interview at six months. Consent forms described the project and gave permission for interviewers to contact the individual. The consent forms also gave permission for the researcher to contact community informants if the subject could not be found. Community informants included the following places: the Franklin County jail, COPH, community mental health centers (CMHCs), Social Security Administration, Franklin County Health and Human Services, homeless shelters and soup kitchens in the community, and relatives (Appendix A). Patients were recruited during March, April, May and June and the sample consisted of those persons who had consented and left the hospital during April, May, June and July of 1985.

Three hundred-six patients passed through the COPH wards from March of 1985 to July of 1985. Approximately 82 percent of these patients were approached to participate in the study. One hundred and fifty-four patients initially agreed to be in the larger cohort of patients who would be tracked. One hundred thirty-two patients stayed in the study for the entire six months. During the first month of the study, eight subjects terminated when contacted and one subject moved from the area. During the three-month contact point, three additional subjects terminated and one moved from the area. No subjects terminated or moved during the six-month contact period. Nine subjects were excluded because of having criminal
charges pending or because they were discharged to a county other than Franklin. This meant that a total of 22 patients dropped out, moved from the research area, or were subsequently disqualified because they had criminal charges pending and were avoiding detection. Subjects with criminal charges pending and "in hiding" posed an unnecessary threat to the researcher and his assistants; therefore they were not pursued. All subjects were accounted for either by personally contacting the subject or through confirmation by community informants.

The most important goal of the study was to identify as early as possible those subjects who became homeless during the six months of the study period. This identification began with verifying whether the subject was living at the place that was described in the COPH discharge summary. Those who were not found at those addresses were selected for a more intensive investigation. This entailed contacting relatives, community agencies, reviewing hospital records, "hanging out" on the street and in contact places such as a soup kitchen or a homeless shelter in order to obtain any possible information about the person.

The sample eventually consisted of 47 persons who became homeless; they became the focus of this research.

Data Collection and Time Frame

Persons who had agreed to be studied were scheduled to be contacted one month, three months and six months after their date of discharge from COPH. During the one- and three-month contacts, these
persons were asked a series of open-ended or orienting questions. These questions were concerned about their life in the community (See Appendix B). The purpose of these questions was to set the tone or the atmosphere of each interview by helping the researcher to get started. As the interview progressed the specific style of each interview was tailored to meet the demands and needs of each subject. Examples of questions included: Have you been taking your medication during the past month? How did you come to be living where you are currently living? Have you been experiencing any problems during the past month? Each interview was unique and the nature of the interview depended upon the interaction between the subject and the interviewer. The purpose of the one- and three-month interviews was to identify those persons who had become homeless so they could receive more intensive tracking, to establish a baseline to evaluate future contacts with the subjects, and to identify those subjects who needed more intensive tracking even though they were not homeless. The baseline was used with all subjects, but not for the purposes of a comparison analysis. Instead, the baseline was used to aid the researcher in tracking the subjects. The interviews with those living in some type of home were brief, but the interviews with homeless persons were more extensive.

Homeless persons were asked similar questions as the nonhomeless subjects at the one- and three-month follow-up, but homeless persons were encouraged to discuss the homeless condition and how they came to be living in such an environment. The purpose of asking those subjects living in homes questions was to aid in tracking them in
future months, and it was not meant to compare those subjects living in homes and those who became homeless. For example, if a subject said that he/she had quit taking his/her medication and was going to have their Supplemental Social Security Income (SSI) benefits terminated, this information would be helpful in tracking them in future weeks. Such a subject might need more intensive tracking even though they might not be homeless.

During this time, contacts with shelter staff and other agency people who served the homeless were also intensified. This contributed to the development of persistent observation, prolonged engagement and triangulation.

Two master's-level social work students were also utilized during this time to review patient records at COPH (See Appendix C). Information such as employment history, onset of psychiatric illness, past involvement by family members, number of past hospitalizations in a psychiatric facility, educational attainment, and involvement with the criminal justice system were noted. These record reviews were used to help in tracking subjects and establishing patterns in subjects' lives.

Data Collection Instrument

An open-ended set of orienting questions were used in the study. These questions were brief and could be expanded according to the needs of the interview situation. This is consistent with qualitative research methodology. The orienting questions developed as more familiarity was gained with the subjects. The interviews would change
depending upon the needs and capabilities of the subjects. In order to add to the consistency of the interviews, a case file was developed for each homeless subject and a record of each contact was maintained. The case files contained a chronological record of each contact with the subject or contacts with community informants that were made in an effort to locate the subject. The recorded contacts were summary field notes that provided the researcher with the highlights of interviews or observations. Direct quotations were included where possible. Tape recorders were not used because other researchers who have studied homeless persons have noted that mechanical instruments often frighten homeless persons (Baxter and Hooper, 1982).

The case files provided a record of contacts with subjects which established thick description. Thick description had to be built gradually as the researcher gained "intimate familiarity" with the setting and the subjects. This helped further to develop persistent observation, prolonged engagement and triangulation, which contributed to the trustworthiness of the data and future use by other researchers and practitioners.

The human as instrument is critical in qualitative research methodology. The interaction that develops between the researcher and the subject is to be understood instead of being controlled or eliminated. Any research instrument has a certain bias depending upon the assumptions that were used in creating the instrument. Similarly, the human as instrument has certain biases about which the reader of the research needs to be informed.
The researcher in this study is a trained and experienced clinician with a bias toward the biological view of mental illness. He believes that mental illness is a disease process that has acute and chronic courses; that some forms of mental illness require medical forms of treatment such as chemotherapy and hospitalization and that some persons with chronic schizophrenia are not capable of complete autonomy, depending upon the nature of their illness, in the community.

The particular lens that the researcher used to view the subjects could be qualitatively different from a researcher who is an experienced administrator or a university professor with less clinical background. Neither perspective is preferred, and the differences in perspective need to be understood as different avenues for arriving at a discovered reality.

Objectivity is added by the activities of persistent observation, prolonged engagement and triangulation. These activities ensure that the researcher cannot simply go into a research setting hoping to prove a particular bias. This is accomplished by demanding that the researcher be involved in the research setting long enough that he/she gains "intimate familiarity" with the stresses and strains that subjects experience while living in the setting. Triangulation demands that the researcher listens to what community informants have to say about the experiences of the subjects in the research setting. Qualitative research maintains that total objectivity is impossible to attain (Lincoln and Guba, 1985). However, some objectivity can be added to a study by following the above mentioned guidelines.
Context

This is critical to any qualitative research because the transferability of the data depends upon the similarity of the sending and receiving context. In order for transferability to be possible, the sending context must be described in some detail.

The study took place in Franklin County, Ohio from April 1985 to January 1986. Franklin County contains Columbus, which is the state capital, and outlying areas. The economy is mainly made up of state government, a large state university, several research facilities, small manufacturing plants, retailing distribution centers and surrounding agriculture producers. Columbus is a Midwestern city with a predominantly white Anglo-Saxon population. It contains 15 percent black persons and 2 percent other minority persons (County and City Data Book, 1983). Franklin County and the Columbus metropolitan area houses approximately 1,500,000 people.

Central Ohio Psychiatric Hospital (COPH) is the state hospital which serves the central area of the state. The hospital primarily serves persons who are mentally ill and (generally) lack funds or those who have no insurance. Persons with adequate medical insurance or personal resources tend to use other hospitals. Some of the COPH patients have medicaid because many of the private or not-for-profit hospitals within the Columbus metropolitan area do not accept medicaid psychiatric patients.

Ohio is aggressively continuing the implementation of its deinstitutionalization plan. COPH has four admissions wards which
serve the Columbus metropolitan area. They are operated by NETCARE Corporation, a community-based mental health organization, that has a contract with the Ohio Department of Mental Health (ODMH). Persons who are considered dangerous to themselves or others are initially assessed at one of the four community mental health centers in Franklin County, where a psychiatrist makes a determination whether the persons are dangerous to themselves or others. Other commitment criteria exist in Ohio such as grave disability and inability to care for one's needs, but such criteria are rarely used in Franklin County. This means that unless a determination is made that the persons are dangerous to themselves or others, they cannot be committed to COPH.

If such a determination is made, persons are taken to COPH. The maximum length of stay in the COPH Franklin County Admissions Wards is 21 days. At the end of 21 days, persons can be transferred to a ward operated for longer term treatment by the state. In practice, such transfers only occur if persons continue to be dangerous to themselves or others. All others are released into the community.

According to COPH policy, when persons are discharged from the hospital they are referred to a community mental health center (CMHC) where outpatient treatment is supposed to continue. The referral is initiated by a discharge social worker who works at one of the COPH Admissions Wards. The hospital discharge social worker notifies a social worker at the CMHC to which the patient will be referred. An appointment time is arranged and the patient is discharged from the hospital with the appointment time and enough psychotropic medication
to last the patient until he or she is seen by the community social worker.

Aftercare arrangements in Franklin County are voluntary. The patient is expected to be responsible enough to follow through with the discharge plan and aftercare arrangements that are outlined while the patient was in the hospital. If a patient fails to come in for his or her aftercare appointment, a letter is mailed to the address listed on the hospital discharge summary.

The voluntary nature of the aftercare system assumes that patients are recompensated and the aftercare plans reflect consensual participation. It is also assumed that former patients maintain a permanent address and can therefore be reached by mail.

These assumptions have not been tested and agreements, attitudes and the mental condition of the patient may change once the patient is in the community. Franklin County assumes further that a community link has been established by the time the patient leaves the hospital. These untested assumptions create a unique context because Franklin County does not actually assess the validity of these assumptions as do other counties within Ohio.

Context of Homelessness

The struggles and problems of homeless persons in Columbus elude many citizens. This phenomenon occurs partly because many sections of the city appear to have no homeless persons in residence. Attitudes in Columbus concerning the problems of homeless persons have not been measured, however the city has made some financial commitments towards
helping homeless persons. This would suggest that some people are aware of the problem and politicians feel there is enough support for some commitment to this population.

The Ohio Department of Mental Health has funded an organization in Franklin County known as Project Liaison which operates from Southeast Community Mental Health Center. This organization attempts to find homeless persons in the community and link them with available resources. Social workers are sent out into the community and they search homeless shelters and other known spots where homeless persons live in order to begin to establish a relationship of trust. This organization primarily concentrates its efforts on helping homeless mentally ill persons. This project has been successful in helping some homeless persons secure housing, but the numbers of homeless persons who need outreach services may be too great for the limited staff resources available in Columbus.

A study conducted in 1984 estimated the number of homeless persons in greater Columbus to be at about 9,000 people, including 7,400 single adults and 1,600 family members (Metropolitan Human Services Commission, 1984). Most of the homeless persons in Franklin County are under 40 years of age, with males making up the majority. These estimates suggest that the population is made up of 25 percent who are high school graduates, 19 percent who have attended or graduated from college, 37 percent who have served in the military and 13 percent who are Vietnam War era veterans (Roth, Bean, Lust and Saveanu, 1984).
Other specifics on the homeless population in Franklin County, Ohio are sketchy. Nevertheless, The Open Shelter, Inc., a homeless shelter located in Columbus, reported that as of October 1986, it is housing an average of 96 men a night with 70 regular residents, 11 in Protective Service for Public Inebriates and 15 on their overflow list (made up primarily of Mental Retardation/Developmental Disability, mental health clients, police referrals or other individuals incapable of successfully following their sign-up and curfew procedures) (Beittel, 1986). The maximum number of residents the shelter can house is 110. The Open Shelter Inc. estimates that since 1985 there has been an increase in requests for housing averaging 23 percent a year above the previous year's request. The Open Shelter Inc. is one of the two largest shelters. The number of homeless people is outpacing the number of shelter spaces available.

In spite of the growing number of homeless persons in Franklin County, Ohio, the conditions of homelessness have not reached the proportions that they have in Washington, D.C. or New York City. A few "bag ladies" can be seen wandering the streets and some homeless people can be seen sleeping on park benches and in deserted alley ways, but most homeless people seem to have a place to go where they are out of sight.

Many homeless persons congregate in the downtown sections of the city among office workers and shoppers. They tend to become part of the landscape and, although they are noticed because of their inability to totally become part of the sidewalk, they are largely ignored.
Columbus is served by two large shelters; one accommodates only men and one accommodates men and women. The other large shelter in Columbus is operated by the Friends of the Homeless. This shelter houses mainly men, but also has a separate facility for women. It is a nonprofit agency and operates in many respects like The Open Shelter, Inc.

There are also several smaller shelters which have various requirements such as having to attend a nightly religious service in order to be given shelter. These smaller shelters include Faith Mission, Volunteers of America and the Salvation Army. These shelters were contacted before the study began to assess their participation in the study.

The director of Faith Mission, in early 1985, pointed out "I would not find any of the men I was looking for at the Mission." He went on to point out that most of the men who stayed at the Mission were not mentally ill. He did say that "I might find women who were mentally ill at the Mission because there was little space for women at the other shelters."

The director of Volunteers of America pointed out that her facility was not a shelter. People could only stay there if they were "between jobs." The more "hard core" cases were referred to The Open Shelter. Staff at the Salvation Army pointed out they were a family shelter, and they also housed some recovering alcoholics who were interested in starting a "better life."

Information as to where homeless mentally ill persons tended to stay was also obtained from COPH social workers and ward nurses. They
confirmed that the Salvation Army and Volunteers of America served a useful purpose for some persons in need by providing a type of shelter for reforming alcoholics, families and persons that would be resuming work in the near future. These facilities, however, were not considered an open facility where homeless persons could simply seek shelter. The staff at COPH did point out that Faith Mission was used frequently by women since there was very limited shelter space for women in Columbus.

Estimating the number of persons who stay in shelters in Columbus is made difficult by in-fighting between shelter operators over what type of persons they will accept as appropriate in their respective shelters. For example, staff at The Open Shelter frequently accuse Volunteers of America of "dumping" on The Open Shelter persons who Volunteers of America consider inappropriate for their facility. Cooperation in counting the number of persons in need is made difficult by this friction. Some shelter operators have estimated the average city-wide shelter census per night to be approximately 300 to 350 persons, yet the number of homeless persons is estimated to be as high as 9,000 people per year. Assuming many of these homeless persons stay with friends and relatives on a nonpermanent basis and others included in the 9,000 figure may find a home for a few months, the number of people seeking shelter continues to be far greater than the number of persons being included on a nightly shelter census.

This suggests that many homeless persons have found a place to exist elsewhere. Therefore, it was decided that going only to homeless shelters would probably not account for all those persons who
would become homeless. Learning the context of homelessness in Columbus in order to locate all potential homeless subjects meant establishing contacts in the community who might have knowledge about the whereabouts of homeless persons.

These contacts consisted of a wide variety of persons and together they provided a wealth of information on different geographical locations where homeless persons were known to frequent. The author established a relationship with the desk clerk of the Norwich Hotel, a single room occupancy (SRO) facility, in order to keep abreast of persons who might have been evicted and become homeless. A sergeant at the Franklin County jail agreed to provide lists of all subjects arrested. Staff with Project Liaison established a reciprocal arrangement with the author in which information about homeless persons was shared.

Other community informants, such as police officers who were known by the author, were asked about homeless persons. Homeless shelter staff at The Open Shelter allowed the author to "hang out" in the shelter and listen to homeless persons discuss the whereabouts of subjects for whom he was looking. Southwest Community Mental Health Center also provided the author with a place to "hang out" and observe and listen to what was happening to some of the subjects in the study.

Many community informants were developed in the process of locating a homeless person. For instance, a mailman was asked information about a vacant building on his route. The author came in contact with mailmen on several occasions and conversations often revealed information about homeless persons.
Descriptions of how homeless persons faced a daily struggle to survive gradually emerged from these multiple conversations and observations. These descriptions helped to better portray the context of homelessness in Columbus.

Data Analysis

The data consisted of tracking notes which were maintained on each subject in the study. Files were developed from the tracking notes on each subject. Files on those subjects who did not become homeless and were relatively easy to locate were not extensive. These files reflected a brief contact at one, three and six months after discharge from the hospital. They contained answers to questions which dealt with the subjects' future plans, medication compliance and a list of problems experienced.

Files on homeless subjects were more extensive and reflected interviews, COPH record reviews, and any other background information that was gathered in the process of finding and keeping track of the subjects. When a subject became homeless, the researcher had to usually contact the local community mental health center, review COPH records, interview relatives and shelter staff. These efforts could be brief or long depending upon how easily the homeless subject was located. Once located, the researcher attempted to maintain closer contact with the homeless subject by attempting to find the person as often as possible. For example, the researcher visited The Open Shelter, Inc. as often as three times a week, and when he visited he
would inquire about the condition and whereabouts of subjects who were known to use the facility.

The data were analyzed on an ongoing basis throughout the life of the project. Working hypotheses were developed as they emerged from the data and were evaluated immediately. Many working hypotheses were evaluated, rejected and reformulated at the same time. The researcher would go into the field with several working hypotheses and by the end of the day had developed new ones. This process depended upon the continual emergence of new ideas. Eventually new ideas became less frequent and working hypotheses began to repeat themselves and a point of saturation was reached.

The constant comparative method as outlined by Glaser and Strauss (1967) was utilized to analyze the data. This method entails the constant comparing of notes, interviews and other information to determine what categories emerge from the data. Overlap is eliminated so that the best fit between the category and the subject is accomplished. From the categories, a series of "working hypotheses" emerged which began to explain why subjects were classified into particular categories.

The categories were developed according to how subjects became homeless. Commonalities were noted and verified as the process of homelessness was documented for each homeless subject. If a "working hypothesis" was developed and a subject after more careful examination was found not to fit into the category, then the subject was reclassified. The categories emerged: they were not formulated in advance.
This process of sifting through the data, forming categories based upon how subjects became homeless, exploration of that category with subjects, and the development of new categories that were more appropriate continued throughout the six months. More extensive analysis took place after the completion of the data collection, which resulted in a final definition of categories.

The literature was reviewed throughout the life of the project so that new insights from recent research could be compared with the findings of the project.

The trustworthiness of the data analysis was maintained by ensuring that persistent observation, prolonged engagement and triangulation were developed. The categories were evaluated on the basis of their fit with these three criteria. While the categories did not always represent a negotiated outcome with the subjects, other sources of data were used to verify the categories. These sources included community contacts, COPH records and conversations with relatives.

It has already been pointed out that it was not always possible to have the categories represent a negotiated outcome with the subjects because many of the subjects were severely mentally decompens- sated. In order to resolve this problem, the reality of the subject is presented with the interpretation of that reality by the re- searcher. This presentation of two views represents a better alterna- tive than only presenting the researcher's interpretation of the subject's reality.
An audit trail was maintained, and it was evaluated by an independent reviewer who found the findings to fairly represent the data as recorded. Given the multiple sources of data and the repeated interaction with the subjects and the context of the research setting, the data received extensive review before categories were considered complete.
CHAPTER IV

FINDINGS AND DISCUSSION

The findings will be presented as a series of qualitative
categories. For the convenience of the reader, appendixes containing
demographic data and a summary of the particular pattern of homelessness for each category, including case examples, are presented at the end of the study, (see Appendixes D, E, F, and G). These categories emerged from the data on the basis of common elements that were found to be present in two or more of the subjects. A major common element of each category was the process in which persons in the category became homeless. This also served as a working hypothesis.

Each category represents a working hypothesis that was discovered and structured during the life of the project. Each category will be presented with demographics describing the members of the category, two case examples that help to better describe the category, the working hypothesis which describes how the members of the category became homeless and a case example which describes the working hypothesis. A discussion of each category will immediately follow. After all four categories have been presented, a discussion of the findings in relation to the homeless mentally ill people in general will be presented.
Forty-seven subjects emerged as being homeless at some point during the six months. This represents 36 percent of the 132 patients who were followed for the six months of the study. The 47 subjects who emerged as homeless were the major focus of the study. They are unique persons who do not appear to fit into the current model of care for mentally ill persons. Their inability to respond to the model of service delivery described in this research demands further attention.

Four categories emerged from the data:

Appendix D: Qualitative Category I: Subjects who were chronically homeless and chronically mentally ill. (33)

Appendix E: Qualitative Category II: Subjects who had previous histories of being homeless and chronically mentally ill but escaped homelessness during the study. (5)

Appendix F: Qualitative Category III: Subjects who were temporarily homeless due to a combination of situational and mental illness factors. (7)

Appendix G: Qualitative Category IV: Subjects who apparently chose a life of homelessness to avoid contact with law enforcement agencies. (2)
Qualitative Category I - The Wanderers

These subjects were found to be chronically homeless and severely mentally disabled. From the total of 47 homeless individuals who emerged from the sample of 132 subjects, 33 subjects fit into Category I.

The mean age of this group was 33.12 and there were 15 white persons and 18 black persons contained in this group. Twenty-five of these persons were male and eight were female. The majority of these individuals (16) were diagnosed as suffering from schizophrenia, 11 suffered from affective disorders, five suffered from personality disorders and one was diagnosed as suffering from drug intoxication.

Only two of these individuals followed through with aftercare arrangements while 31 did not. There were four general types of homelessness found within this group; 10 consistently stayed with family and/or friends, but on a nonpermanent basis, 10 consistently stayed in limited shelter or on the street, one person stayed consistently in SROs and 12 survived in a variety of homeless situations.

The ability to maintain income also varied among this group; 13 members of the group had no source of income during the six months of the study, nine consistently maintained Supplemental Social Security Income (SSI), three consistently maintained General Relief (GR) and eight were not able to maintain consistent support. These eight people began with one source of income and later lost their source of income.
Appendix D illustrates how the 33 persons in this category were the most severely debilitated and were the most lacking in resources of those persons who made up the 47 subjects who were homeless. Their isolation from "normative" reality can best be illustrated by their types of homelessness.

Appendix D also contains case studies of Jenny, John, Joe, Fred and Ted. In order to add more consistency to the study, the case studies contain a much more detailed explanation of their lives than is contained in the text of the study. These cases will be referred to in the text and material describing the issues identified in the text will be excerpted to provide more illustrative support.

The individuals in this group were also the most difficult to describe according to the principles of qualitative methodology. Very little if any negotiation could take place between what they perceived as reality and what this researcher discovered. Their perception of reality was clouded by references to manifestations that were the result of their psychosis. Reality changed on a daily basis depending upon the interaction between environmental and already existing biological tendencies. Many of these respondents talked to their coffee and expected a response, when they received no response from their coffee they began to utter a long string of ramblings that lacked any organization. The journey into their world experienced by the researcher revealed a group of persons who wandered in and out of "normative reality." They appeared unable to make any sense out of their own perception of reality.
The following descriptions attempt to present both the perspective of the subject and the interpretation of that perspective by the researcher.

Ten individuals stayed with family and/or friends, but on a nonpermanent basis. These homeless subjects did not know where they were staying from night to night and the family and/or friends had little idea of their whereabouts and often did not care.

Ten of the 33 subjects lived on the streets or in shelters or missions. Many of these ten people tended to wander from shelter to shelter and would often leave for no apparent reason. Several of these ten individuals said that they had to leave the shelter because the "man" was getting too close or the "war" was about to get them. These ten individuals would either talk very slowly or very rapidly and their thought processes were difficult for this researcher to interpret. They would often talk about things such as a car or food in the same way as the researcher would talk about such things, but these references would be tangential phrases in a stream of incoherent ramblings. They were obviously attempting to make some sense out of their reality, but their flight from shelter to street and the repetition of the process indicated some problems with this attempt.

One of the 33 stayed in SROs, but on a nonpermanent basis. This individual is presented as John (see Appendix D). Hospital records noted that John "roams Ohio." On one occasion when this researcher visited John he began to talk about how people were out to get him. Demonstrating this fear, he kept checking the hallway. He said that
someone had been in the hallway just before the researcher had arrived. From a clinical standpoint, John presented all the symptoms of an extremely agitated paranoid schizophrenic who had gone without medication for some time. He was grossly psychotic and not oriented to time, place or person.

John talked about how a lawyer was attempting to take his money away from him. He spoke softly, but would occasionally shout at the researcher to make sure the researcher was being attentive. John would begin to ramble in his thoughts and point out how Christmas was next week and he needed to buy a new winter coat. At this juncture, the researcher attempted to clarify what John had said and John began to speak more rapidly and became more frustrated. John was interviewed in July and it was approximately 95 degrees outside.

Twelve of the 33 people in the category changed living conditions during the six months of the study. Nine of these 12 people moved from living with family or shelter to no shelter at all. Two moved from living on the streets to living with family and/or friends on a nonpermanent basis. One individual was rehospitalized within 20 days of being discharged and remained at COPH for the remainder of the study. This individual will be called Bob for purposes of illustration.

Bob was discharged from the hospital to arrange his own housing, however Bob was admitted homeless and had not been living in any type of housing for over a year. Bob survived on the streets by begging, searching through garbage cans for food, and "shot dope" to "feel
good." He was readmitted to the hospital after being in the community for only 20 days during which time he had rapidly deteriorated both mentally and physically. Bob was asked in the hospital if he had a home and he pointed out that the "street is my home." Bob frequently went AWOL while in the hospital and would often sit out on a bench on Broad Street and watch the buses go by. He commented that he wanted to be free, but he could not really say what freedom meant. This apparent inability to formulate plans and set goals seemed to lead to frustration which would often manifest itself in tantrums. He would go into a store and begin to throw items on the floor until a clerk called the police and the police transported him to a CMHC for assistance. He described these episodes as "you know, I am trying to get it together." This behavior is representative of how the other 33 subjects in this category lived their lives. They were clearly searching for something, but apparently were not able to find what it was they were searching for.

Maintaining a source of income was a significant problem for the majority of these 33 subjects. Thirteen of them went without income the entire six months of the study. They went to soup kitchens, begged from strangers, ate out of garbage cans, slept in shelters and sought out relatives who responded with temporary assistance.

Many of these 13 individuals did not conceptualize money in the same manner as did the researcher. Often money meant coffee or cigarettes. Barter had replaced hard currency. They had no need for banks or other commercial financial institutions. Understandably,
many of these 13 people did not really know how to go about renting an apartment or how to apply for SSI. Many still understood what these terms meant, indicating that they did not represent a different culture, but for some reason had trouble both remembering and logically processing what certain things meant.

Jenny understood that an apartment had to be rented from a landlord, but this relationship often became "lost" in a mass of confusion. At times she believed that the landlord was actually God while at other times she believed that the landlord was a psychiatrist from COPH. In reality, the landlord was an uncle of Jenny's who worked for the city as a garbage man. Jenny also became confused as to how she was entitled to live in the apartment. She assumed that when she paid rent that she was actually purchasing the property. Unable to organize her thoughts into a logical framework led Jenny to make conclusions that were not based in "normative" reality.

In order to survive in "normative" society, certain means of social intercourse are expected as given. Being able to write a check, use a bank, utilize a post office, read a newspaper and use currency to purchase goods and services are examples of means of such "normative" social intercourse. However, the 33 individuals in Category I had gradually lost the ability to engage in such activities and obtain results. John would go to a post office box and attempt to search for clothing. He thought that, like a drop box for old clothing used by Volunteers of America, a post office box would also
have clothing. John seemed surprised when his hand grabbed a handful of letters instead of clothing.

Jenny read the newspaper but pointed out that it did not contain any information about the person who had raped her on the previous afternoon. Conversations with Jenny revealed that she had engaged in sexual activity with a "man" on the previous afternoon and afterwards had called the police, however once she was taking antipsychotic medication the "man" was revealed to be a product of a delusion. These two examples are illustrative of the behaviors of the 33 persons in Category I, although each person had their own unique "flight from reality."

Failure to engage in "normative" social intercourse and achieve desired results led to frustration and the discovery that they could use other forms of discourse to obtain needed items. This intercourse also distanced them more from "normative" society. John would frequently barter a shirt in exchange for a piece of bread. Jenny believed that if she invoked the Lord's name against her landlord that the landlord would disappear. His continued presence after she used her newly discovered technique proved to be more confusing for Jenny because the identity of the landlord became less "real" and more imaginary. There was some commonality among homeless persons in terms of objects such as believing that any box bolted to a piece of concrete was a dropbox for Volunteers of America; however, each homeless person had a slightly different interpretation as to the meaning of these objects. Some interpreted a mailbox as a place to
collect garbage. This individual uniqueness often meant that several homeless mentally ill persons would be "communicating" with one another with none of them apparently understanding what the others were attempting to say.

The culture that was created by these individuals would often change depending upon the progress or regression of their mental illness. A person suffering from paranoid schizophrenia would apparently experience remissions and active phases of their illness; their mood, cognitive understanding and general alertness would change depending upon their fluid condition. Often the only consistent experience in a person's life would be the delusion that would also remit or become active depending upon the individual's phase of illness. Interestingly, the delusion might fade into the background, but would generally remain consistent in its content.

The case of Ted illustrates the persistence of delusions that plagued these 33 individuals. Ted realized he was "sick" and often acted "crazy." This was particularly true when he failed to take his psychotropic medication. The difference between "normative" reality and his own disorganized presence of mind often became blurred for Ted. He talked with the author in COPH after being on psychotropic medication for several days. The conversation followed a logical progression at first, but then Ted began to mix in thoughts which had nothing to do with the conversation. At one point, he began talking about his "home in the woods," then he stopped and admitted he had no home in the woods. Fred talked about his mother as if she were alive
and then he stopped and stared at the wall for several minutes. He eventually reported that his mother was dead, but often he believed she was alive because she talked with him. He also said that these conversations were as "real" as the conversation that he was having with the author.

The experience of decompensation and regression would often lead to a loss of set, which has been explained by Harrow et al (1983) as an intermingling of ideas that appears in a stream of conscious thought without being requested by the person. In other words, many of these individuals would be speaking about a subject and other phrases or words would begin to intrude upon the person's cognitive process and verbal communication creating a situation where the individual became quickly confused and often agitated.

Confused, agitated, and unable to determine cause and effect relationships, many of these individuals began to make random movements in response to cues from the environment. John would interpret a letter received in the mail as a "sign" that "agents of the government were getting closer." He would then move to a new SRO as quickly as possible to avoid being detected. John would look out the window and "listen for a sign from God" to determine where he should go next. Apparent random movements such as John's illustrate the process of how many of the subjects in this group lost benefits. It also shows that any money that was in the possession of the subject was often "lost" in response to these random movements.
Twelve of the 33 people were able to maintain SSI or GR during the entire six months of the study. This was verified by checking with landlords, community mental health center staff and other community workers who were familiar with these cases. For these people, income did not prevent them from becoming homeless. They often were unable to manage their money or were unable to pay for things in a fashion that would secure a home. Lack of understanding and apparent distance from "normative" reality was also a problem for many of these 12 subjects.

Eight people in this group of 33 experienced changes in their source of income during the study. Six individuals lost their benefits. Their reasons for doing so range from "I forgot" to "I am not sure how it happened." This apparent ambivalence to a need for money in a competitive society is a good indicator of their decompensation. Or it could be interpreted to mean that they are rejecting the norms of society and would therefore be happy with their lives. However, observing their lives on the streets indicates that they are not happy with it.

Two individuals did manage to regain lost benefits having been discharged from the state hospital with no benefits. These two individuals were happy about regaining their lost benefits. They pointed out they needed money to "make it."

Joe illustrates how many of these persons were able to maintain income, but their disorganized thinking and general deterioration of their mental condition led to distancing from "normative" reality. Joe
reported to the author, while in the hospital, that he was very concerned with religious issues and he wanted to make sure that people "know the Lord." Joe also reported that he had difficulties keeping his thoughts "straight" even though he took his medication, and he would often "jumble" his thoughts up. He reported being so convinced that he must "save" people that he often went to the corner of Broad and High Streets to preach the gospel. Joe observed one day in conversation with the author that, as he became more "concerned" about religion, he began to lose "touch" with the world around him. He described how on several occasions he received a rent notice but since he thought the Lord was looking after him, he would ignore the notice. He went on to further point out that this led to him being evicted, which he interpreted at the time to be a "sign" from God that he should go to the corner of Broad and High Streets on a permanent basis to "preach the gospel." Joe reported that at this point he was not taking his medication, and he began to shake people so they would "hear the Lord." He pointed out that one day the police came and "grabbed" him and took him to COPH. He told the author that once he was back on his medication he realized that he had gotten "carried away" with his preaching.

After he had been on psychotropic medication for several days, the author asked Joe about his "preaching" on the corner of Broad and High Streets, and he quietly smiled and said that "if you listen, you will also be saved." The author approached him after he was in COPH for two weeks and he was still "concerned" about not being able to
"preach the gospel," but he also pointed out that he had been "troub- led" and the medication had helped him to "think straight." Interestingly, as Joe became more able to "think straight" he began to realize that in order to "keep" an apartment, rent had to be paid.

All 33 subjects had been involved with the criminal justice system and 12 were arrested and jailed during the six months of the study. Many of these 12 persons pointed out that they did not know why they had been arrested. Ted was arrested for trespassing; he had gone into a farmers cornfield in Delaware County to get something to eat. This seemed very logical to Ted, but Ted also thought that he was "on the run from the Ku Klux Klan." Ted later admitted that he liked to watch old movies about the "Klan." Unable to understand sanctions imposed by "normative" society, such as society's demands that people not trespass on other people's property, these 12 persons responded to the criminal justice system in ways that showed a failure to understand the wrongness of their actions. These 12 persons described the criminal justice system as a place to seek shelter from the cold, and they assumed that other persons "living" at the jail were also seeking shelter.

All but one of the 33 subjects had a previous history of homelessness, yet 18 of the 33 were discharged homeless from the state hospital. When asked why or how they had become homeless, it is interesting to note that no one could answer this question. Two subjects who were rehospitalized pointed out that "gradually we lost things, a house, a car, income, etc." Cause and effect were difficult
to determine. Many subjects talked about how the "world once made sense." Some subjects talked about how they had "lost their mind."
The author explored this issue with these subjects and determined that they apparently meant that they had once had a mind, but they had lost it as would a person lose a purse. One subject talked about "searching for his mind" in the same way a person would search for a misplaced fountain pen. All 33 subjects talked of a time when they were able to "think straight" but such an ability was lost.

The case records of all 33 subjects were reviewed to determine the onset of illness, onset of homelessness, past history of employment, family involvement and any other past events that indicated both stability and the beginning of decompensation. The 33 subjects in this category were determined to be chronically mentally ill and either grossly psychotic or severely depressed and also psychotic. They had a unique reality that had been shaped by a combination of surviving the daily struggles of being homeless and their mental illness, which often left them confused and "lost" in a world they no longer fully understood. Their disorganized behavior, which appeared to be the result of their impaired thinking, provides support for the finding that these 33 individuals were mentally ill. They shared some of the same value orientations and norms of the researcher and "normative" society, yet they were unable to participate in "normative" society because of their inconsistent behavior. While sharing these same reality constructions, they were both in the process of losing touch with these constructions and also desperately attempting
to hold on to the fragments of these constructions. This indicated to the researcher that there was a process of decompensation present.

Records reviews indicated that eight of the 33 subjects had begun to exhibit psychiatric problems in their teen-age years and gradually the condition became chronic. The chronicity was exacerbated by a consistent failure to comply with psychotropic medication.

Twenty-four people in the group began to exhibit psychiatric problems in young adulthood and followed similar patterns of chronicity and exacerbation brought on by failure to comply with psychotropic medication. One person was an alcoholic for a number of years, was involved in a car accident and began to suffer from an organic brain syndrome. He developed patterns that were similar to the others after that point.

The review of hospital charts and continued conversations with the subjects and community gatekeepers led to the development of a working hypothesis: gradually these subjects began to experience a loss of supports which was in part triggered by mental illness. It was often exacerbated by poverty, discrimination and other societal influences, but mental illness seemed to trigger the process.

All 33 of the subjects had worked at one time, but with the exception of two people, the work was characterized by low wages and minimal benefits. All of the people experienced a psychotic break and gradually their psychiatric condition worsened, leading to less frequent contact with "normative reality." This was often complicated by use of alcohol and street drugs. They eventually lost their jobs
and went on SSI or GR, but lost these benefits as they continued to become distanced from reality.

Their lives became nomadic as they were rehospitalized for short hospital stays and often discharged back into the same condition. Contact with family members also became less frequent as their behavior was often bizarre, and their family members could not or would not tolerate it. Their psychiatric condition gradually worsened which further complicated and contributed to their aimless existence. The case examples of Fred and Ted help to illustrate this working hypothesis (Appendix D).

Fred and Ted both experienced a psychotic break in young adulthood and gradually decompensated into a life of homelessness. Unable to maintain themselves in the community in a nonhomeless condition due to their mental illness, they developed a flight syndrome in which they wandered from place to place. Occasionally, they were hospitalized and began to clear on medication. Both Fred and Ted pointed out that they were less "crazy" on medication, but they did not continue their medication once discharged into the community.

Discussion

Psychiatric rehospitalization interrupted the cycle of homelessness for these 33 subjects, but it did not stop it. Once they left the hospital they were often out of touch with the mental health treatment community until they were rehospitalized. It is interesting
to note that 17 of these 33 people were rehospitalized at least once within the six months of the study.

Only two of the 33 people consistently followed through with medication, the others generally contacted a mental health center on an emergency basis, often when they were being recommitted. Addressing the problems of this group suggests that two issues must be recognized. First, all 33 people were significantly and severely decompensated in terms of their mental and social functionings. Acute care has been unsuccessful in treating their long standing debilitation. Recompensation is often a long and difficult process and each individual progresses at his or her own pace, depending upon their strengths and weaknesses (Lamb, 1984).

Recognizing that these 33 subjects are not appropriate for acute care suggests that another type of support system must be conceptualized which would provide them with food, clothing, shelter and access to medical care until they are able to respond to acute care treatment methods. Such a conceptualization could be called an asylum or a sanctuary. Providing such care would be preferable to letting these persons starve or die of exposure on the streets (Treffert, 1985).

Medical science is not yet at a point where it can cure mental illness, and psychotropic drugs do not cure but merely ameliorate symptoms. The concept of providing asylum and sanctuary recognizes the limits of medical science while also providing for human decency to this type of mentally ill individual. Tracking these 33 subjects in the community for six months demonstrated that once they are
released to the community, they resume their process of decompensation and homelessness.

State hospitals are the most likely candidates to house such facilities, because if patients remain in these facilities they are more likely to enjoy improved access to new breakthroughs in medical science. Homes in the community which would probably be run for-profit might repeat the same tragedy that has befallen this nation's elderly people. Discharged to the community, they become forgotten and medical science may be more likely to ignore them.

The second major issue that emerges from the working hypothesis that psychiatric decompensation led to their homeless condition is the relevance of rehabilitation to this group. The actions of this group indicated that many had lost their grasp on "normative reality." This indicates that when recompensation does take place these individuals will probably need to be reoriented to the world in which they must survive.

Finally, any improvement in community services for this particular group of homeless mentally ill persons can be made only when persons are discharged from the state hospital after they are adequately recompensated to respond to the community in which they are to be discharged. This means that each discharge plan must reflect an assessment of the patient's prognosis, strengths and weaknesses. The plan must also reflect an assessment of the community situation into which the patient is to be discharged. For example, if a patient is to be discharged to their parent's home, then a history documenting
the negatives and positives for both the patient and the parents needs to be completed. Otherwise, patients will be discharged into situations which are destined to fail. This is particularly true for persons with a history of being homeless. Their community placements have not been satisfactory, and an assessment needs to be completed to reflect the problems experienced by both the patient and the community.
Qualitative Category II - Tenuous Planners

These subjects were found to have a previous history of homelessness and chronic mental illness, but found homes during the study. From the total of 47 homeless individuals who emerged from the sample of 132 subjects, five fit into Category II.

The mean age of this group was 35.40, and there were three white persons and two black persons within this group. One of these five was male and the other four were female. Two of the five were diagnosed as suffering from schizophrenia and the other three were diagnosed as suffering from affective disorders.

Four of the five people followed through with aftercare arrangements, while one did not. All five had mixed experiences in their types of homelessness, but were living in a nonhomeless condition by the sixth month. All five had different experiences with sources of financial support.

Appendix E contains two case examples, Peggy and Robin, that are illustrative of the five individuals in this category. Portions of their cases will be excerpted in order to better describe different issues discussed in the text of the study.

Their conceptualizations of reality were much the same as the researcher's. They saw their predicaments as being largely the results of their illnesses and an unjust social system. Four of the five people were able to find places in which to "get it together" after their discharges from the hospital. The fifth person also found a place where he was able to accomplish the same results, but he did
not conceptualize his place of retreat from the world in as logical a manner as the other four subjects.

This group was similar to the first group in that they all suffered from what is currently believed to be biologically based mental illness, which had in the past shown a positive response to psychotropic medication. They were not as debilitated as the first group and their concepts of normative reality were relatively unimpaired.

Appendix E points out the various demographics of this group and presents several case examples. The one month follow-up interview found two of these subjects living in shelters or missions, one living with family and/or friends on a nonpermanent basis, one living on the streets and one living in cheap hotels or SROs.

By the sixth month, all five of these subjects had found nonhomeless living conditions. Three were living in halfway houses, but they considered themselves to be nonhomeless and were soon to move into independent housing. These five subjects were identified as being homeless at the beginning of the study, but their similarities were noticed, and they emerged as a separate category as the study progressed. Once the parameters of this category became more fixed, points of interest about this group were investigated more intensely. These five individuals were able to utilize their often meager resources and find homes.
Four of the five subjects had no source of income upon discharge from the state hospital. Yet by the sixth month, these four individuals were able to secure sources of funding such as SSI and GR. They were also able to utilize these new found resources in such a way so that they could find homes. These four people were specifically asked how they were able to accomplish the often difficult task of securing SSI or GR and also finding a home. They pointed out that this had been a goal they had wanted to accomplish for a long time, but in the past a "cloud" or a "fog" had prevented them from planning how to reach this goal. Continued questioning and analysis of the data revealed that the "cloud" or "fog" referred to the psychotic confusion or apathy experienced by many persons with schizophrenic and major affective disorders.

These four persons also realized that they needed to take their psychotropic medication on a regular basis and they were gradually developing a basic understanding of their illness. All four of these persons took their psychotropic medication on a regular basis after discharge. The fifth person decided to quit drinking, which effectively reduced the schizophrenic symptomology. He did not believe he was suffering from schizophrenia, but he did know that when he drank he would get "sick in the head" and could not accomplish his goals.

It is interesting to note that four of the five people were discharged homeless but were able to establish a retreat or a place of asylum for themselves on their own. Peggy is illustrative of this process. Peggy was discharged to the Franklin County jail and from
there became homeless. She realized that, although "better," she was not "doing well, because she still felt pressured to do too many things." She felt that she needed a place "to get it together." Peggy realized that she suffered from bipolar disorder and needed to take her medication in order to "feel less pressured." She found a group home where she was able to "pull it together." Unfortunately, the group home placed demands upon Peggy which conflicted with her need for "down time." Peggy pointed out that the group home set expectations for her and when she did not accomplish them, the staff in the group home became impatient. This created additional pressure for Peggy. Unrealistic expectations set by the places of asylum where four of these five individuals lived almost led to eviction and a return to a life of homelessness. These four persons were rejected by many persons such as community mental health staff, group home staff, relatives and other persons in their lives because they were seen as malingering. Places of asylum included group homes, a relative's home, a homeless shelter and the YWCA.

Interviews with four of these subjects and reviews of hospital records confirmed that they had initially become homeless because of their continuing psychiatric decompensation. They gradually lost many of their social supports and due to the "fog" or "cloud" which prevented them from thinking clearly, they began to lose touch with normative reality. Their distancing from normative reality was never so great that they totally lost sight of how to survive in society. Robin pointed out that "sometimes I can't seem to do what I know I
need to do. I don't know why it happens. I guess my thinking is still screwed up."

Peggy and Robin pointed out that there was nothing particularly "special" about their time in the community during the study as compared to past times in the community. Community mental health workers had treated them in a similar manner on previous occasions. They pointed out that their caseworkers "went over the routine, come in for aftercare and take your medication." The difference between their contact with their caseworkers and previous contacts appeared to be related to their cognitive functioning. Peggy and Robin said they "felt better and they were not as sick as before." Robin said that her mind did not "play tricks" on her as it had done in the past. All five subjects in this group talked about improvements in their ability to "hear" what the world was "telling them." These improvements in their ability to organize themselves helped these individuals to escape their homeless condition.

The fifth subject in this category did not utilize medication, but he said that he was not "as sick. I feel more at ease and settled than before." The fifth subject was diagnosed as having schizophrenia and this was complicated by alcohol abuse. This subject knew enough about his condition to realize that "booze" was "bad" for him and he refrained from drinking. Improvements in his ability to organize himself also helped him to escape his homeless condition.
Discussion

These five individuals had not reached a level of cognitive disorganization and confusion as compared to the 33 individuals in Category I. They also had not experienced a long term impoverishment of resources as a result of homelessness and their disorganization and confusion. They were able to "get it together" to find asylum and/or sanctuary in the community although, because this place of retreat was not conceptualized as necessary by the community mental health system, their dependency needs were almost rejected. These five subjects indicate a different level of homelessness among mentally ill persons, but they also document that persons decompensate to different levels and decompensate at their own pace.

While all five of these subjects were living in nonhomeless situations by the sixth month, their ability to escape the homeless condition needs to be understood as an individual accomplishment instead of a group phenomenon. During the six months, each individual would make progress and then regress. Each would take advantage of some opportunities and then not take advantage of others. Their struggles to escape homelessness were intimately interlocked with their ongoing struggle with their psychiatric illnesses.

Understanding their struggle with their psychiatric illnesses often required time and resources unavailable in the community mental health system. Often times isolated by their struggle to overcome their illnesses, retreat or asylum provided them with time to think and search for understanding.
The community mental health system does not seem to recognize
down time when their patients may not be making progress. There is an
expectation that, even though their patients are mentally ill, the
patients' thinking is goal directed. These five individuals illus-
trate that an expectation of being goal directed may be premature for
some mentally ill persons. Instead, these five individuals needed
time to readjust to being free of impaired thinking. The ability to
think logically represented a reality that had not been present in the
lives of these subjects for some time. Robin pointed out that she
often became "frightened by her success." This suggests that expecta-
tions need to be based upon the prognosis and unique characteristics
of each individual instead of grouping individuals together according
to prognosis and determining expectations by group norms.

The time in which these five individuals struggled with their
illness represented a time when they were highly vulnerable to
regressing to a lower state of functioning and were a dependent
population. This suggests that they need to be provided for differ-
ently than mentally ill persons who are either less dependent or not
dependent. Eligibility for welfare benefits is not enough to restore
these persons to "normative" society. Instead these persons may need
additional assistance such as more intensive follow-up in order to
ensure that welfare benefits are utilized to secure food, clothing and
shelter.

These five individuals were not always able to respond to any
help because of their continuing psychiatric disability. Instead of
viewing this inability to communicate and understand conversations as possible evidence of decompensation, counselors viewed these individuals as uncooperative, malingering, or unworthy. Peggy was told repeatedly by her counselor that she better "get her act together." She said that she had "tried but things did not work out." She felt that her counselor was rejecting her.

These five individuals' abilities to escape homelessness should be viewed as positive. They were able to utilize available resources by structuring the group home experience as a place to "get it together." The community mental health system needs to assist persons like the five individuals described in this category to make better use of available resources in order to ensure a smoother transition from homelessness to nonhomeless conditions. This will not increase the burden to the mental health system by asking for extensive program changes. Instead, more intensive tracking after hospitalization and more advocacy on the part of the assigned worker with the various components of the community services system could have lessened these five individuals' vulnerability to longer lives of homelessness.
Qualitative Category III - Temporary Homelessness

These subjects were found to be temporarily homeless due to a combination of situational and mental illness factors. From the total of 47 homeless individuals who emerged from the sample of 132 subjects, seven persons fit into this category.

The mean age of these seven persons was 31.71, and there were five black persons and two white persons included within this group. Four of these seven individuals were diagnosed as suffering from a substance abuse problem, two were diagnosed as suffering from an affective disorder and one was diagnosed as suffering from a personality disorder.

Four of these seven individuals did not follow through with their aftercare arrangements, two complied at some point during the study but eventually terminated contact with the aftercare system and one consistently complied. All seven persons in this category experienced mixed types of homelessness, but by the sixth month all had found nonhomeless living arrangements.

The ability to maintain income also varied among this group: one was unable to maintain any source of income, one consistently maintained SSI/SSDI, one consistently maintained GR, one consistently maintained earned income and three persons experienced inconsistent types of income support.

Appendix F contains two case examples that illustrate the seven persons in this category. Descriptions will be excerpted from these cases to better explain issues discussed in the text.
This group was quite different from the subjects in Categories I and II. Their psychiatric disorders are not generally considered biologically based, and they did not have a history of positive response to psychotropic medication. Their level of decompensation and psychiatric debilitation also was not as severe as those subjects in groups I and II. All seven were able to escape their homeless condition by the sixth month. They felt that they needed a place to get "away," but not the "loony farm."

Their view of reality was representative of normative society for their particular income stratum. As a group, they did not view themselves as mentally ill. One subject did feel that he was suffering from a mental illness, but he blamed it on his parents. All the subjects in this group generally felt that they had been hospitalized because of a great misunderstanding.

Pete is illustrative of how these subjects perceived their hospitalization as a great misunderstanding. Pete's wife had called the police because she felt that Pete was becoming "excessively" drunk and had "tried to hurt himself." Once sober, Pete denied that he had attempted to hurt anyone. He told the author that the "wife gets these ideas in her head after she goes to church." He went on to point out that "all I need is a place to get over this drunk."

The belief that they had been hospitalized inappropriately relates to their reasons for being homeless. Two people were homeless because of domestic disputes, and when marital separation occurred they lacked the financial resources to secure adequate housing. One
person was homeless because he abused his child and had to leave his home because of resulting marital problems. Again, this person lacked adequate financial resources to secure adequate shelter.

Two people were homeless because of continuing use of street drugs and consistent inability to manage their money. One burned down his house in the midst of a psychotic break which was induced by drug intoxication. The seventh individual was homeless because of a general inability to stay organized and was not able to arrange an adequate placement upon discharge.

Multiple factors had created a situation in which individuals would attempt to hurt himself or herself or others which precipitated their commitment to CPH. Poverty, lack of adequate outlets and financial resources exacerbated these situations. The state hospital provided an environment in which these individuals could "blow off" their troubles in a setting where they were less likely to hurt themselves or others.

Four of the seven subjects did not comply with aftercare during the six months of the study. The other three people at times complied but by the sixth month only one of them was taking his/her medication. The four people who did not comply felt that the mental health system was making an unwarranted intrusion upon their lives.

Six of the seven people had no history of homelessness; one had a history and the homelessness appeared to be the direct result of his/her psychiatric condition. As a group, the individuals were less debilitated than the other groups. This is evidenced not only by
their history of nonhomelessness but also by their lack of previous involvement with the criminal justice system. Financially, this group also fared better with the majority maintaining some source of income support throughout the six months of the study.

Three of the seven people were rehospitalized during the six months of the study, but all three people were readmitted for drug related treatment. Their level of psychiatric disability did not seem to be as severe as groups I and II, with all seven being oriented and alert when interviewed. They all exhibited problems in formulating plans and meeting goals, but the reasons for these problems were not clear to the researcher.

Many of these subjects, shared some of the same values as others in "normative" society, yet did not have the resources necessary to obtain those values. Lacy illustrates this phenomenon. Lacy and her husband had gotten into a fight, and she had been hospitalized. When discharged, Lacy decided that she did not want to go back to her husband, but she had no other financial resources. This created a situation in which she became homeless. Lacy told the researcher that she "really did not want to kill herself and she was just trying to scare her husband." Lacy and her husband had few financial resources and no health insurance. When the police were called, they took her to a mental health center for observation. The decision to hospitalize Lacy was made "simple" according to staff at the mental health center, because she had no relatives, no friends and no financial resources of her own to go anywhere else for a "timeout" but the state
hospital. Limited options for alternatives to the state hospital were characteristic of the people in this category.

All seven subjects in this group believed that their homelessness was beyond their control. While each of their situational factors was slightly different, the constraints of their limited social environment contributed to their homelessness. These seven individuals present evidence for considering the possibility that the state hospital is often used as a social control mechanism by society.

Discussion

American society prefers that its members not kill each other or themselves and has designed laws that prohibit such actions. Involuntary civil commitment is a case in point. Nevertheless, committing these individuals to a state hospital may not always be appropriate. Instead of hospitalization, persons such as these in Category III may need a place where they can receive the benefit of a "time out" without the medical or psychiatric intervention of a state hospital.

An alternative policy solution needs to recognize that persons such as those in Category III are not diagnosed as suffering from largely biologically based mental disorders, instead they were diagnosed as suffering from characterologically based disorders. These later disorders have shown no positive response to psychotropic medication or short term psychiatric intervention. Therefore, intervention by society should be designed to prevent these persons from killing themselves or others. They could be screened by a
psychiatrist and if not in need of psychiatric or medical intervention they could be placed in a holding facility until such time as they were ready to return to the community.

All seven of these individuals decided that they were not in need of mental health care and unlike the 38 persons in Categories I and II they are less cognitively impaired and more able to reach a decision that is not influenced by psychotic problems. Their lack of motivation to be involved with psychotherapy after they have recovered from their anger, intoxication or frustration should be relevant when considering less costly alternatives than state hospitalization. They are clearly able to find and maintain a home in the community whereas the 38 persons in Categories I and II are either not able to do so or they are less able to do so. This finding suggests that the seven individuals in this category are in need of less intrusive intervention in their private lives. When intrusion is necessary, it should be only enough to ensure that they do not harm themselves or the community.
Qualitative Category IV - The Dropouts

These subjects apparently chose homelessness to avoid involvement with the criminal justice system. From the total of 47 homeless individuals who emerged from the sample of 132 subjects, two persons fit into this category.

The mean age of this group was 31.5, and there was one white person and one black person within this group. Both members of this group were male. One individual was diagnosed as suffering from alcohol abuse and the other as suffering from drug abuse.

Neither of these individuals complied with their aftercare arrangements. One experienced different types of homelessness and the other person consistently stayed with family and/or friends but on a nonpermanent basis. One was consistently employed and the other person maintained no source of income during the period of the study.

Appendix G contains a case example called Tom which is illustrative of the two persons in this category. Material from his case will be used to highlight issues discussed in the text.

Both cases had long histories of homelessness and involvement with the criminal justice system. Their psychiatric disabilities did not seem severe as compared to the subjects in Categories I and II. One earned income and the other depended upon family and/or friends for income.

Their conceptualizations of reality were different from that of the researcher. They appeared to think in terms of how to survive outside of traditional society. They developed their own styles of
living which often conflicted with societal norms. They would steal from another person or sell street drugs to another person for their own gain. These actions elicited no apparent remorse, and they frequently said that "he (victim) deserves it." They believed that their "hardships" such as having to "hide" from the police were the fault of society. Tom talked about "staying ahead of the man." He later told me this meant the police. Tom would not say if he had broken any laws, but he did say "hey, I am living on the edge." More conversations with Tom revealed that the "edge" meant the thin line between law abiding behavior and behavior that broke the law.

The researcher interpreted the mental health problems of these individuals to be characterologically based. The persons in the category were committed to the state hospital because of reported threatening behavior while under the influence of drugs/alcohol. The subjects denied that they had acted in a threatening manner and pointed out that "society had the problem not me."

**Discussion**

Homelessness for these two individuals was apparently the result of choice and not due to prolonged mental illness. They were concerned about avoiding involvement with the police and chose a lifestyle which from their standpoint provided them with the least exposure to officials of traditional society. Intervening in these persons' lives is clearly different than helping someone to compensate who is suffering from a mental illness such as schizophrenia.
Persons suffering from a mental illness such as schizophrenia may appear to have rejected societal norms, but once stabilized on psychotropic medication they often said that they actually endorse societal norms, but were unable to do so because of their impaired cognitive functioning. The persons in Category IV made a decision that was not the result of a psychotic process, whereas the persons in Categories I and II made the decisions that were the result of their biologically based impaired judgment.

Persons described in Categories I and II were less able to make clear and informed decisions about their lives due to the nature of their illness. Persons in Category IV made a decision which may not have been in society's best interest and may not be construed as "informed" as compared to what a middle class citizen would make, but it was an "informed" decision that was free of impaired judgment because of psychosis. These distinctions need to be further investigated to determine the appropriateness of housing individuals such as the subjects in Category IV in a state hospital, even for a short period of time.

Homelessness for the two subjects in Category IV is probably not easily avoided. They have decided to reject traditional values and norms, therefore their homelessness is of their own choosing and not within the purview of the state mental hospital. If they desire psychotherapy, the community mental health system can adequately respond to their needs on an outpatient basis.
CHAPTER V
IMPLICATIONS

The findings from this study suggest that mentally ill persons have multiple needs which may vary depending upon the relationship between the environment and their own particular mental health problems. Meeting these changing needs demands a total care environment that is reflective of an improved continuum of care for all persons. The implications in this chapter will focus on improving the continuum of care for mentally ill persons who have a history of homelessness or who have become homeless. Changes in the mental health system which may prevent homelessness for some mentally ill persons also will be suggested.

The mental health system is currently responsive to the needs of a majority of mentally ill persons, and studies seem to conclude that the majority experience successful community tenure. Efforts to improve the total care environment need to be organized so as to create less vulnerability for mentally ill persons by filling gaps that have been found to exist.
Policy and Practice Implications

The categories of homeless persons identified in this study suggest changes in policy and practice that are particularly appropriate to their needs. Accordingly, implications will be presented for Categories I and II together because their needs are somewhat similar. The needs of Categories III and IV are also similar; therefore, they will also be presented together.

Many persons in Categories I and II drifted into lower levels of the social strata due to their continuing problems with their mental illness. This process will be first examined before entering into a discussion of the specific changes that need to be made in the mental health system in order to prevent mentally ill persons from becoming homeless.

Drift

There are two types of drift that occurred in Categories I and II. The first type appears to be a general tendency to drift from one place to another for no apparent reason. The second type appears to be specific among schizophrenic persons who suffer from Social Breakdown Syndrome.

The general tendency to drift is described by Lamb (1980) as the result of many factors. Some mentally ill persons seem to be searching for autonomy as a way of denying their dependency. This denial is often the result of their own mental illness which prevents them from viewing their interactions with the world in realistic terms. As they
drift over longer periods of time, they "will more than likely stop taking their medications and after a while lose touch with Social Security and no longer be able to receive their SSI checks" (Lamb, 1984, p.65). The further distanced they become from "normative" reality the more they become vulnerable to greater poverty, homelessness, hospitalization or criminalization.

The cause of the general tendency to drift among homeless mentally ill persons appears to be linked to their inability to understand their reality in a consistent manner. This leads to random movements which lack a direction that would lend to the achievement of goals. It could be argued that the reason that homeless mentally ill persons begin to drift is goal directed, but that goal direction quickly becomes lost as the homeless mentally ill person becomes further disorganized and mentally decompensated. This apparent wandering could be observed in all 33 persons in Category I, and the five people in Category II pointed out that they had been involved in similar types of behavior in the past.

The second type of drift, observed among the persons in Categories I and II, was specific to those persons who were diagnosed as suffering from schizophrenia. This drifting has been observed as being caused by Social Breakdown Syndrome (SBS). SBS is when the schizophrenic person begins to develop the persistent inability to formulate and execute plans and subsequently withdraws from society. This can result in the loss of supports and important resources (Dawson et al, 1983). Drift can begin early in the lives of persons
suffering from schizophrenia and is related to selection (Cancro, 1982).

Selection is described as a process by which poor premorbid characteristics and the insidious onset of schizophrenia handicap an individual's upward progression on the social class ladder (Liberman, 1983). This can often impair a young person's education and occupational attainment. Drift can then result from the downward mobility of a person's continued inhibited progression up the social class ladder. This downward mobility is often accompanied by lack of appropriate access to medical care, which can result in chronic sickness. This can further create impediments to the upward progress of these individuals within society, creating an environment of a downward spiraling series of events, which can develop into a sustained series of failures in a person's life.

Failure to meet desired goals can create frustration and result in a tendency to retreat from life's expectations. This retreat has been labeled as the Social Breakdown Syndrome (Gruenberg and Archer, 1983). SBS was first thought to be the result of living in institutions, but schizophrenic patients are vulnerable to SBS in the community as well (Gruenberg and Archer, 1983).

SBS can result in loss of supports and resources which ultimately causes the person suffering from this syndrome to become more vulnerable to greater poverty, homelessness, and criminalization. All of the schizophrenic persons in Category I appeared to be suffering from
SBS, and the two persons in Category II who were currently suffering from schizophrenia had apparently suffered from SBS in the past.

Proposed changes in the mental health system that would prevent mentally ill persons from becoming homeless must address the issue of drift. The addition of more structure to the mental health system is one way of more appropriately intervening with mentally ill persons to avoid the high cost of drift. Specific changes to create more structure should address these areas of policy and practice: commitment legislation, length of stay in hospitals, provision for asylum and sanctuary, outpatient commitment and the extension of the community support program.

These five changes need to be considered as interrelated and the success of one often depends upon the implementation of the other. They will be discussed separately for the convenience of the reader.

**Commitment Legislation**

The interpretation of current commitment legislation focuses on a finding of dangerous to self or others. Whereas most states utilize this interpretation, most states also have a third criterion on their statute books. This third criterion is grave disability.

Currently, the third criterion, grave disability, is utilized in varying degrees in different Ohio counties. Those counties that utilize this criterion also interpret it differently depending upon the stance of the local mental health system, the stance of the local judiciary, the availability of resources both in the community and the
state hospital, and the perceived status of the Ohio Department of Mental Health within the particular county. The creation of additional resources within the community and the state hospital would be necessary before the third criterion could be interpreted more broadly; otherwise both the community and the state hospital system would be quickly overcome by too many patients. The need for a broader interpretation of the third criterion would first have to be documented in order to create additional resources. The interpretation and documentation of this need would require a change in orientation by the Ohio Department of Mental Health. This change is particularly important because the department of mental health in a state generally seeks to create an atmosphere or policy framework which influences the practice of mental health in the state. The judiciary determines actual cases, but state leadership creates an atmosphere which can influence the interpretation of these cases.

Currently, state leadership in the Ohio Department of Mental Health appears to believe that the third criterion should be interpreted very narrowly in order to prevent the inappropriate commitment of persons to the state mental hospital. This leadership needs to be convinced that a broader interpretation of the commitment legislation would not result in more persons being inappropriately committed. One method of accomplishing this goal would be through the case examples in this study. Many of the persons in Category I were denied admission to the state hospital because they were not considered gravely
disabled. The following case example illustrates the problems when the criterion is interpreted too narrowly:

Joe presented himself at a community mental health center asking to be admitted to the state mental hospital. It was 22 degrees outside and Joe wore no jacket and had on a short sleeve shirt. He was aware of who he was, but he appeared to be unaware of the specific nature of his circumstances—the fact that it was 22 degrees outside. The examining psychiatrist determined that since Joe had the awareness to come in for "help" and since he was wearing something over his body, he was not gravely disabled because of his mental illness. A similar framework of reasoning was used with the other 14 persons in Category I who presented themselves for admission. The examining psychiatrist in each case appeared to utilize a framework of interpretation that was a series of Catch-22s; if a person had enough awareness to come into a mental health center, then they were not judged to be gravely disabled even though they may have been in need of hospitalization.

Leadership within the Ohio Department of Mental Health could encourage members of the mental health practice community and the judiciary to consider a broader interpretation of the grave disability criterion when examining persons for commitment to the state mental hospital. This would begin to promote the message that it could be in the best interest of some mentally ill persons to have them committed before they suffer a massive deterioration in both their mental and physical conditions.
This would help to prevent homelessness for mentally ill persons by lessening the vulnerability of living in the community. It would also add to the total care environment by improving access for persons who are in need of mental health hospitalization.

Length of Stay in Hospitals

The length of stay in state mental hospitals needs to be determined on a case-by-case basis that reflects the particular needs of the patient instead of discharge being predetermined by an administrative set of criteria.

Once in the hospital, the length of stay needs to be determined by the severity, prognosis and needs of each person. All the persons in Category I had documented histories of deterioration in their mental conditions after being discharged from the hospital. This was the result of many factors, including failure to take their medication, abuse of alcohol and drugs and factors related to their mental illness. Regardless of the specific interaction of these factors in the community, some of the persons in Category I and all the persons in Category II would have appeared to have benefited from a longer hospital stay. The five persons in Category II pointed out to the author that they needed a longer time to recover before being discharged to the community.

Several persons in Category I appeared to have needed structure which the hospital provided. In the hospital and on medication, they
functioned without significant cognitive impairment; however, once in the community, they began to rapidly decompensate.

This is not to suggest that these persons should remain in the hospital on a permanent basis, but they should remain in the hospital until they can be discharged into a setting where both they and the hospital staff believe that a more successful community adjustment is possible. The discharge summaries of the persons in Categories I and II, under the prognosis section, pointed out that the clients' potential for a successful community adjustment was guarded because the clients were not yet recompensated enough to fully understand the world around them and function well in a nonstructured environment. Under present law, when a person is no longer dangerous to themselves, dangerous to others or is not gravely disabled, they can be discharged. In order to accomplish longer hospital stays, the interpretation of the grave disability criterion would need to be broadened to reflect the severity, prognosis and needs of the client.

The determination of duration of stay in the hospital according to the redefined needs of the client could help to prevent homelessness by helping to ensure that persons are significantly more mentally recompensated before being discharged into the community.

Provision for Asylum and Sanctuary

Researchers, including Bachrach (1984) and Lamb (1984), have suggested that persons such as those in Category I would have benefited from some form of asylum and sanctuary. The persons in Category
II reported to the author that they were in need of a "place to rest and get it together." The specific location of the asylum and sanctuary should depend upon the severity, prognosis and needs of the clients.

Continuing mental confusion on the part of the 33 persons in Category I suggests that they needed some structure to prevent them from wandering aimlessly and not meeting their needs for food, clothing and shelter. It needs to be pointed out at this juncture that the 33 persons in Category I were often not aware of who they were and where they were. They were also paranoid and significantly confused. This suggests that they may need to be confined by legal statute in a place of asylum and sanctuary until they were more aware of their circumstances. In other words, their rights may need to be violated in order to meet their needs. Whereas this raises ethical and moral dilemmas, failure to provide asylum and sanctuary poses risks to their survival in a world they do not completely understand and in which they have significant difficulty. Obviously, the provisions of asylum and sanctuary for persons such as those in Category I needs further consideration in order to meet the needs of clients with a minimal violation of their rights.

Persons in Category II need a different type of asylum and sanctuary. They appear to have been less cognitively impaired, less distanced from "normative" reality, most importantly they realized they needed a place to "get it together." Structure in terms of a legal demand that they remain within the place of asylum is not
necessary. There would be a variety of ways of meeting these clients' needs for asylum and sanctuary. This could include adult foster care homes and halfway houses. The important function of these places would be to place few demands upon the client until the client and the staff could reach some type of consensus that the client was ready to begin a more complete reintegration with society.

The provision of asylum and sanctuary does not mean that the mental health system is "giving up" on these persons, instead it recognizes that because of differences in severity, prognosis and the needs of some mentally ill persons, an environment that places few demands upon the client may be necessary for a period of time. This can prevent homelessness by allowing such persons to benefit from food, clothing, shelter and medical care while they have the opportunity to mentally recompensate.

Outpatient Commitment

Lamb (1984) has observed that structure may be the ingredient missing from the community mental health system. One method of providing more structure in the community would be through the provision of outpatient commitment. Under this type of arrangement, clients could be committed to treatment on an outpatient basis. This would allow them to enjoy more freedom while also benefiting from a structured system of aftercare services.

Outpatient commitment can provide an alternative to commitment to the state hospital for mentally ill persons who, for a variety of
reasons, fail to take their psychotropic medication on their own. Persons could be committed to the community mental health system on an outpatient basis provided they took their medication. For those persons who were on an oral dosage of medication, some type of daily check-in system in conjunction with weekly visits from a mental health official could better ensure that persons complied with their medication requirements. Those who failed to respond to outpatient commitment would need to be committed to a more structured environment, such as the state hospital, until they were ready to participate in a less intrusive method of supervision. Those clients who received their medication intravenously would have to report in for their scheduled appointments, otherwise they would be committed to a more structured environment.

Although improving the total care environment, outpatient commitment poses ethical and moral dilemmas which would have to be worked out in a manner that created the least restrictive environment for the client. It should be remembered that the least restrictive environment refers to that environment that will restore the client to a higher level of functioning, while at the same time taking place in an environment that provides the client with the greatest degree of freedom (Gutheil, Appelbaum, Wexler, 1983). The conditions of maximum potential restoration for the client and the least restrictiveness to the client must be decided as being interdependent.

The potential benefit of preventing homelessness for mentally ill persons makes the consideration of outpatient commitment a necessary
ingredient in improving the total care environment. It would help to provide not only more regular medication compliance, but help to better ensure that clients were not deteriorating due to a lack of food, clothing, shelter and medical care.

**Extension of the Community Support Program**

Improvements in community services also could be of great benefit to both preventing homelessness among mentally ill persons and also helping those mentally ill persons who are already homeless. This study documented that currently the mental health system is often unaware of what happens to its clients once they are discharged from the state hospital until they fail to come in to a mental health center for a scheduled appointment. One way of correcting this dilemma is through more aggressive aftercare. Once discharged from the hospital, mentally ill persons who have shown some instability in the past or who are judged by the hospital staff to have potential problems in community adaptation, could be more closely monitored by their respective case managers in the community. Either the case managers or community workers assigned to work under the supervision of the case managers could make frequent contact with mentally ill persons to assist them in linking up with existing community resources and to encourage them, in taking their medication. They would act as a system of support for more severely mentally ill persons who often do not experience such support from family members.
More aggressive aftercare would demand more flexibility from the mental health system. Social workers who are the primary human resources within the mental health system would have to become more mobile in order to respond more appropriately to their clients who are more likely to have nontraditional life styles. These clients are often not employed, move frequently and may not have a phone; therefore, home visits may be required of the social worker to ensure that adequate client contact is maintained. This would demand reduced case loads in order to allow time for the social worker to leave the office.

Jenny, in Category I, moved frequently and quickly lost contact with her aftercare worker. As she lost contact, she distanced herself more and more from "normative" society. Home visits to Jenny before she became homeless could have possibly prevented her greater distancing from "normative" society. This could have made intervention more possible and reduced the time needed to build a relationship with Jenny after she was rehospitalized.

More aggressive aftercare would help to build a more total care environment and add greatly to the continuum of care by more quickly identifying problems such as beginning mental decompensation and providing more immediate intervention. This would lessen the vulnerability of clients and help to prevent homelessness.
Conclusion of Policy and Practice Implications for Categories I and II

Changes in the interpretation of current commitment legislation, and changes in the length of stays in state hospitals, combined with the provisions of asylum and sanctuary, outpatient commitment and more aggressive aftercare would create a more total care environment and reduce existing gaps in the service delivery system.

It needs to be remembered that more intensive use of the state hospital does not mean an abandonment of the community system, instead it facilitates an improved continuum of care which supports the community system.

Policy and Practice Implications for Categories III and IV

Individuals within these categories are markedly different from the persons in Categories I and II. Therefore, individuals in Categories III and IV have different needs and demand different solutions.

Persons in these two categories pose different problems than do the persons in Categories I and II. Mental illness was not as much of a contributing factor towards their homelessness as it was to the persons in Categories I and II. Persons in Categories I and II were also more distanced from "normative" reality that were the persons in Categories III and IV. Persons in the latter two categories distanced themselves from "normative" reality, but it was more the result of conscious choice and less the result of their mental illness. Persons
in Categories I and II were also suffering more from biologically based mental illness, whereas the persons in Categories III and IV were suffering from characterological forms of mental illness.

These differences suggest that persons in Categories III and IV may benefit from an intervention designed to meet their immediate needs and also take into account the characterological basis of their mental illness. Medication compliance is not at issue with these persons since psychotropic medication is not generally indicated for characterologically based mental illness, and none of the nine people in Categories III and IV were prescribed medication upon discharge. Impairments in cognitive functioning because of psychosis or depressive problems are also not at issue with these persons. Improvement in mental health functioning for persons with characterological problems are usually related to changes in personality and behavioral characteristics.

This confluence of factors suggests that mental health intervention needs to be based upon issues which the client has agreed are important. It needs to be emphasized that these persons were unlike the persons in Category I who were so cognitively impaired that when they distanced themselves from "normative" reality, they were unaware of what they were doing. They also differed from the persons in Category II who wanted to reintegrate themselves into "normative" reality. The nine persons in Categories III and IV had by choice rejected "normative" reality and did not want to participate in mental health treatment. This suggests two possible changes that could be
made in the mental health system that could better serve the needs of these clients.

Two possible interventions could include: length of stay in the hospital based upon severity and prognosis, and the increased use of community education. Together these two approaches would help to create a more total care environment, and they would also minimize the intrusion into the lives of private citizens.

Length of Stay

Length of stay in the hospital would be based upon the severity, prognosis and needs of the client instead of being predetermined by administrative guidelines. Changing hospital policy so that length of stay is determined according to the clients' severity, prognosis and specific needs would allow hospital and community mental health staff to tailor programs of intervention that fit the particular life situation of each client. Persons in Categories III and IV needed emergency detention to prevent them from hurting themselves or someone else, but once removed from the situation they often quickly felt more in control of their lives. This suggests that a section of the hospital might be set aside for very short term intervention in which a person could receive the benefits of medical and mental health attention, but also be more quickly reintegrated with the community.

The nine persons in Categories III and IV wanted to be released as quickly as possible and were not cognitively impaired as compared with the persons in Categories I and II. The hospital provided a
"time out" but once the precipitating incident had passed, the necessity for hospitalization was less justified.

Community Education

Increased community education through public service messages on television and radio, advertising through newspapers and with local groups such as bowling leagues could help to encourage persons similar to those in Categories III and IV to 'work' on their problems before they became so burdensome that they attempt to hurt themselves or someone else. The absence of cognitive impairment because of the lack of psychosis and depression increases the chances that community education could be effective in encouraging these types of individuals to 'work' on their problems.

Implications for Social Work Education

This study suggests that social workers need to be made aware of the unique problems of mentally ill persons who become homeless. It also suggests that social workers need to consider issues that have often been avoided by the profession. The violation of peoples' rights in order to meet their needs is one such difficult issue. Recent advances in the study of schizophrenia and affective disorders suggest that persons may decompensate even though they are regularly taking their psychotropic medication (Harrow et al, 1983). During the decompensation phase, persons may be unable to take care of their needs and may become homeless. This poses a challenge to a profession
that is concerned with facilitating the best fit between the person and the environment. In order to meet the persons' needs for food, clothing, shelter and medical care, the person may have to be committed.

Committing a person to a hospital in order to ensure that they do not die because of the lack of food, clothing, shelter or medical care raises ethical dilemmas. Specifically, the issue of a client's self-determination needs to be addressed. It is the author's opinion that when a client is seriously psychotic and is not oriented to reality, they are not capable of self-determination. Instead, they are so severely mentally ill that their cognitive abilities are significantly limited. At that juncture, the social worker has the responsibility to advocate for the client's eventual right to exercise their self-determination. In other words, the client's mental functioning has to be restored before he/she can effectively exercise his/her rights. This argument poses the proposition that it is at times and under certain limited conditions in the clients' best interest to violate their rights in order to meet their needs.

This unique dilemma has implications for social policy, human functioning, research and practice. One method of demonstrating the interrelatedness of these different areas with this dilemma would be through the use of a special topics class. Students would be asked to design a social policy which would better intervene with persons who are gravely disabled because of their mental illness. The policy would need to address the important issue of actually meeting gravely
disabled clients' needs with a minimal violation of their rights. In order to achieve this goal the person's social functioning would have to be carefully compared with the practice value of client self-determination. Once the policy had been formulated, the students would need to design research proposals that could effectively examine the social policy they had designed. The goal of the course would be to inform students that the four substantive areas of social work education--policy, practice, social functioning and research--cannot be easily separated from each other without creating problems for the clients that social work as a profession is attempting to serve.

Practitioners in the field could be educated about this dilemma through continuing education workshops which also require the participants to design appropriate interventions.

In order to enhance the material presented both in social work classes and in continuing education workshops, an interdisciplinary approach could be utilized. For example, a psychiatrist could present the latest research about biological issues in the treatment of mentally ill persons. The purpose of these classes and workshops would be to challenge social workers to question current assumptions of intervention because these assumptions have proven to be unworkable with this difficult-to-help population.
Implications for Research

Each of the suggestions discussed under implications for policy and practice for all four groups could be incorporated in a demonstration project which would need more research support and would also need to be evaluated. For example, outpatient commitment could be attempted in one county in Ohio and then compared with a county with similar demographic characteristics to compare effectiveness of outpatient vs. no-outpatient commitment.

The specific criteria of effectiveness would need to be as holistic as possible. For example, when attempting to measure the effectiveness of an outpatient commitment program, the intended and unintended effects would have to be considered. Not only would the quality of living of those clients who participated in the outpatient commitment program be examined, but also that of those clients who were rejected as inappropriate for the outpatient commitment program. In addition, the financial and social cost to all agencies that provided services to the participants in the program would need to be examined. This type of evaluation would be both complex and expensive to implement, but more informed decisions about the effectiveness of programs could help to create a more total care environment.

In addition, the total cost of caring for mentally ill persons in the community is not known. For example, the cost of police, emergency squad staff and equipment, emergency room staff and equipment, and other costs to society have not been evaluated in relation to the cost of maintaining a homeless mentally ill person in the community.
vs. the cost of maintaining them in a hospital. Social security payments could be used to defray the cost of maintaining a person in a hospital, but these benefits are often "lost" in the community. The operating assumption traditionally has been that the cost of caring for someone in the community is cheaper than the cost of caring for someone in an institution. This may be false given the multiple needs of mentally ill persons who become homeless. Institutional care may provide both less costly care and more humane care. Research can help to better estimate the social, as well as financial, costs of such care.

This study provided a detailed examination of why some mentally ill persons became homeless. Also important, is why many mentally ill persons apparently were able to provide a home for themselves. Future research needs to examine the strengths of these persons in order to better determine positive factors in both the individual and the community which contribute to mentally ill persons finding and maintaining homes. The five persons in Category II all had strengths in which they were able to build upon in order to eventually find homes. One strength was the insight that medication was necessary in order for them to recover from their mental illness. The development of this insight needs to be explored in order to document the process of that development.

Finally, this study has demonstrated the utility of qualitative research in gaining a better understanding of persons who are often difficult to understand through traditional research methods. This
suggests that the profession of social work should consider undertaking more qualitative research studies since many of our clients have problems that defy traditional frameworks of understanding.

**Conclusion**

This chapter has demonstrated that the needs of mentally ill persons who become homeless are complex and varied. Any response to those needs must begin with a better understanding of how and why they became homeless. Improved research methods are the key to a better understanding of mentally ill persons who become homeless. This dissertation has provided improved understanding of these persons, and it has demonstrated the strengths of qualitative research to obtain this knowledge.

This research should be viewed as one of the many contributions to a greater understanding of how mentally ill persons become homeless. It is not meant to provide a definitive explanation of how this process occurs, instead it more modestly has sought to aid the readers in their journey into the world of homelessness among mentally ill persons. The suggestions of changes in the mental health system also need to be viewed as providing alternative ways of understanding how the mental health system might function to prevent some mentally ill persons from becoming homeless.
APPENDIX A

CONSENT FOR PARTICIPATION IN RESEARCH STUDY
CONSENT FOR PARTICIPATION IN RESEARCH PROJECT

You are being asked to participate in a research study about what happens to people after they leave the hospital. This study will provide information about better ways to help people prepare to leave the hospital. If you are willing to help, we need your permission to do three things:

1. To contact you six months after you leave the hospital in order to interview you about how you are doing and to get your opinions about your experiences in the community.

2. If you accept a referral to a Franklin County Mental Health Center, we would like your permission to get a summary of the number of times you went there and the types of services you received during the six months after you leave the hospital.

3. So that we can find you at the end of the six months, we would like to contact you briefly during the six month period, and, only if we can’t find you, we would like your permission to contact human service agencies such as the Social Security Administration, the Franklin County Department of Human Services, or the Franklin County Mental Health Centers, as appropriate, to see if they have your current address or know where you can be located.

The interview at the end of the six months will be an in person conversation with a trained interviewer. The information from the interview will be used for research purposes only and will not have your name on it. The interviewer will try to answer any questions you may have about the interview questionnaire.

All information from this study will be held strictly confidential and you will not be identified in any way. You may refuse to answer any questions or withdraw from participation at any time without penalty. You will be given a copy of this consent form. If you have further questions about the study, please call Carol Sylvester at COPH, Ext. 2383.

I, ___________________________ acknowledge that ___________________________ has fully explained to me the purpose of this study and the procedures involved. I am willing to participate in the study and freely and voluntarily agree to items one, two, and three above.

______________________________
Signature of Respondent

______________________________
Signature of Staff Person

______________________________
Date

Consent to contact the Social Security Administration and/or the Franklin County Department of Human Services and other human service agencies expires eight months after the above date.

Consent for the follow-up interview expires one year after the above date.

Thank you for your help.
The following procedures were used when contacting possible subjects for the study at COPH:

1. Medical personnel and ward staff at the four COPH admissions wards "cleared" possible subjects for contact. Persons were "cleared" if their condition had stabilized to the point where their mental status was such that they could understand the project. "Cleared" also meant that persons were approaching release.

2. Social workers who discharged persons at COPH, two MSW students and John Belcher, MSW, who is also a Ph.D. student, contacted possible subjects throughout the week by reviewing a list of those "cleared" for contact.

3. When a person was approached, they were asked "Do you want to participate in a study after your release?" If the person answered "no" then the person was thanked for their time and contact terminated.

4. If the person responded "yes," they were told about the purpose of the study, nature of the contacts and the amount of time required. They were given a consent form to read. If they still wanted to participate, they were requested to sign the consent from along with a carbon copy, which was given to them for their records. The consent form was signed in the presence of the contact person.

5. They were thanked for their cooperation and reminded that they would be contacted in one month after their release.
Consent Getting
Instructions

1. List of patients yet to be contacted will be on each ward in a
   manila envelope also containing blank consent forms, carbon
   paper, instructions, messages, etc.

2. Don't worry about guardians -- go ahead and get consent and we'll
   check charts for guardians after discharge. If you know the
   patient has a guardian make a note of it on the master list and
   don't bother to approach them.

3. When you arrive each day, check for messages and check the master
   list. Identify for first contact any person who is being
   discharged and has not yet been contacted. Next contact persons
   on the ward identified on the list as ready to be approached. You
   can also check with the Charge Nurse or other treatment team
   member to identify other persons ready to be contacted. Please
   note any information you obtain on the master list.

4. When you approach a patient or group of patients, introduce
   yourself, explain your function at the hospital, Mental Health
   Center, etc. Explain that you are working on a research project
   being done by the hospital and community system and that we need
   their help. We want to find out more about the sorts of things
   people need in the community so that they can avoid having to
   come back to the hospital. Explain what would be required of
   them (items 1, 2, & 3 on the Consent Form). Let them read the
   Consent Form or read it to them and let them ask questions.

   It may help some people to know that we are trying to ask
   everyone on the ward for the next several months if they will
   participate. On item 2 it might help some people to know that we
   will be asking for only numbers and types of services from the
   mental health system -- that's all they are giving permission for.
   In addition, when explaining item 3 on the Consent Form, they
   should know that we would only contact those agencies if we can't
   find them any other way and then will only be checking to see if
   the agencies have a more current address. Also, we would go to
   "logical" agencies - i.e. if someone is receiving SSI, we would
   check with Social Security, not the Welfare Department.

5. Try not to let them say no the first time you approach them. If
   you sense resistance or that they are unsure, leave a copy of the
   form with them and tell them we'll get back to them later. There
   will be a column on the master list for you to mark such "first
   approach made" instances.

6. If you don't feel that the patient is capable of informed
   consent, as you are talking to them, wait until another time.
7. If they agree to participate have them sign 2 consent forms (using a carbon) then you sign and date it and leave the carbon copy with them.

Key Instructions: Make sure you complete 8 and 9 every time.

8. Mark all information you obtained on the master list - people ready to be approached, people who said yes or people who said no, people you left a form with to be contacted again. This information is crucial so that someone else coming on the ward will know the status of the ward.

9. Put all signed consent forms and the master list back in the ward manila envelope before you leave the ward.

Further Notes

1. We have arranged for "ward coordinators" during day shift on each ward. Approach them first if you need to know things like whether certain patients are ready to be approached, where patients can be found, who needs to be contacted first because of imminent discharge. Also talk to them or leave them a note if you have questions, concerns, or problems regarding ward procedures for the study. They may also be leaving messages for you. They are:

   Mary Brown - Ward 2
   JoAnn Madison - Ward 4
   Charlie McCutcheon - A4
   Bonnie Goings - A2

2. If you have questions, concerns, problems, or suggestions for how to do things in a better way, please call Carol Sylvester at ext. 2383 or Carol Yonek at ext. 2229 -- or leave us a message in the on-ward envelopes.

Thank you for your help!

CTS/vg
enc.
APPENDIX B

ORIENTING QUESTIONS
Contact Sheet

(Circle appropriate information)

1. How long has subject been at his/her present address?
   a. since discharge
   b. other (explain)

2. How did he/she come to reside at that address?
   a. discharged to that address because of relative
      1. mother
      2. aunt
      3. other (specify)
   b. subject provides own support and owns or rents own residence.
   c. other circumstances (specify)

3. Do they plan to remain at present address?
   a. yes
   b. no (if "no," where do they plan to go?)

4. Has subject experienced any problems since discharge?
   a. psychiatric
   b. physical
   c. income
   d. shelter
   e. agency
   f. food
   g. family
   h. problems
   i. other (explain)

5. Is this where he/she went to live upon discharge from COPH?
   a. yes
   b. no (explain)

6. Has subject been homeless or in jail? If yes, then elaborate if possible. How did they become homeless or incarcerated? GO TO HOMELESS QUESTIONNAIRE.

7. Complete Brief Psychiatric Rating Scale (BPRS). Some questions may not be appropriate if contact is phone conversation.
Brief Interview for Those Found to be Homeless During Ongoing Tracking

1. How did you come to be here?

2. Economic resources?

3. Brief Mental Status
   a. orientation x 3
   b. any signs of psychotic impairment
   c. any signs of depression
   d. general appearance, behavior, motor status
   e. insight

4. What did you do when you left the hospital?

5. What are your future plans? (Compare this with their discharge)

6. Is subject satisfied with level of food, clothing and shelter?

7. Do you have any family support?

8. Any network of friends or contacts?

9. Agency support?
CENTRAL OHIO PSYCHIATRIC HOSPITAL
RECORDS REVIEW

Name

Birth Date

Social Security No.

Marital and Relationship History
Dates

Relationship

Education: highest grade completed? ________

Year of onset of psychiatric illness? ________
Where and with whom was person living at onset? ________
Was person employed at onset and if so what type of employment? ________

Diagnosis and Treatment History
Dates

Diagnosis

Facility

Does patient have a history of following through with aftercare?

Employment history
Dates

Type of Employment

History of homelessness
Dates

Reasons for Homelessness

Where
### Economic History

<table>
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### History of Family Assistance

<table>
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<th>Type</th>
<th>Dates</th>
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If family is not involved with subject, do COPH records point out why? ____________________________

### History of Involvement with the Judicial System

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<th>Dates</th>
<th>Involvement (chg/pick ups)</th>
<th>Disposition</th>
</tr>
</thead>
</table>

Has patient ever been transferred to a long-term ward at COPH? This would be any other ward than ward A-2, A-4, 2 and 4. Document the history if one exists.

Document why the patient is in Franklin County. Example: the parents moved to Franklin County when the patient was six-years-old.
APPENDIX D

CATEGORY I: THE WANDERERS
Summary of Patterns--Qualitative Category I

General Description: Subjects who were chronically homeless and severely mentally disabled.

From the total of 47 homeless individuals who emerged from the sample of 132 subjects, 33 fit into Category I.

Age: \( \bar{x} = 33.12 \)

Diagnosis:
- 16 Schizophrenia
- 11 Affective Disorders
- 5 Personality Disorders
- 1 Drug Intoxication
- 33

Race:
- White 15
- Black 18

Gender:
- Male 25
- Female 8

Summary of Selected Characteristics

Medication Compliance:
- Did not comply 37
- Complied at some point 2

Types of Homelessness:
- Consistently stayed with family/friends but on a nonpermanent basis 10
- Consistently stayed in limited shelter or on the street 10
- Consistently stayed at SROs 1
- Experienced several varieties of homeless conditions 12

Income:
- No income during six months of study 13
- Consistently maintained SSI/SSD 9
- Consistently received GR 3
- Received inconsistent types of support 8
Key to Chart of Selected Characteristics

Source of Income= SI
Medication Compliance= MC
Living Conditions= LC
Jail= J
Prior Homelessness= PH
Discharged Homelessness= DH
Not Homeless= OK

Types of Income:

Earned Income= E
Supplemental Social Security Income= SSI
Workers’ Compensation= WC
General Relief= GR
No Income= D
Family/Friend Support= FF
Social Security Disability Income= SSD
Social Security (Survivors Benefits)= SS
Social Security (Old Age Benefits)= SD

Type of Homelessness:

Limited or no shelter= (H1)
Shelters or missions= (H2)
Cheap motels, etc. when the intent to stay or length of stay is 45 days or less= (H3)
Staying with family or friends when the intent to stay or length is 45 days or less= (H4)
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Pattern Notes of Category I

Types and Patterns of Homelessness

Twenty-nine of the 33 subjects were homeless all six months.

Three were living in nonhomeless situations the first month and then became homeless the third month and remained homeless.

One was homeless the first month and was then rehospitalized at COPH and remained there for the remaining six months of the study.

Ten stayed with relatives or friends but on a nonpermanent basis the entire six months.

Ten lived on the street (limited shelter) or in shelters or missions the entire six months.

One lived in cheap hotels or motels the entire six months.

Twelve changed living conditions (types of homelessness) during the six months, they are characterized as follows:

Four at first stayed with family or friends on a nonpermanent basis and then by the third month had no shelter or used public shelters.

Three were living in nonhomeless conditions the first month and by the third month had no shelter or used shelter or missions.

One started out staying with family/friends, the third month used cheap hotels and by the fifth month was using public shelters or living on the streets.

One started out with no shelter, used cheap hotels and then went back to no shelter the fifth month.

Two started out in the shelters and then moved in with family and friends on a nonpermanent basis.

One started out with no shelter and was then rehospitalized at COPH remaining there for the remainder of the six months of the study. He did sometimes go AWOL and when he did he was homeless each time.
Income

Thirteen of the 33 were without a source of income for the entire six months.

Nine maintained SSI or SSD for the entire six months.

Three maintained GR for the entire six months.

Eight experienced changes in their source of income during the six months. The eight people are characterized as follows:

Three of the eight lost their SSI benefits at the three-month follow-up.

Three of the eight lost their SSI benefits at the six-month follow-up.

One of the eight managed to obtain GR the sixth month having been without income for the previous five months.

One of the eight lost SSI benefits the third month but managed to regain them the sixth month.

Involvement With the Criminal Justice System

All 33 had a history of involvement with the criminal justice system. Twelve had been arrested and jailed during the six months of the study.

Place of Discharge

Eighteen were discharged homeless. Some of the addresses were fraudulent. This could have been done on the part of the patient, the part of the discharge planner or the subject could have been too psychotic or confused to know if they had an address when discharged. Some were discharged to a homeless shelter although only the address was listed (Not the name of the shelter). Some were discharged to "self." For those who were admitted to CPH homeless, being discharged to "self" usually meant continued homelessness.

Fifteen were discharged to an address but only three of these addresses were living situations that could be considered marginally stable.
Medication Compliance

Only two of the 33 were following through with medication by the sixth month. Only three had started the first month taking their medication, and they had stopped taking their medication by the third month.

Previous Homelessness

Hospital records reviews revealed that only one of the 33 people had not been homeless in the past.

Rehospitalizations at COPH

Seventeen of the 33 were rehospitalized at some point during the sixth months.

Level of Psychiatric Disability

No specific instrument was used to estimate the extent of psychiatric disability. A mental status examination was used to estimate the gross level of psychiatric impairment. Every subject when interviewed, exhibited gross psychiatric impairment. Some were grossly psychotic exhibiting both auditory and visual hallucinations. Some were significantly cognitively disorganized when interviewed. All could have benefited from mental health intervention when interviewed.

Reasons for Homelessness

This was difficult to determine because of the gross psychiatric impairment exhibited by the subjects. There was no one reason such as getting kicked out of the house. The reasons were complex and cause and effect would be impossible to specifically pinpoint. It is interesting to note that none of the 33 considered themselves homeless because of psychiatric disability. The reasons ranged from lack of adequate income to an inability to stop the "war" that was "after" them.

The process of homelessness will be illustrated through the use of case examples.
Case Examples - Category I

In order to provide the reader with a more comprehensive picture of the lives of the subjects, three case examples will be presented as part of this Table.

Case 1: This is a 33-year-old black female with a previous history of homelessness. She will be called Jenny for the purposes of this presentation.

I talked with Jenny the first time over the phone. I had visited her discharge address but it was vacated and had been for the last six months even though Jenny supposedly went there to live upon discharge. I called Jenny's parents and they gave me the number of Jenny's brother where Jenny was living.

Jenny answered the phone by pointing out that the man she was living with was abusing her and that man was not her brother. Jenny said that she was "going to get away from that nigger." Suddenly, Jenny began arguing with the man who was supposedly abusing her. I could not hear anything except Jenny. Jenny next pointed out that the "shit that the MAN gave her did not make her feel right and she was going to church where Jesus would heal her." Jenny hung up and I did not see her again for two months until she was rehospitalized at COPH.

I visited Jenny at COPH. She was dancing around the room and was shouting "Jesus" will punish the wicked and that "Jesus" would "strike" down the MAN. I attempted to ask Jenny about why she had been homeless but she only started to lunge at me shouting that "Jesus" would "smite down" white folks. Jenny stopped and went back to her room.

Jenny was never compensated enough to conduct an intensive interview but our conversations did suggest that Jenny did not feel she was homeless or mentally ill. She felt that the MAN was trying to hurt her.

A review of Jenny's file and conversations with COPH ward staff, the mental health center who has treated Jenny, Jenny's brother and my own interviews confirmed that Jenny was in fact suffering from a bipolar disorder that usually manifested itself in a manic psychotic phase. Jenny's first hospitalization took place in 1967 and she was never placed on a long-term ward at COPH. She has not worked for at least ten years. She always fails to take her medication, has been involved with the law for minor infractions, receives nonconsistent help from her family, is not able to maintain a consistent source of income. It is difficult to say when exactly she became homeless. She has maintained no permanent address for the last five years.

She is the product of the streets, short hospital stays, and severe mental illness which is not being treated. COPH has often
interrupted her cycle of homelessness but it has not intervened to stop it. It appears that she is usually discharged before she is completely recompensated.

Jenny went AWOL during her rehospitalization and she was not seen by this interviewer again. Relatives were contacted who confirmed that Jenny maintained no permanent address and lived where she could.

Case 8: This is a 43-year-old black male with a previous history of homelessness. He will be called John for purposes of this presentation.

John was interviewed the first month at a single room occupancy hotel (SRO) in Columbus. John pointed out that he "felt" fine and that he did not need the medication that the doctor had given him. He next began to look down the hallway to make sure no one was following me. He examined my drivers license and shut the window in his room. It was approximately 93 degrees outside and there was no air conditioning in the room. John was dressed in a coat and tie.

John began to talk about how a lawyer was trying to get all his money and that he (John) would have to move soon in order that the lawyer would not find him. I asked him about being homeless and he said that he was not homeless just trying to "keep ahead of those people." John began to inspect the room and he started to talk to the walls. He asked me to make sure I did not let in the people trying to kill him on my way out. I left immediately and checked with the local mental health center. They reported that John was in an adequate placement.

A review of John's records revealed that John had been first hospitalized for psychiatric problems (Schizophrenia, paranoid chronic) in 1973 and had repeated hospitalizations since that time. He tended to stay in one SRO until he decided that he was going to be killed and then he would move to another SRO. His mother maintained his Social Security Disability (SSD) and John would contact her when he needed money.

John had worked up until 1973 when he had suffered an apparent psychotic break and had begun wandering the country. The COPH chart notes that John "roams Ohio." I contacted John's brother and mother and they also confirmed this history.

John had moved by the third month and had left the state, according to his brother. John had a history of not taking his medication, constant flight to avoid detection (from his psychotic manifestation), repeated hospitalizations of 21 days or less, minimal family contact and a worsening of his psychiatric condition. His hospitalizations are becoming more frequent and it appears his ability to remain outside of the hospital is lessening.
John thought he was "fine" but from my estimation he was extremely paranoid, grossly psychotic and not oriented to time, place or person. He thought he was in Cleveland instead of Columbus. He also thought it was cold but sweat was rolling off his body. I could only remain in his room for 20 minutes before I began to be overcome by the heat.

John has declined to the point that he no longer realizes the difference between homelessness and nonhomelessness. He pointed out that he feared COPH but he also thought that the lawyer who was trying to get his money worked at COPH.

Case 32: This is a 41-year-old black male with a previous history of homelessness. He will be called Joe for the purposes of this presentation.

Joe has a consistent history of not being able to manage his money (SSI) so he identified his father as his payee. Joe has a problem with alcohol which negatively effects his primary psychiatric diagnosis which is schizophrenia. His illness is further complicated by his consistent failure to stay on his psychotropic medication. I interviewed Joe at the one month follow-up at an SRO in Columbus. Joe's father had "set" Joe up in the SRO because the family had grown wary of Joe's bizarre behavior when he would become "sick."

Joe appeared to be doing well at the one month follow-up. He was taking his medication, was not drinking alcohol and had plans to rent an apartment and move out of the SRO.

Joe was readmitted to COPH where he was interviewed for the three month follow-up. Joe told me he was on the corner of Broad and High Streets preaching the gospel when "they came and got me." He admitted to drinking heavily since our last contact and he had gone off his medication. Joe began to talk about Jesus and how he would heal the sinners. He told me to "get right with the Lord" and then he began talking about going for a hamburger. He thought he was on the corner of Broad and High Streets but he was in COPH on the day of this interview.

Joe was released from COPH and went to live at one of the homeless shelters in Columbus. Joe was interviewed for the sixth month interview and pointed out that he was confused and depressed. He was living with some relatives on a nonpermanent basis. He said that he did not really believe he was "sick" but each time he went off the medication he "got crazy."

Joe once worked as a clerical worker but could not maintain that job because of his rapidly declining psychiatric condition. He has had 17 admissions at COPH since 1971. His pattern of life is the same: he is discharged from COPH after 60 days or less, usually 21 days, promising to take his medication and not use alcohol. Within a
short time he is not taking his medication and is drinking heavily. This leads to a disruption in his living condition and he moves from relative to relative sometimes ending up without shelter. He has had numerous problems with the law ranging from burglary and receiving stolen property to disorderly conduct.

Joe does not believe he is "sick" but when he is in a controlled setting and is stabilized on medication he points out that he probably has a problem that medication helps. Joe's type of homelessness varies with the severity of his psychiatric condition and sometimes he is able to set up a room as a home. During these times he is able to maintain himself for a month or two in a home, but he always needs some supervision in managing his money and eventually becomes homeless again.

Creation of the Condition of Homelessness

The pattern of homelessness for the majority of the subjects was established by CDPH records review and interviews with subjects.

Onset of Illness

Eight of the 33 people in Category I began to exhibit psychiatric problems in their teen years and gradually the condition became chronic. The chronicity was exacerbated by a consistent failure to comply with taking their psychotropic medication.

Twenty-four of the 33 began to exhibit psychiatric problems in young adulthood and then gradually the condition became chronic. Their chronicity was also exacerbated by a consistent failure to comply with taking their psychotropic medication.

One was an alcoholic for a number of years, and he was involved in a car accident which led to organic brain syndrome. Failure to comply with taking his psychotropic medication and the chronic and decompensating nature of the condition led to severe chronicity.

Gradual Loss of Supports

At one time or another in their lives all 33 people had been employed at some workplace. With the exception of two, the type of work was marginal and characterized by low hourly wages and no benefits. As their psychiatric conditions worsened these 33 subjects were less able to maintain consistent work.

The worsening of their psychiatric conditions often meant gross psychosis. This was often complicated by a failure to take psychotropic medication and use of alcohol and/or drugs. Gradually their
contacts with "normative reality" became less frequent. Some of the 33 at various times were able to maintain some type of public support, such as SSI or GR, but often they would find a relative or friend to act as their payee. Their life became nomadic as they wandered in search of something.

Bizarre behavior also began to characterize their conditions. This would often necessitate police intervention sometimes resulting in psychiatric hospitalization. This acting out behavior further isolated them as relatives and friends grew less tolerant of their frequently "strange" behavior.

This series of gradually declining and disorganized behaviors usually meant frequent psychiatric hospitalizations. A pattern of homelessness had often been established by this point. There was sometimes one particular psychotic break that seemed to trigger the homelessness but more often it was the end result of a worsening of their psychiatric condition and the inability to maintain themselves in adequate nonhomeless conditions.

Psychiatric hospitalization interrupted their pattern of homelessness for a brief time but eventually they were discharged either into immediate homelessness or to a marginal living situation that quickly led to continued homelessness.

Those able to maintain some source of public support did receive some contact with "normative reality" once a month when they received their check either because they had to cash it at a bank or they contacted their payee to receive their money. Nine maintained SSI for the entire six months and all but one of these nine used a payee. They would often see their payee once a month and the rest of the time the payee would frequently not know of their whereabouts. The payses all stated they were frustrated with the homeless persons they were acting as payee for because they felt "abused." Several payees said they were considering ending the relationship.

Thirteen of these 33 subjects had no income for the entire six months and their only consistent source of contact with "normative reality" was the jail, police, soup kitchen, shelter workers or mental health staff at either the mental health center emergency services unit or CPH. All 33 of the subjects were difficult to track because of their "flight" patterns and the severity of their mental illness. Often the way I found them was to interview them when they were readmitted to CPH. Many would not be seen by any of the above mentioned personnel for days or weeks at a time, and when I was able to find the subject, they could often not account for their whereabouts. Many simply wandered aimlessly.

None of the 33 subjects received consistent support from family or friends and their loss of supports was in varying phases. All 33 of these individuals had a history of a relationship with a friend or
relative but they had either broken off contact with that person or
the relative or friend had broken off contact with them because of
"bizarre behavior."

The loss of supports had been gradual and some of the 33 were
able to reestablish some contact with someone for a short time but it
was sporadic in nature. The confluence of factors mentioned such as
onset of illness, failure to take medication, use of alcohol and/or
drugs, worsening of psychiatric illness, loss of employment, inability
to maintain social contacts, and lack of consistent treatment led to
homelessness. Factors related to homelessness include involvement
with the law and ineffective psychiatric hospitalization. It would be
difficult to determine which factor caused the other and why some
mentally ill persons become homeless and others do not. Taken
separately these factors do not specifically lead to homelessness but
interaction of the factors creates the homeless condition.

Case Examples

Two cases will be presented which demonstrate the gradual loss of
supports which results in homelessness.

Case 2: This is a 23-year-old white male who has a previous
history of homelessness. For purposes of case presentation he will be
called Fred.

Fred pointed out that when he graduated from high school he
attempted to work as a mechanic but he had problems with his "mind."
He said that he could not think straight, and he would hear voices and
could not sleep. He did not go for any counseling and eventually
started using street drugs to "feel better." Fred began his odyssey
into homelessness gradually. He lost his job, began to use alcohol
and drugs and his psychiatric condition worsened. He suffered an
apparent schizophrenic break around the age of 20 and his problems
seemed to worsen. His "mind" got more "crazy" and he became involved
with the law, serving time in jail for robbery and other misdemeanors.

Fred was hospitalized frequently but he said that he wanted to be
"free." It was difficult to determine what freedom meant to Fred
because when he talked of freedom he said that he liked to sit on a
bench and watch the cabs on Broad Street. Fred next pointed out that
then he would get hungry, but he did not know how to find food. He
said that would make him sad and he would find some "reefer" and he
would feel better until the next time he could not find food.

Fred pointed out that he knew that he needed some medication, but
he did not like to take it. Fred said that he could no longer
remember what it was like not to be homeless, "being homeless ages you
fast you know." Fred has a mother but she broke off contact with Fred
because Fred would go "crazy" and "destroy" her house. Fred confirmed this point.

Fred could not identify one factor that led to his homelessness, "it just sort of slowly happened."

**Case 4:** This is a 29-year-old black male with a previous history of homelessness. For purposes of case presentation he will be called Ted.

Ted suffered a psychotic break around the age of 22 and began to decompensate after that point. He was hospitalized in another state but they "let me go to be crazy again." He began to wander and was hospitalized in three other states before coming to Ohio. His family attempted to "look after him" but they became frightened by Ted's frequent attempts to hurt them. Ted becomes grossly psychotic without medication and threatens to hurt people. Ted has been arrested frequently for breaking and entering and assault.

Ted pointed out that he began to get "crazier" as he got older. He also pointed out that, "I do not like being crazy, and I try to fight it." Fighting it means to flee the geographical area in which he is staying. Ted believes that somehow this will cure him.

Ted does not like being in the hospital but he admits that when he is not in a "place" he fails to take his medication and gets "sick." Ted pointed out that he would like to be married but "girls won't talk to me because I am crazy." Ted became homeless gradually after his first psychiatric episode when he was 20. His wanderings became more frequent and his cognitive disorganization became more severe. He had lived with his sister in another state but his attempts to flee his illness led him to Ohio.

Ted did become more organized and free of gross psychotic behavior while in the hospital and on medication, yet his loss of set, cognitive disorganization, and delusional system remained in spite of medication. These residual symptoms were the "sickness" that Ted tried to flee when he left the hospital.
APPENDIX E

CATEGORY II: TENUOUS PLANNERS
Summary of Patterns--Qualitative Category II

General Description: Subjects who had a previous history of being homeless and chronically mentally ill, but found homes during the study.

From the total of 47 homeless individuals who emerged from the sample of 132 subjects, five subjects fit into Category II.

Age: \( \bar{x} = 35.40 \)

Diagnosis: 2 Schizophrenia
3 Affective

Race: White 3
Black 2

Gender: Male 1
Female 4

Summary of Selected Characteristics

Medication Compliance:

Did not comply 1
Complied consistently 4

Types of Homelessness:

All five had mixed experiences with homelessness but were living in a nonhomeless condition by the sixth month.

Income:

Inconsistent types of support 5
Summary of Selected Characteristics of Persons in Category II*

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</table>

*Please refer to page 146 for description of Key to Chart.
Pattern Notes of Category II

**Types of Homelessness**

Two lived in shelters or missions at the one month follow-up.

One lived with family and/or friends on a nonpermanent basis at the one month follow-up.

One lived on the streets with no shelter at the one month follow-up.

One lived in cheap hotels at the one month follow-up.

All were not homeless by the sixth month. Three were living in group homes preparing to move out into an independent living situations. Two were living in independent living situations.

**Income**

Four had no source of income at the one month follow-up.

One received SSI at the first month and maintained SSI for the six months.

By the sixth month all of the four who were without income at the first month were receiving some type of financial support:

1--SSI  1--GR  1--ADC  1--Employed

**Involvement with the Law**

Two had a history of involvement with law enforcement while the others did not. Only one was involved with law enforcement during the six months.

**Place of Discharge**

Three of the five were discharged homeless.

Two went to shelters.
One went to the Franklin County jail where they were released to homelessness.
One was discharged to family but only remained there a few days.

One was discharged to an independent living situation which did not work out.

*Medication Compliance*

Four of the five took their medication the entire six months.

One of the five did not take medication at all but quit using alcohol which had a positive effect.

*Previous Homelessness*

All five of the subjects had a previous history of being homeless.

Four of these subjects were homeless on admission to COPH. All four had been homeless for at least six months prior to admission to COPH.

One of the five had been homeless at different points in his life but was not admitted to COPH homeless.

*Relospitalizations*

Only one of the five was rehospitalized.

*Level of Psychiatric Disability*

All five were depressed at the first contact. One attempted to kill herself and one became more depressed by the third month. All five were in good spirits and not depressed by the sixth month.

*Reasons for Homelessness*

Four of the five only continued a pattern of homelessness that they had begun months before. All four reported initially becoming homeless because of psychiatric disability and continuing decompensation. They stated that they could not get their lives "together" because they always felt disorganized.

The fifth person became homeless because his spouse divorced him while he was in COPH and he had no place to go upon his release. His alcohol abuse had contributed to the poor domestic situation.
Case Examples—Category II

Case 41: This is a 32-year-old white female who has a previous history of homelessness. For purposes of case presentation she will be called Peggy.

Peggy was discharged from COPH to the Franklin County jail which according to Peggy was a formality. She was released from the Franklin County jail and she became homeless. Peggy suffered a manic break prior to her admission to COPH because she went off her lithium. She left her husband and committed some minor crimes. She also became homeless. She realized that she needed to stay on her medication when she was released. She also pointed out that she needed a place "to get it together." She had no income upon release and had to live with "whoever" until she could find a "place." Peggy has suffered previous episodes of manic psychosis.

Peggy found a group home and moved in about the second month. She stayed there throughout the rest of the study. She also found a job and began to get her life back in order. Peggy pointed out that COPH gave her a chance to begin to "get it together."

Peggy said that she did not want to be homeless and realized that she needed to take her medication in order to stay "OK." Peggy's tenure of homelessness was short lived due to her insight and ability to maintain herself in the community.

Case 43: This is a 32-year-old black female with a previous history of homelessness. For purposes of case presentation she will be called Robin.

Robin pointed out that she suffered a psychotic break when she was 29 years of age. She lost her part-time job but continued to live on ADC. She also quit taking her medication and she heard voices and "people" got "to me." Gradually she lost control and FCCS took her children away because of Robin's nomadic lifestyle and apparent lack of concern for her children but the "fog" kept getting "deeper" and she did not know how to cope. Without ADC and due to her worsening condition she became homeless. She was hospitalized four times since January of 1984, but she could never seem to get it together.

Robin was homeless when hospitalized at COPH on her most recent admission. This time Robin kept taking her medication and for some reason the "fog" began to clear, at least enough so Robin could begin to figure out a way out of homelessness. She worked with FCCS and managed to establish a plan for the return of her children. With her ADC returned, Robin was able to escape homelessness. Robin pointed out, "I guess the sickness ran its course."
Robin was in an independent living situation by the sixth month and was working closely with the mental health center.

Escape From Homelessness

Four of the people in this category were admitted to COPH from either a shelter or the streets. Upon discharge they all reported that they knew they had to keep taking their medication. This did not mean that they were free of illness but they slowly began to take more responsibility for themselves. One subject pointed out, "If you do not take care of yourself, no one else will."

There was nothing particularly special about the six months of this study. Nothing out of the ordinary happened in these persons lives. The four reported that they started to "feel" better and became more organized. One subject pointed out that a similar experience had taken place before but she had not taken advantage of it. All four stayed in counseling and they pointed out that it was not so much what the counselor said but that the counselor was there and they (the subjects) felt like hearing it.

A window of opportunity had opened up for these four individuals and their illness had apparently gone into a dormant phase. It is interesting to note that one subject mentioned a period before in her life when this had taken place suggesting a possible cycle to her illness.

The fifth subject did not like living in SROs pointing out that he was getting "too old" for that. He decided to quit using alcohol and although he did not take medication, he reported feeling more organized about life.
APPENDIX F

CATEGORY III: TEMPORARY HOMELESSNESS
Summary of Patterns—Qualitative Category III

General Description: Subjects who were temporarily homeless due to a combination of situational and mental illness factors.

From the total of 47 homeless individuals who emerged from the sample of 132 subjects, seven fit into Category III.

Age: $\bar{x}=31.71$

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Summary of Selected Characteristics

Medication Compliance:

- Did not comply: 4
- Complied at some point: 2
- Consistently complied: 1

Types of Homelessness:

All seven persons in this category experienced mixed types of homeless conditions and by the sixth month all had found a nonhomeless arrangement.
Selected Characteristics of Persons in Category III*

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</table>

*Please refer to page 146 for description of Key to Chart.
Types of Homelessness

All seven of the subjects were homeless the first month. They all lived with friends or relatives on a nonpermanent basis for 45 days or less.

By the sixth month follow-up, all seven had moved out of homelessness and were living in independent living situations. All but one of the seven were homeless at the three-month follow-up.

Income

Two of the seven maintained SSI and CR respectively for the entire six months.

One maintained and earned income for the entire six months.

One had no real source of income and was marginally supported by his mother for the entire six months.

Three changed their sources of income during the six months. They are characterized as follows:

One had started out with no income and then moved in with her spouse the sixth month and he supported her.

One had no source of income at discharge but by the third month had managed to get CR.

One had no source of income at discharge but by the sixth month had managed to find a job and was able to support himself on this earned income.

Involvement with the Law

None of the seven had a history of involvement with the law and only one of the seven was involved with the law during the six months.

Place of Discharge

Four of the seven were discharged to family members on a nonpermanent basis until they could find independent living situations.
One was discharged to a "fake" address. It was difficult to determine if the subject had given false information to the discharge planner or the discharge planner had merely listed an old address.

One was discharged to his former address which he had burned down prior to his admission to COPH.

One was discharged to an independent living situation which she left shortly after her arrival.

**Medication Compliance**

Five of the seven did not take their medication the first month and four of the five did not take their medication at all during the six months.

Two were taking their medication the first and third month but by the sixth month only one was taking their medication.

**Previous Homelessness**

Six of the seven had never been homeless while the seventh person had a previous history of homelessness.

This individual had been homeless for some months prior to being admitted at COPH. His homelessness was a direct result of his psychiatric condition.

**Rehospitalizations**

Three of the seven were rehospitalized at psychiatric facilities in Columbus during the six months. The other four were not rehospitalized.

**Level of Psychiatric Disability**

Three of the seven who were discharged were fairly stable in terms of their psychiatric illness. The three who were rehospitalized suffered continuing psychiatric problems, but by the sixth month only one was suffering continuing problems.

The overall level of psychiatric disability was not severe as compared to Category I.
Reasons for Homelessness

Two were homeless because of domestic disputes. These two were living with their spouses by the six-month interview.

One was homeless because of child abuse and resulting domestic problems. He lacked the financial support to live independently without his spouse.

Two were homeless because of continuing use of drugs and consistent inability to manage their money in such a way that they could maintain a nonhomeless condition.

One burned down his house in the midst of a psychotic break induced by drug intoxication.

One because of psychiatric disability and the general inability to stay organized was not able to arrange an adequate placement upon discharge.

Case Examples--Category III

Two cases will be presented which will help to describe this category.

Case 34: This is a 61-year-old white male who has no history of previous homelessness. For purposes of case presentation he will be called Pete.

Pete was discharged to return to his house where he lived with his wife. Pete had a long history of problems with alcohol, but he said that he refrained from drinking in order to save his marriage. Marital separation occurred within one month after discharge, and Pete lived with friends and/or relatives on a nonpermanent basis until he could find a place to live permanently.

He was able to work during this time, but he did not take medication. Pete was arrested during the first month after discharge for disorderly conduct.

His homelessness was related to a long standing problem and resulting marital problems. By the sixth month, Pete and his spouse were living together and he was no longer homeless.

Pete pointed out that he would not have been homeless but when he separated from his wife he did not have enough money to find a "decent place."
Case 35: This is a 23-year-old white female who had no previous history of homelessness. For purposes of case presentation she will be called Lacy.

Lacy was discharged to an address where she had not resided for at least six months prior to her admission to COPH. Lacy was homeless for the first three months of the study due to a domestic problem. She left her husband but did not have enough money to find an independent living situation. Lacy lived with friends and/or relatives during this time. She did not take any medication for the entire six months of the study.

Lacy pointed out that she was "fine" but she and her "old man" had simply gotten into a "fight" and that was why she was homeless. She denied any psychiatric problems and said that her confinement in COPH was a mistake on "someone's" part.

Lacy moved back in with her spouse the fourth month and reported doing "fine" at the sixth month.

Situational Factors Led to Homelessness

All seven of the subjects in Category III believed that they were not mentally ill and their homelessness was due to situational factors beyond their control. Each of their situational factors was slightly different. Lack of money was the most often mentioned factor in leading to their homelessness. In three of the cases, domestic breakup created a situation where, without adequate savings, the subjects had no choice but to become homeless. Three more of the cases cited low payment levels by GR and SSI which prevented them from securing a nonhomeless situation.

The person who burned down their house pointed out that basically he was "OK" if he had enough money to find a new place to live.

Living with friends or relatives gave these seven individuals enough time to gather enough financial resources to either find a place to live or allow enough time for their spouses to return to them.

Drug abuse certainly interacted in five of these cases and mental illness interacted in all seven of these cases, but the subjects denied this premise.
APPENDIX G

CATEGORY IV: THE DROPOUTS
Summary of Patterns--Qualitative Category IV

**General Description:** Subjects who chose homelessness to avoid involvement with the criminal justice system.

From the total of 47 homeless individuals who emerged from the sample of 132 subjects, two fit into Category IV.

**Age:** $\overline{x} = 31.5$

**Diagnosis:**
- 1 Alcohol Abuse
- 1 Drug Abuse

**Race:**
- White 1
- Black 1

**Gender:** Male 2

Summary of Selected Characteristics

**Medication Compliance:**
- Did not comply 2

**Types of Homelessness:**
- Mixed types of homelessness 1
- Consistently stayed with family/friends 1

**Income:**
- Consistently employed 1
- No source of income 1
Selected Characteristics of Persons in Category IV*

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*Please refer to page 146 for descriptions of Key to Chart.
Pattern Notes of Category IV

Types of Homelessness

Both were homeless for the entire six months.

One stayed with family and/or friends.
One stayed in cheap motels or hotels.

Involvement with the Law

Both had a history of involvement with the law. During the six months one was involved with the law and one was not.

Place of Discharge

One was discharged to family and/or friends.
One was discharged AWOL.

Medication Compliance

Both did not comply with medication.

Previous Homelessness

Both had a long history of homelessness.

Rehospitalizations

Neither was rehospitalized during the six months.

Level of Psychiatric Disability

Both presented as cognitively disorganized at each contact.

Reasons for Homelessness

Both apparently chose a life of homelessness because they could avoid contact with others and maintain a low profile. This allowed them to be involved in minor criminal activity in order to support their chemical abuse habits.
Case Example--Category IV

Case 46: This is a 28-year-old black male who has a previous history of homelessness. For purposes of case presentation he will be called Tom.

Tom had been homeless for at least six months prior to his admission to COPH. He was discharged to his sister, but Tom pointed out that this was so he would have a name to give the social worker at COPH. He was employed but he continued to drink heavily and abuse drugs. Often times Tom would pass out in an alley and sleep in a car but he maintained a room in a cheap motel as well. Tom said that he enjoyed his life and he was trying to get his "shit" together, but he also said that he wanted to stay ahead of the MAN which he later pointed out meant the police.

Tom could not be classified into Category I because he was not chronically mentally ill and his life of homelessness was a choice and not the result of psychiatric disability. He was not psychotic and, although often cognitively disorganized, he was oriented and had plans that were consistent and organized.
REFERENCES


Rose V. Cameron, (1966). 373 F.2d., at 452.


Report to the President from the President's Commission on Mental Health (1978), Vol. 1. Washington, D.C., p. 44.


