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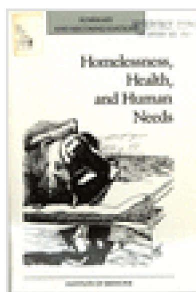

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SUMMARY AND RECOMMENDATIONS

Homelessness, Health, and Human Needs

Committee on Health Care
for
Homeless People

INSTITUTE OF MEDICINE

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NOTICE: The project that is the subject of this report was approved by the Governing Board of the National Research Council, whose members are drawn from the councils of the National Academy of Sciences, the National Academy of Engineering, and the Institute of Medicine. The members of the committee responsible for the report were chosen for their special competences and with regard for appropriate balance.

This report has been reviewed by a group other than the authors according to procedures approved by a Report Review Committee consisting of members of the National Academy of Sciences, the National Academy of Engineering, and the Institute of Medicine.

The Institute of Medicine was chartered in 1970 by the National Academy of Sciences to enlist distinguished members of the appropriate professions in the examination of policy matters pertaining to the health of the public. In this, the Institute acts under both the Academy's 1863 congressional charter responsibility to be an adviser to the federal government and its own initiative in identifying issues of medical care, research, and education.

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Preface

This study was undertaken at the request of the U.S. Congress as stated in the Health Professionals Training Act of 1985 (P.L. 99-129). The act directed the secretary of the Department of Health and Human Services to arrange with the National Academy of Sciences, through its Institute of Medicine, for a study of the delivery of inpatient and outpatient health care services to homeless people. That provision was one of various legislative initiatives concerning the growing problem of homelessness that the Congress has considered in recent years (see Appendix A). The congressional mandate in P.L. 99-129 was implemented in October 1986, when the Department of Health and Human Services, through its Health Resources and Services Administration, entered into a contract with the Institute of Medicine. Additional funding was provided by the National Research Council and, subsequently, by the U.S. Veterans Administration.

The study was directed at three tasks specified in P.L. 99-129: (1) an evaluation of whether the eligibility requirements in existing health care programs prevent homeless individuals from receiving health care services; (2) an evaluation of the efficiency of the delivery of health care services to homeless individuals; and (3) recommendations for activities by federal, state, local, and private entities that would improve the availability of health care service delivery to homeless individuals.

As in all studies done under the auspices of the National Academy of Sciences, the first step in the process was to select a committee of knowledgeable people to conduct the study. A 13-member panel was drawn from the disciplines of anthropology, economics, epidemiology, family and internal medicine, law, nursing, political science, psychiatry,

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public administration, and social work. At its initial meeting in December 1986, the Committee on Health Care for Homeless People adopted the following approach for the study.

Recognizing the limitations of the research literature on homeless people, their health problems, and the health services they receive, the committee directed a search of unpublished reports as well as published studies and documents. To supplement the existing literature, the committee commissioned the following 10 papers written by experts on subjects of special concern:

- ''Legal Barriers to Access: The Unmet Health Care Needs of Homeless People,'' Arlene Kanter;
- ''A Critique of the Methodologies of Counting the Homeless,'' Charles Cowan, William Breakey, and Pamela Fischer;
- ''Rural Homelessness,'' Lawrence Patton;
- ''The Dynamics of Homelessness,'' Russell Schutt;
- ''Homelessness: A Medical Viewpoint,'' William Vicic and Patricia Doherty;
- ''Shelter and Health Care of Homeless Families, Homeless Children, Homeless Adult Individual Females, and Homeless Battered Women and Their Children,'' Deborah Reisman Fink;
- ''Ancillary Health Care Services for Homeless Persons: Availability and Delivery,'' Marianne Gleason;
- ''Mental Health and the Homeless Population,'' Andrew Ziegler;
- ''Alcohol Problems Among the Contemporary American Homeless Population: An Analytic Review of the Literature,'' Pamela Fischer; and
- ''Illicit Substance Abuse Among the Homeless,'' Virginia Mulkern.

Significant findings from these papers are incorporated throughout this report; two papers, those on the methodologies of counting the homeless and on the homeless in rural areas, are included as Appendixes B and C, respectively.

The committee regarded both the gaps in data and the desirability of first-hand acquaintance with homelessness as reasons to conduct site visits. Members of the committee, accompanied by Institute of Medicine staff and consultants, visited 11 cities and (with separate funding from the Department of Health and Human Services) rural areas in four states to learn the characteristics of homelessness in those communities and the nature of health services directed to homeless people. These sites were selected not as a representative sample of programs for the homeless but, rather, as potential models of service delivery. At the same time, by interviewing both homeless individuals and people attempting to help the homeless, committee members were able to assess the validity of many findings that appear in the literature.

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The committee benefited greatly from the assistance of the national Health Care for the Homeless program of the Robert Wood Johnson Foundation and the Pew Memorial Trust. The directors and staff members of the 19 projects supported by these foundations provided much valuable information for this report. In addition, the Social and Demographic Research Institute of the University of Massachusetts at Amherst, which is under contract with the Robert Wood Johnson and Pew foundations to provide program monitoring and evaluation, generously shared its data and undertook special analyses on the committee's behalf.

This report begins by trying to answer the question, "Who are the homeless?" To dispel myths about homelessness and to provide information about its causes, Chapter 2 discusses the dynamics of homelessness. Chapter 3 describes the health problems of homeless people. Chapter 4 describes the major barriers homeless people encounter in their effort to obtain health care. Chapter 5 examines health care and health-related service programs designed to meet the special needs of homeless people. Chapter 6 summarizes the committee's findings and sets forth its recommendations.

Two aspects of the work of the committee warrant further explanation. First, although the committee's charge was fairly narrow, its examination perforce was fairly broad. Early in the study, the committee determined that the specific aspects of health and health care contained in the congressional charge could not be separated from many aspects of homelessness itself.

The second has to do with the relative amounts of attention, both in the study and in the report, invested in specific health problems and particular subpopulations of the homeless. Reports of studies of some health problems common among homeless people, such as alcoholism or mental illness, are numerous and readily available; these could be summarized rather succinctly. Information on other types of health-related problems, however, often was more anecdotal or based on very recent data, some of which were provided especially for use in this study. Therefore, parts of this report may appear to place greater or lesser emphasis on certain problems than might seem to be warranted by their actual proportion among the hardships of the homeless.

The report, in response to P.L. 99-129, is directed to the United States Congress and to policymakers on the national, state, and local levels, but the committee hopes it will also be of value to those who work directly with the homeless and to the average citizen who has concern for them.

* * * * *

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As chairman of the committee responsible for this report, I want to take this opportunity to thank my colleagues on the committee for their dedication, patience, and extremely hard work on this study. I also wish to acknowledge the many people outside the Institute of Medicine who gave so generously of their time to help enrich our study (see Appendix E). In addition to the authors of commissioned papers listed in the Preface, we take particular note of the contributions of Pamela Fischer of John Hopkins University; Deborah Franklin, a doctoral student in history of science at the University of Pennsylvania; Max Michael of the University of Alabama at Birmingham Medical Center; and James Wright of the University of Massachusetts. I owe a particularly large debt of personal gratitude to Susan Neibacher, director of the New York City Health Care for the Homeless Program at the United Hospital Fund, who generously served, with her customary great patience and tolerance, as my personal guide through the thicket of issues the committee encountered on homelessness.

None of these efforts, of course, would have produced a report without the intensive labors of a dedicated professional staff at the Institute of Medicine, especially the study director, Alan Sutherland, and his deputy, Deborah Swansburg. An especially large thank you is owed to their supervisor, Fredric Solomon, director of the Division of Mental Health and Behavioral Medicine, and to the Institute's Associate Executive Officer for Programs, Marian Osterweis.

BRUCE C. VLADECK, *Chairman*
Committee on Health Care for
Homeless People

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Summary and Recommendations

ORIGIN OF THIS STUDY

Among congressional actions taken in recent years to address both the broader aspects of homelessness and the more narrow issues relating to the health of homeless people was the Health Professions Training Act of 1985 (P.L. 99-129). This mandated that the secretary of the Department of Health and Human Services ask the Institute of Medicine of the National Academy of Sciences to study the delivery of health care services to homeless people. This report is the result of that study.

The study committee was composed of experts in fields such as medicine, nursing, and social sciences; two public officials who administer statewide health and human services programs also served on the committee.

The charge to the committee and its staff was stated in P.L. 99-129:

1. evaluate whether existing eligibility requirements for health care services actually prevent homeless people from receiving those services;
2. evaluate the efficiency of health care services to homeless people; and
3. make recommendations as to what should be done by the federal, state, and local governments as well as private organizations to improve the availability and delivery of health care services to homeless people.

The members of the study committee endorse the analyses and conclusions of the report but unanimously wish to express their strong feeling that the recommendations are too limited in addressing the broader issues of homelessness—especially the supply of low-income housing, income maintenance, the availability of support services, and access to health care for the poor and uninsured.

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At the request of the study's funding agency in the Department of Health and Human Services, the Health Resources and Services Administration, the committee took a broad view of health care and of needs for health care-related services, including matters such as nutrition, mental health, alcohol and drug abuse problems, and dental care.

STUDY PROCESS

The study committee met five times during a 10-month period (December 1986 to September 1987); individual committee members participated in site visits to 11 cities and to rural areas of four states to observe the problems of the homeless firsthand. The committee also commissioned 10 papers on specific areas of concern, such as the legal aspects of access to health care and the problems of providing health care for homeless people in the rural areas of America. Committee members, assisted by a study staff of two professionals, reviewed what is known about the health of homeless people, as evidenced in the scholarly literature, reports of public and private organizations, and—in particular—the ongoing evaluation of work of the 19 Health Care for the Homeless projects funded by the Robert Wood Johnson Foundation and the Pew Memorial Trust.

In the course of this study, the committee encountered several major methodological problems. For example, the lack of a uniform definition of homelessness results in substantial disagreement about the size of the homeless population. Some people define the homeless as only those who are on the streets or in shelters; others include those who are temporarily living with family or friends because they cannot afford housing. For its working definition, the committee adopted the one contained in the Stewart B. McKinney Homeless Assistance Act of 1987 (P.L. 100-77), which defines a homeless person as one who lacks a fixed, permanent nighttime residence or whose nighttime residence is a temporary shelter, welfare hotel, transitional housing for the mentally ill, or any public or private place not designed as sleeping accommodations for human beings (U.S. Congress, House, 1987).

The committee commissioned a study of the methodology of counting the homeless, which is included as Appendix B to this report, but refrained from providing its own quantitative estimate of the number of homeless people. One recent estimate of the number of homeless people in the United States, published in June 1988 by the National Alliance to End Homelessness (Alliance Housing Council, 1988), calculates that currently, on any given night, there are 735,000 homeless people in the United States; that during the course of 1988, 1.3 million to 2.0 million people will be homeless for one night or more; and that these people are among

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the approximately 6 million Americans who, because of their disproportionately high expenditures for housing costs, are at extreme risk of becoming homeless.

WHAT WAS LEARNED

Who Are the Homeless?

Contrary to the traditional stereotypes of homeless people, the homeless of the 1980s are not all single, middle-aged, male alcoholics. Neither are they all mentally ill people made homeless as a by-product of the policy of deinstitutionalization of mental health care.

The homeless are younger, more ethnically diverse, and increasingly are more likely to be members of families than is generally believed by the public. In most cities around the country, minorities—especially blacks and Hispanics—are represented disproportionately among the homeless as compared with their percentage of the overall population of those cities. Children under the age of 18, usually as part of a family headed by a mother, are the fastest growing group among the many subpopulations of the homeless. On the other hand, the elderly are underrepresented among the homeless in comparison with their percentage in the general population. There are a substantial number of veterans among the homeless, especially from the Vietnam era.

Homeless people tend to be long-term residents of the city in which they live. The homeless in rural areas, as well as homeless urban families, usually have gone through several stages of doubling up with family and friends before becoming visibly homeless.

Although the old stereotype of the public inebriate does not reflect the diversity of homelessness in the 1980s, alcohol abuse and alcoholism are still the most frequently diagnosed medical problems among homeless men (more than 40 percent). Substance abuse with drugs other than alcohol also appears to be more prevalent among homeless adults than among the general population, as is "comorbidity"—that is, multiple problems in the same individual such as alcoholism and mental illness.

The homeless have also been stereotyped as uniformly mentally ill, in part because *severe* disorders such as schizophrenia are conspicuously overrepresented among homeless individuals on the street. Most studies of mental illness among the homeless reveal that 30 to 40 percent of the adults show evidence of some type of major mental disorder; 15 to 25 percent acknowledge having been hospitalized for psychiatric care in the past. These rates are several times higher than those of the general population (Chapter 3).

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Why Do People Become Homeless?

The answer to this seemingly simple question is quite complex. Among the many causes of homelessness, the committee identified three major, interrelated factors that, in the face of a relatively strong economy, have contributed to the increased number of homeless people in this decade:

1. *Housing*—The supply of housing units for people with low incomes has decreased considerably, while the number of people needing such housing has increased.
2. *Income and employment*—There has been a tightening of the eligibility criteria for public assistance programs (especially locally funded general relief), as well as a decline in the purchasing power of such benefits for those who do establish eligibility. This reduction in benefits comes at a time when the number of people living in poverty has increased.
3. *Deinstitutionalization*—The policy of deinstitutionalization, which characterizes the way state mental health systems have been administered since the early 1960s, is clearly a contributing factor; in addition, a policy of noninstitutionalization—that is, not admitting people for psychiatric care except for very brief periods of time—has further exacerbated the problems of mentally ill homeless adults. Both policies were based upon the assumption that treatment, rehabilitation, and appropriate residential placement would be provided in the community. This has not happened anywhere near the extent originally envisioned. Similar attitudes regarding extended confinement have come to characterize policy toward general hospitals and correctional, rehabilitation, and mental retardation facilities.

One result of these factors is that the system for providing temporary shelter for people who are homeless has been burdened beyond its capacity, despite enormous expansion in the last few years; people are staying in these emergency facilities for many months, not only a few days or weeks.

What Are the Health Problems of the Homeless?

Homeless people experience illnesses and injuries to a much greater extent than does the population as a whole. The committee identified three sets of health problems that specifically relate to homelessness:

1. Some health problems can cause a person to become homeless, for example, injury on the job resulting in the loss of employment and

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income, severe mental illness, alcoholism, drug abuse, and, more recently, AIDS (acquired immune deficiency syndrome).

2. Other health problems result from homelessness, for example, problems resulting from exposure, such as hypothermia; problems resulting from not being able to lie down, such as vascular and skin disorders of the legs and feet; and problems resulting from specific hazards of the homeless life-style, such as trauma from being mugged or raped on the streets.

3. Many health problems require treatment that is made more complicated or impossible by the fact that the patient is homeless. Almost all illnesses and injuries fall within this category, and the difficulty encountered in attempting to treat even minor ailments when the patient is homeless is one of the major issues facing health care providers. One example would be the dietary limitations and the medication regimen that are part of the routine care of hypertension, a problem of particular significance among those past middle age and among blacks. Medication can rarely be taken as prescribed, and the sodium content of food derived from soup kitchens cannot be controlled. A simpler example would be the frequent order to "rest in bed"; this is virtually impossible if one does not have a bed, and very difficult at best if one must give up one's bed in a shelter every morning and wait until evening to be reassigned a bed.

What Other Problems Do Homeless People Have with Health Care?

The primary problem that homeless people have with health care is access, both financial and physical. With regard to financial access, homeless people generally face the same problems as do other poor and near-poor people: eligibility requirements for financial assistance, benefit levels well below the current market price for health care, and a reluctance of health care providers to supply low-cost treatment (especially in specialties like obstetrics, for which malpractice premiums are extremely high). Recent legislation has begun to eliminate one of the most serious obstacles to financial access for homeless people, that is, the requirement for a fixed address as a prerequisite for determining eligibility for public health care benefits. Depending on the state and the city, however, many homeless people—especially single, nondisabled adult individuals—are simply not eligible for such benefits.

With regard to physical access, those obstacles that often prevent the domiciled poor from obtaining health care prove to be still more difficult for the homeless. Hospitals, clinics, and mental health centers often are located far from the districts of cities where homeless people congregate.

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The primary means of getting to health care programs is public transportation, which homeless people often cannot afford. In addition, if they do get to such programs, the long wait for services may mean that they miss the deadline when they must be back at the shelter to sign up for a bed for the night. Given a forced choice between treatment and a shelter for the night, shelter invariably becomes a first priority.

Responding to the health care needs of the homeless is more difficult than serving the medically indigent population generally. Personnel need special training and support for working with people who often are very distrustful, lack a network of social supports, and have a multiplicity of medical and social needs.

What Is Being Done About the Health Problems of Homeless People?

During the course of the study, members of the committee and the staff observed many commendable, well-utilized (and often overextended) health care and health care-related programs for homeless people throughout the country. Meetings were held with local officials, service providers, volunteers, and advocates for the homeless; numerous reports of other programs were evaluated. Of particular interest were the efforts of the 19 Robert Wood Johnson Foundation-Pew Memorial Trust Health Care for the Homeless projects, because they represented a particular targeted approach to providing health care services to homeless people. Moreover, while this study was in progress, Congress passed and the President signed into law the Stewart B. McKinney Homeless Assistance Act (P.L. 100-77), which provides new funding for a range of services, including general health and mental health care, in an effort to help the homeless (U.S. Congress, House, 1987).

However, even the most energetic health care worker is repeatedly confronted with the reality that poor and homeless people have trouble separating a specific need, such as health and mental health care, from the other activities needed for survival, such as securing housing and food. The committee concluded that even if the health care services that are clearly needed by so many of the homeless were widely available and accessible, the impact of such services would be severely restricted as long as the patients remained on the streets or in emergency shelters.

CONCLUSIONS AND RECOMMENDATIONS

Five Critical Observations

The fundamental problem encountered by homeless people—lack of a stable residence—has a direct and deleterious impact on health. Not only does homelessness cause health problems, it perpetuates and exacerbates

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poor health by seriously impeding efforts to treat disease and reduce disability.

Although the urgent need for focused health care and other prompt interventions is readily recognized, the committee found that the health problems of the homeless are inextricably intertwined with broad social and economic problems that require multifaceted, long-term approaches for their resolution. In spite of the limitations brought about by the committee's charge and the limitations of the committee's resources in its ability to formulate detailed recommendations to deal with the root causes of homelessness, the committee believes that those who seek solutions to the homelessness problem itself and to its attendant health-related problems must take into consideration the five critical observations described below.

1. More than anything else, homeless people need stable residences.

The health problems of homeless people that differ from those of other poor people are directly related to their homeless state. Homelessness is a risk factor that predisposes people to a variety of health problems and complicates treatment. The committee considers that decent housing is not only socially desirable but is necessary for the prevention of disease and the promotion of health. Yet the number of housing units for people with low incomes has been steadily decreasing since 1981, while the number of people needing such housing has been increasing during that same period.

2. People need income levels that make housing affordable, both to reduce and to prevent homelessness.

The issue of affordable housing has two sides: On one side is the supply of housing at a given price; on the other is the amount of money an individual or family has with which to pay rent. The committee observed that in many communities neither employment at the current minimum wage nor welfare benefits for those who are eligible provide enough income for them to acquire adequate housing. Given the irreducible economic cost of housing in those communities, income adequacy must also be addressed if homelessness and its attendant health problems are to be prevented or remedied.

3. Supportive services are necessary for some homeless people who require assistance in establishing and maintaining a stable residence.

Although the main issue is housing, for some homeless people, such as the chronically mentally ill, the mentally retarded, the physically disabled, those with histories of alcohol and drug abuse, the very young, and the very old, housing alone may not be sufficient. They need the kind of social support systems and appropriate health care that would allow them to maintain themselves in the community. Effective discharge

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planning, outreach services, and casework are necessary to identify needs and to ensure that these needs are met. With the proper support systems, many will outgrow their need for therapeutic milieus and specialized housing and will eventually become self-reliant. For some, however, the need may be lifelong.

4. Ensuring access to health care for the homeless should be part of a broad initiative to ensure access to health care for all those who are unable to pay.

In its deliberations, the committee examined ways to increase and to try to ensure access to health care for the homeless as a special group. It concluded, on both ethical and practical grounds, that a targeted approach was inappropriate in the long run. The committee found that, as a practical matter, those who provide health care services to homeless people also encounter other poor, uninsured people seeking access to health care. Moreover, as discussed in Chapter 2, the boundary between the homeless and the nonhomeless is thin and permeable. Although there are some chronically homeless people, many poor people slip in and out of homelessness. Extending health care services to the homeless while continuing to deny them to the domiciled poor is, thus, not only administratively impractical and bureaucratically cumbersome but also ethically difficult for those who provide or finance health care services. The committee agrees with the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1983) that the federal government has an obligation regarding access to needed health care:

> When equity occurs through the operation of private forces, there is no need for government involvement, but the ultimate responsibility for ensuring that society's obligation is met, through a combination of public and private sector arrangements, rests with the federal government.

5. Short-term solutions will not resolve what has clearly become a long-term problem.

The immediate and desperate need for shelter and food has overridden attempts to design and implement policies that might provide some long-term solutions. In the committee's view, what is needed now is planning and action at the federal, state, and local levels to coordinate and ensure the continuity of appropriate services and housing for homeless people. Although short-term, problem-specific approaches provide essential and sometimes lifesaving services, the committee does not believe that they will result in major enduring change.

Keeping these five observations in mind, the committee offers some recommendations about preventing and reducing homelessness before

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turning to recommendations focused on the immediate health care and other service needs of homeless people.

Preventing and Reducing Homelessness and Its Related Health Problems

As expressed throughout this report, health care and other services, including temporary shelters, can only help relieve some of the symptoms and consequences of homelessness. Coordinated efforts to address housing, income maintenance, and discharge planning are needed to prevent and reduce homelessness.

Housing

The problem of homelessness will persist and grow in the United States until the diminution and deterioration of housing units for people with low-incomes are reversed and affordable housing is made more widely available. Because of recent media attention to the refusal of certain homeless people to reside in institutional domiciles, there may be a misconception that homeless people will reject offers of decent and appropriate housing. There are no known studies that prove that if affordable housing were provided to homeless people they would use it, but several reports of the U.S. Conference of Mayors (1986a,b; 1987) regarding shelter utilization in excess of capacity support the belief that if such housing were available, the great majority of homeless people would surely accept it.

This is not a report on housing, nor was this committee made up of housing experts.* However, in light of the frequency with which the subject of housing arose during the course of this study, the committee makes the following observations:

1. For nearly five decades, beginning with the National Housing Act of 1938, the federal government has acknowledged, as a matter of explicit policy, its obligation to help ensure that every American family has access to decent housing. Because of the retreat from that commitment over the last several years, there has been a dramatic increase in the number of homeless people. The committee believes that if the health problems caused by homelessness are to be prevented, this commitment to housing should be reaffirmed.

2. Increasing the number of housing units for low-income people

* For a thoughtful analysis of this very complicated set of issues, see Alliance Housing Council (1988).

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obviously requires major budgetary commitments. The lack of funds, however, is only one of several impediments to augmenting the housing supply. Among the nonfiscal issues that must be addressed are the impact of zoning regulations, real estate tax exemptions as incentives or disincentives to construct low-cost housing, local building construction standards, and the need for greater communication and coordination between the public agencies responsible for the disposition of abandoned housing and the public and private agencies that seek to help the homeless and ensure an adequate supply of affordable housing.

3. Many individuals and families only require a stable place to live, but some, especially the mentally ill, alcohol and drug abusers, the physically handicapped, and those with chronic and debilitating diseases, need housing and an array of professionally supervised supportive services in order to remain in the community—and, in many cases, to enable a transition to independent living. The committee believes that supportive housing programs for homeless people with disabilities are likely to be cost-effective and may lead to a reduction in future public expenditures; eventually, they may also enable these individuals to become economically productive citizens. Although there has long been a commitment to provide specialized housing (in the Community Mental Health Centers Act of 1962 [P.L. 88-164], for example, and implicitly in state governments' deinstitutionalization policies), the federal and state governments have not lived up to this commitment.

4. The Emergency Assistance program plays an important role in the provision of housing, especially as it relates to homeless families. In the committee's opinion, major aspects of this program that need to be reassessed include voluntary versus mandatory participation by the states, the use of Emergency Assistance funds to prevent—rather than simply to alleviate—homelessness, and the period of time and type of facilities (hotel rooms versus apartments) for which Emergency Assistance funds can be used. This reassessment is especially urgent in light of the present high prevalence of homelessness and the widespread expectation that the problem will get worse before it gets better.

Income and Benefits

Throughout its deliberations, the committee was impressed by the fact that improvements in income maintenance and other benefit programs for people in poverty would help appreciably in preventing and reducing homelessness and its related health problems. In this section the committee offers some observations and conclusions, urges the implementation of existing legislation, and recommends that some new legislation be considered.

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The committee observes that a growing number of people with full-time jobs are becoming homeless. During its site visits around the country, the committee heard numerous references to people who are working but who cannot afford the most basic form of housing, not even a single room (see Chapters 1 and 2). This suggests that the relation of the minimum wage level to housing costs should be reexamined.

The committee also observed that many homeless people do not qualify for federally supported entitlement programs such as Medicaid and food stamps. Moreover, for those who do qualify, the benefit levels are so low as to make it impossible for them to obtain adequate housing or services. The committee did not find that there is any substantial justification for major geographic variations in eligibility standards. There may be a basis for some differences in benefit levels because of regional variations in the cost of living, but the dramatic differences in benefit levels from state to state identified in Chapter 4 do not appear to be justified.

Therefore, we recommend **that the federal government should review all federally funded entitlement programs in order to create rational eligibility standards and establish benefit levels based upon the actual cost of living in a specific region.** The committee commends state courts, such as those in Massachusetts and New York, for their recent decisions holding that entitlement benefits should be great enough to enable the recipients to afford that for which the benefits are intended, whether it be housing, food, or health care (see Chapter 5), and recommends that this approach be adopted by other states and the federal government in establishing benefit levels.

In terms of eligibility for benefits, the committee found that the 1986 federal legislation requiring the development of procedures to ensure that the absence of a permanent address does not constitute a barrier to receipt of cash assistance, food stamps, Medicaid, and other benefits has yet to be fully implemented. **The committee urges prompt, uniform implementation of these procedures. Furthermore, the committee recommends that state and local governments reexamine their documentation requirements for public benefit programs** to ensure that they, too, do not impose unrealistic requirements on homeless people (Chapter 2).

The committee observed that some homeless people who are eligible for income and other benefits are unaware of their eligibility or are unable to secure them. Augmented outreach efforts to identify and assist the homeless and those at risk of becoming homeless (especially those about to be discharged from institutions) could reduce and prevent homelessness (see the section Health Care and Related Services in this chapter for a more complete discussion of outreach). The committee recommends the following:

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- **The effects of extending the presumptive eligibility guidelines for Supplemental Security Income (SSI) to include disabled homeless people (especially homeless people who have been discharged from a mental hospital within the preceding 90 days [Chapters 2 and 4]) should be evaluated in order to assess the costs and impact on the rates of homelessness.**
- **The effects of the current federal regulation that mandates a 33.3 percent cash reduction in benefits for SSI recipients who live with other people should be carefully assessed.** Questions such as the following need to be addressed: To what extent is the regulation contributing to homelessness by deterring people from sharing housing? Given the high cost of even the most basic forms of shelter services, would there be savings that would result from removing this regulation and, if so, what would the magnitude of the savings be?

Finally, the committee recommends that **serious consideration** be given to the following two changes in the Medicaid system:

- **Medicaid eligibility should be decoupled from eligibility for other benefits, and a national minimum eligibility standard should be established for Medicaid** (Chapter 4). These changes would enhance access to health care for certain vulnerable groups—such as families whose Medicaid eligibility is lost if they lose Aid to Families with Dependent Children (AFDC) benefits.
- **Medicaid regulations should be amended to provide reimbursement for community-based services (e.g., day treatment and case management) for homeless people with psychiatric or physical disabilities in order to assist them in community integration (Chapters 1, 3, and 4) and reduce current incentives for institutionalization.**

Discharge Planning

Inadequate discharge planning coupled with inadequate community-based support and housing can cause homelessness. State, local, and private mental hospitals; inpatient substance abuse facilities; facilities for mentally retarded and developmentally disabled people; general hospitals; nursing homes; and correctional facilities all share a common responsibility to help arrange access for their clients or patients to appropriate and affordable postinstitutional living arrangements, including supportive services when necessary. Three sets of variables appear to affect the likelihood of postinstitutional placement most frequently:

1. Whether a person was homeless at the time of admission or became homeless during his or her institutional stay.
2. Whether there is a supply of affordable housing and supportive services or whether such housing or services are virtually nonexistent.

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3. Whether even a basic minimum effort to locate housing and services is expended by the institution or whether that task is inappropriately delegated to shelters.

Some people become homeless because the institutions that are responsible for their care fail to ensure that they can maintain themselves in the community after they are discharged. Although the committee recognizes that there is a shortage of affordable housing, it believes that more effective discharge planning will help homeless people have greater access to that which is available. (On the related issue of the need for additional services for those who require posthospital nursing care, see the section Convalescent Services later in this chapter.) Just as it is inappropriate for a person who is not sick to remain in a hospital, so is it inappropriate for institutions simply to discharge people to shelters or to the streets without having made even the most basic efforts to find alternative living arrangements.

The committee recommends that public and private institutions adopt and observe discharge planning processes that ensure in advance of discharge—to the extent possible—that clients have suitable living arrangements and necessary supportive services. To help increase the availability of adequate postdischarge arrangements, such institutions must work to improve communications and coordination with organizations that provide postdischarge ambulatory care, home health care services, and other relevant community agencies and organizations (Chapter 5).

Moreover, **federal and state agencies that provide financing to hospitals and other relevant institutions should extend to all beneficiaries of public programs the standards for discharge planning that now apply to Medicare patients.**

Health Care and Related Services

The committee found that the most effective health care and other services for homeless people are those that recognize the special needs and characteristics of the homeless. With this in mind, the committee recommends that the following general strategies be adopted:

- **services should be provided on a voluntary basis**, respectful of individual privacy and dignity;
- **intensive efforts should be made to engage homeless people by reaching out to them at the places where they congregate;** this requires appropriately skilled and trained health care professionals who can link clients to and provide continuity of services in community-based health care centers, free-standing clinics, hospital outpatient departments, and other existing providers of services;

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- **health care providers should be trained in the special problems of patient engagement and communication;**
- **health care providers should be trained in the diagnosis, treatment, and follow-up of those conditions that are especially prevalent among homeless people;**
- **techniques should be developed to address the particular difficulties homeless people have in maintaining medication or dietary regimens; and**
- **ways should be developed for homeless patients to obtain needed medicines, medical supplies, or equipment.**

In many respects, homeless people have the same health care needs as other poor people. A high prevalence of acute and chronic diseases is found among the homeless, so health care needs to be available and accessible. **The committee recommends that serious efforts be made to identify those in need of treatment and to encourage intervention at the earliest appropriate time in order to avoid unnecessary deterioration in their health status. Such health care should include, for example, either by direct provision or by contractual agreement, primary health care services such as pediatric care (including well-baby care and immunizations), prenatal care, dental care, testing and treatment for sexually transmitted diseases, birth control, screening and treatment for hypertension, podiatric care, and mental health services.**

Outreach

As discussed throughout this report, homeless people have multiple service needs. The provision of such services is complicated by the state of being homeless. Although there have been occasional reports of homeless people refusing services, data from the 19 Johnson-Pew projects indicate that, when properly approached, the homeless welcome services. In fact, demand for services has exceeded earlier projections for the utilization of both health care services and shelter space (U.S. Conference of Mayors, 1986a; Wright and Weber, 1987).

Aggressive outreach efforts and coordinated case management are crucial to successful service provision to homeless people. Intensive efforts to identify homeless people who are in need of health care and other services, to determine eligibility for benefits, to encourage acceptance of appropriate treatment, and to facilitate receipt of services are needed.

The committee recommends that the Social Security Administration substantially expand its outreach efforts, already mandated by statute, to include sites at which homeless people congregate. Special efforts should be made to expedite the assessment of eligibility for disability benefits of

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chronically mentally ill people about to be discharged from institutions. For example, consideration should be given to:

- developing descriptive materials on the current prerelease program for use by the Social Security Administration's (SSA) local offices;
- requiring a specific period within which state agencies must file and act upon disability applications received as part of the prerelease program;
- amending SSI regulations to permit applications for SSI to be completed and processed (either granted or denied) before a person's discharge;
- requiring local SSA personnel to routinely seek, accept, and process disability applications from patients in state mental hospitals; SSA workers should be trained to become effective liaisons with institutions in their area; and
- establishing a system for collecting national, regional, and local data on approval or denial of SSI disability claims of individuals in institutions.

Given the apparent effectiveness of the Veterans Administration's (VA) pilot project to reach homeless veterans suffering from mental illness, the committee recommends the following:

- **Additional funding should be appropriated to allow the expansion of the outreach program to those facilities that did not receive outreach staff under the original pilot project and, when necessary, to allow additional staffing for those facilities serving geographic areas with a high prevalence of homeless people. Furthermore, ways should be found to expand the VA's outreach effort to include homeless veterans who are not chronically mentally ill.**
- Because the VA has already shown itself to be willing to assist in preventing homelessness by serving those "at serious risk" of becoming homeless, **the VA should consider expanding its efforts to include outreach to such institutional settings as mental hospitals, acute-care hospitals, and prisons so that assessment and placement can be arranged before people are released from such facilities.**
- The VA has given recognition to the possibility that some homeless veterans are "wary about coming to a hospital" (Rosenheck et al., 1987). **It is recommended that the VA consider alternatives to having psychiatric and medical assessments done at a medical facility and to determine whether changes will increase the number of veterans for whom follow-up care and placement is actually accomplished.**
- **The VA should increase its efforts to publicize its outreach program to providers of non-health care-related services to the homeless; as the outreach program becomes more fully established, the VA should pursue more formal means of linkage with other providers of services.**

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• During several of its site visits, including a site visit to the community placement program at the VA Medical Center in Lexington, Kentucky, committee members heard frequent reference to a lack of appropriate supportive residential programs for veterans from the Vietnam era. Programs such as the community placement program, although rendering excellent service to the older veterans from World War II and the Korean conflict, were not seen as appropriate for the younger, more active Vietnam veterans. Because the initial outreach effort has determined that a majority of the homeless veterans whom they have seen were from the Vietnam era, **the VA should place a greater priority on developing programs that are more appropriate for meeting the needs of younger veterans.**

Casework

After food and shelter, effective social casework is the fundamental service needed for nearly every homeless person. Such an approach, under appropriate professional supervision, is essential because of the multiple problems homeless people encounter in the complex interactions among employment, personal behavior, and public and private benefit and service programs. A coordinated local effort that enables public and private agencies to improve their communications would increase the likelihood that homeless people would use the programs and services to which they are entitled. In many communities, the creation of such a network will take time. Therefore, in the interim, the committee recommends the following:

• **Ways should be found for providers of services to the homeless, including, for example, shelters, soup kitchens, and drop-in centers, to make casework services available to all clients willing to accept them.** Such intensive case management should focus on enrollment for benefits, services management, health care management, services coordination, and vocational assistance. These efforts should be aimed at ending the client's homelessness and facilitating his or her reintegration into the community.

• **Casework services must be adequately funded.** Federal, state, local, and voluntary agencies that fund services to the homeless should be encouraged to provide adequate resources. For example:

1. For AFDC families, Federal Financial Participation for the administrative costs of casework should be increased as an incentive to states to increase their support (Chapter 4).
2. The Protection and Advocacy for Mentally Ill Individuals Act (P.L. 99-319), which currently applies only to mentally ill people in residential settings, should be amended to support protection and advocacy

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services for homeless people who are mentally ill, irrespective of their location.

Nutrition

Nutrition is of particular concern to the health and well-being of the homeless, who are usually too poor to purchase adequate food and who have no place to prepare it. For those who receive food in soup kitchens and shelters, they get what is available without regard for special dietary needs. Homeless infants, children, and chronically ill adults are especially vulnerable to nutritional problems. Therefore, the committee recommends the following:

- **Providers of food to the homeless, such as operators of shelters, soup kitchens, and food pantries, should be educated in and encouraged to follow principles of sound nutrition and the special nutritional needs of the homeless** (Chapter 3).
- **The recently established practice of permitting food stamps to be used at soup kitchens and other feeding sites should be extended to permit the use of food stamps to purchase prepared foods from restaurants and elsewhere** (Chapters 1, 2, and 4).
- **Because even the most prudent and imaginative parents in homeless families cannot provide adequate nutrition for young children at existing levels of food stamp benefits, such benefits should be recalculated to reflect realistic expenses to meet nutritional requirements.**
- The Special Supplemental Food Program for Women, Infants, and Children (WIC) provides food assistance and nutritional screening to women and children below 185 percent of the poverty level; however, funding for this program is not adequate to provide such benefits to all those who are eligible (U.S. Congress, House, Committee on Ways and Means, 1987). Because many homeless women are pregnant and a growing number of homeless people are children, it is especially important that **the WIC Program be strengthened in order to address comprehensively the nutritional needs of pregnant women and young children.**

Mental Health, Alcoholism, and Drug Abuse

Alcohol-related problems and mental disorders are the two most prevalent health problems among homeless adult individuals, and drug abuse appears to be on the increase. Since the early 1980s the National Institute of Mental Health, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute on Drug Abuse have each funded programmatic and basic research in these areas as they relate to homelessness. More recent programs, such as the community mental health

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services demonstration projects for homeless individuals who are chronically mentally ill and the community demonstration projects for the treatment of homeless individuals who abuse alcohol and drugs (as mandated by Sections 612 and 613 of the Stewart B. McKinney Homeless Assistance Act), have significant potential for combating the major problems of these populations. Increased efforts to aid other homeless people, whether they are individuals or families, should not be at the expense of these existing programs.

In recent years, the trend has been to separate programs that serve the mentally ill, alcoholics, and drug abusers. However, because there is growing evidence of dual and multiple diagnoses among these populations (see Chapters 1 and 3) and because there are certain basic similarities in efforts to provide treatment, those recommendations that address elements common to programs that treat individuals with all three diagnoses are identified before those recommendations relating to individuals with a specific diagnosis. In seeking to resolve the very complicated interrelationships among homelessness and mental illness, alcoholism, and drug abuse, the following services should be included:

- **targeted outreach services** directed at homeless individuals suffering from mental illness, alcoholism, or drug abuse;
- **supportive living environments** encompassing programs ranging from the most structured to the least structured; this is necessary so that as the individual improves, progress can be made through several stages of decreasing support and on to independent living, when possible (some will need various support services throughout their lifetimes);
- **treatment and rehabilitation services** appropriate to the individual's diagnosis and functional level; this must be a range of such services so that, again, the individual who improves can become less dependent on such programs while moving to self-sufficiency; and
- **specialized case management** provided by professionals who not only understand the complexities of these illnesses as they relate to homelessness but who also understand the complexities of systems that seek to provide mental health, alcoholism, and drug abuse services.

In addressing the issues of the mentally ill, alcoholic, or drug-abusing homeless, the committee saw repeated reference in the literature and heard from those actively engaged with these populations that **greater communication, consultation, and continuing liaison** between providers of services are needed. This is especially true for homeless adult individuals who suffer from more than one of these diagnoses, who suffer from one such diagnosis along with some other disabling condition (e.g., a physical disability), or who suffer from one form of substance abuse while using other substances as "enhancers." It is critical that **people suffering from**

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dual or multiple diagnoses (physical illnesses, mental disorders, and addictions) not be left unserved or underserved because of the overspecialization of treatment programs. It is far more cost-effective to coordinate existing services than it would be to create new treatment programs directed at each possible combination of diagnoses.

With regard to specific problem areas, the committee offers the following conclusions and recommendations.

Mental health. The institutional mental health system appears to be an inappropriate place to focus policymakers' attention in trying to resolve the broad problems of homelessness. Proposals purporting to resolve the problem of homelessness by changing commitment laws or by substantially relaxing standards for admission to mental hospitals are misguided and lead to an erroneous belief that the mental health system alone can correct a problem for which all systems bear a responsibility. The central issue in mental health care is the lack of an adequate supply of appropriate and high-quality services throughout the mental health care system, including state psychiatric centers and psychiatric units in acute-care hospitals and in the community. **The committee recommends that the first priority in addressing the problems of the mentally ill homeless must be to ensure the adequate availability of clinical services (including professionally supervised supportive housing arrangements) at all levels.** Of these, the most serious deficiency between supply and demand—and that which is most directly linked to homelessness—is at the community level.

Alcoholism and alcohol abuse. In addition to an inadequate supply of those services cited earlier (outreach, supportive living, treatment, and case management) as they relate to homeless individuals suffering from alcoholism, the committee notes a serious shortage of services directed toward the specific relationship between alcoholism and homelessness. In light of the fact that studies have shown that homeless alcoholics are at significantly greater risk of certain health problems (e.g, tuberculosis and hypothermia) than nonalcoholic homeless individuals and that alcoholism may become an integral part of the life-style of homelessness, the treatment of alcoholism among the homeless in the same manner and at the same locations as those for the domiciled alcoholic may not be the most effective. **The committee recommends that both public and private agencies and organizations treating alcoholism develop programs specifically for the homeless and those alcoholics at high risk of becoming homeless.** The committee notes that recent developments such as alcohol-free living environments (e.g., "sober hotels") and programs that combine both medical and social approaches to the treatment of alcoholism appear to be especially promising.

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Drug abuse. While not yet as prevalent as mental illness or alcoholism among the homeless single adult population, drug abuse, especially among younger adult men, is increasing. In particular, because of its close correlation with AIDS, the issue of intravenous drug abuse has come to greater public awareness, as has the inability of the existing drug abuse treatment system to respond to the increased demand for treatment services. **The committee joins with others in recommending that treatment services for intravenous drug abusers be increased to the extent that anyone desiring such services can be accommodated**. The cost of such services is relatively minor when compared with the costs of treatment and care for those physical diseases associated with intravenous drug abuse, such as AIDS and hepatitis.

The prevalence rates for mental illness, alcoholism, and drug abuse are much lower among adults who are members of homeless families than among homeless adults who are not, but the fact remains that such health problems are more prevalent among homeless parents than among the general population. Furthermore, the long-term impact on treatment programs and social service systems resulting from the effect of the parents' problems on the children could become very costly in the future. Both in terms of their value as a preventive measure and as the more cost-effective approach to contain the need for such services years from now, the committee recommends that **the relevant federal, state, and local agencies, as well as the relevant private not-for-profit agencies, should begin to examine alternate ways to treat mental illness, alcoholism, and drug abuse among homeless parents, giving due consideration to the limitations of time and mobility inherent in a parent's role**. In addition, **Congress should consider extending the provisions of the Stewart B. McKinney Homeless Assistance Act of 1987 that currently deal with mental illness and the treatment of alcoholism and drug abuse in individual adults to cover homeless parents, children, and adolescents as well**.

Convalescent Services

The committee recommends that Federal Emergency Management Administration funds and other funds be made available, in every community, to support the development and operation of facilities in which homeless people can safely convalesce from subacute illnesses or transient exacerbations of chronic illnesses, or to which they can safely and appropriately be discharged from acute-care facilities. As described in Chapter 3, adequate health care for homeless people is often made impossible by the simple absence of a secure place for them to convalesce. There is a clear need for facilities that provide appropriate rest and nutrition as well as limited personal care for periods generally not in excess of 30 days.

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Other Services

The Stewart B. McKinney Homeless Assistance Act of 1987 (P.L. 100-77) creates a federal Interagency Council on the Homeless and charges it to "review all federal activities and programs to assist homeless individuals." This study committee, in the course of its many site visits, observed several programs that are partially federally funded. For example, the Cardinal Medeiros Center in Boston receives some of its funding under the Older Americans Act (P.L. 89-73), and the Larkin Street Youth Center in San Francisco receives some of its support under the Runaway and Homeless Youth Act (P.L. 98-473). Often, these programs are not targeted directly toward, or identified with, the homeless. In some cases, such funding is due to expire along with the enabling legislation.

The committee recommends that the interagency council mandated by P.L. 100-77 give high priority to its review of all programs that might be of assistance in helping subpopulations among the homeless, irrespective of whether such programs are specifically directed toward helping homeless people. The council should:

- conduct an extensive review of such support programs, primarily to identify programs that are providing or that could provide help to subpopulations among the homeless;
- review joint federal–state efforts, such as state veterans homes with partial federal funding, that, although not targeted directly to the homeless, might help many homeless people;
- publicize successful efforts to help the homeless as a means of encouraging other groups to develop similar programs in their communities; and
- consider ways and means of extending or enhancing the funding for programs that are deemed effective in relieving or preventing homelessness until the current prevalence of homelessness is substantially reduced.

Special Needs of Homeless Children and Their Parents

The committee feels strongly that the growing phenomenon of homeless children is nothing short of a national disgrace that must be treated with the urgency that such a situation demands. The committee has chosen to offer a number of recommendations relating to services for homeless children, only because it believes that the fundamental reforms to income maintenance programs, the child welfare system, and foster care programs will take a number of years to implement and that, in the interim, the tens of thousands of homeless children are in urgent need of a broad range of services.

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Recent studies have documented that the majority of homeless children of various ages manifest delayed development, serious symptoms of depression and anxiety, or learning problems (Bassuk and Rubin, 1987; Bassuk and Rosenberg, 1988). These are early signs that vulnerability is turning into disability for these youngsters; efforts by human service professionals may be able to reverse these liabilities and to prevent further damage. There is now a considerable body of evidence demonstrating the benefits to disadvantaged and disorganized families of intensive family-oriented services; such approaches are characterized by flexibility in meeting families' multiple needs and by specific aids such as developmental day care, infant stimulation programs, parental counseling, and Head Start. Such intensive intervention efforts—even if expensive to begin with—have proved to be cost-effective in the long run (Schorr, 1988). Because the homeless are an especially vulnerable subpopulation of poor people, the committee believes that such programs would be of similar benefit to this group. It recognizes that because the population of homeless families includes some of the most hopeless and alienated among the poor—and because they are more likely to move from place to place—there may be obstacles to participation in such programs; therefore, the committee recommends the following:

- **Federal support for enriched day care and Head Start programs should be expanded and coupled with the development of outreach efforts to encourage homeless parents to take advantage of enrichment programs for themselves, their infants, and their young children.**
- **Local and state agencies that receive federal Head Start funds should be mandated to develop plans to identify and evaluate homeless children of preschool age and to provide them with appropriate services.**
- **Federal support for local and state education agencies should be conditional on the adoption of plans for identifying, evaluating, and serving homeless children of school age, including needed transportation services. These plans should include specific mechanisms for liaison and service coordination among educational, shelter, and social service agencies** (Chapters 1 and 3).
- **Apart from any mandates that may accompany federal support, community agencies—acting in concert with school boards, local philanthropies, and other organizations—should be encouraged to develop programs of family-oriented services for homeless children and their parents. Such services need to be both intensive and comprehensive.**

Shelters

In the committee's view, **shelters should not become a permanent network of new institutions or substandard human service organizations.**

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As desirable housing is developed, the shelter system should be substantially reduced in size and returned to its original intent to provide short-term crisis intervention. In the interim, the committee recommends that action be taken to reduce the hazards to the health of homeless people that may be created or exacerbated by shelters.

- **The federal government should convene a panel of appropriate experts to develop model standards for life and fire safety, sanitation, and disease prevention in shelters and other facilities in which 10 or more homeless people are domiciled.** This code should be predicated on the recognition that shelters, welfare hotels, and the like should provide short-term, emergency housing and are not satisfactory longer term substitutes for housing and other services (Chapters 2 and 3).
- Once a model code is developed and after a reasonable amount of time has passed for compliance to be obtained, **the federal government should adopt the standards as a condition for receipt of Emergency Assistance payments or other federal assistance, including Federal Emergency Management Agency funds.** However, Federal Emergency Management Agency funds should be made available to assist existing shelters to achieve compliance with the standards.
- **The federal government should disseminate the model code to encourage voluntary compliance.** State and local governments should be encouraged to adopt it on a mandatory basis for shelters that do not receive federal funds but that do receive funds from state and local governments.
- **Adequate provision must be made to shelter families as a unit.** The consequences of homelessness are serious enough without being worsened by family disruption.
- **In light of the increasing prevalence of sexually transmitted diseases, including AIDS, and unplanned pregnancies among the homeless, the committee recommends that shelters, particularly those used by younger single men, women, and adolescents, provide birth control counseling and services, including free condoms, to reduce the risks of these conditions** (Chapters 1 and 3). It is recognized that data on the effectiveness of these recommendations in shelter populations do not exist and that many individuals, including some providers of services, may have ethical or philosophical objections, but it is the consensus of the committee that this recommendation represents sound public health practice.

Volunteer Efforts

The provision of services to homeless people depends heavily on the efforts of volunteers. Even with the recommended expansion of federal, state, and local government support, volunteers will be needed. The

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committee believes that the extraordinary contributions of services to homeless people by volunteer professionals and laymen must be better recognized, encouraged, and rewarded. **Federal, state, and local governments and local United Way and other charitable agencies should work with service-providing organizations to improve their capacity to recruit, train, use, and recognize volunteers**. Universities should play a major role in providing support by using programs for the homeless as part of their training curricula, especially in social work, law, medicine, dentistry, nursing, optometry, and the allied health professions. Not only would this improve the quantity and quality of volunteer efforts, but it would also provide students with extraordinary learning experiences and make them more sympathetic to those whom they will serve during their careers. Hospitals and other health care facilities should be encouraged to provide in-kind support (including clinic space and medications) for volunteers in their communities who help the homeless. Health professionals and lawyers should be encouraged to provide *pro bono* services, and professional organizations on the national, state, and local levels should establish formal programs in support of such efforts and provide recognition of those who provide such services.

State insurance commissioners should take measures to prevent carriers of medical, professional, or institutional liability insurance from charging additional, excessive, or discriminatory premiums or refusing to provide coverage for health care providers who serve the homeless without adequate documented actuarial experience to justify such action. This is especially critical in regard to malpractice and liability insurance because it is already difficult to recruit volunteers and to create university affiliations for training in the settings in which homeless people are served; these programs can ill afford to bear the additional burden of excessive insurance premiums or the potential loss of coverage.

Research

Many questions about the health of the homeless remain unanswered. Research is needed to elucidate the health and mental health disorders of the homeless, the methods of providing health care, and the factors that affect accessibility.

The Johnson-Pew Health Care for the Homeless projects provide the only extensive data base on the general health condition of homeless people (Wright and Weber, 1987). The shortcomings of these data are that they document health problems in individuals seeking help at clinics and are based on presenting complaints rather than systematic health evaluations; therefore, hidden health problems are not included.

There are no longitudinal data that document the fate of homeless

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people. For example, it is a frequent observation that there are relatively few homeless people over the age of 50, but the reasons for this are unknown. Though there have been calls from many quarters for additional resources to meet the needs of homeless people, there is still a paucity of information as to the ways in which resources should be allocated.

Various subgroups of the homeless have different health service needs; to consider the homeless as a homogeneous population is to be mistaken. Research is needed to identify the various subgroups of homeless people and their particular problems and health service requirements. Regional variations are also important; the problems of displaced workers in rural areas or small towns of the South or Midwest can be very different from those of displaced factory workers in the eastern industrial cities, which have more diversified economies.

Specific disorders deserve particular attention by researchers in epidemiology and health care services. These include tuberculosis and AIDS. Alcoholism has traditionally been and continues to be the most prevalent single medical condition of homeless people; improved methods of outreach, detoxification, rehabilitation, and long-term maintenance should be developed and evaluated. Abuse of other drugs also needs further research. The National Institute of Mental Health and the Robert Wood Johnson Foundation are to be especially commended for the initiatives that they have taken in encouraging and supporting research in the financing, organization, and delivery of services to the severely mentally ill.

Public and private research funding organizations should encourage research into the dynamics of homelessness, the health problems of homeless people, and effective service provision strategies. Specifically, the following research is most critically needed:

- longitudinal studies of the natural history of homelessness;
- studies of the prevalence of acute and chronic diseases in homeless populations;
- the role of illness as a precipitant of homelessness and the ability of health care and social service systems to prevent this outcome;
- studies of the homeless population and the prevalence of infectious diseases (e.g., tuberculosis, hepatitis, and AIDS) and chronic disorders or disabilities (e.g., mental retardation and epilepsy);
- studies of effective treatment programs for homeless alcoholics;
- development and evaluation of programs for homeless people who are mentally ill; and
- studies of the effects of homelessness on the health and development of children and evaluation of strategies to prevent homelessness in families and to give additional support to homeless families.

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NOTE: Additional reference documentation for material in this Summary and Recommendations is presented in the respective chapters of the full report.

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ELLEN L. BASSUK, M.D., is associate professor of psychiatry at Harvard Medical School. She has completed various research studies and written extensively about the origins of homelessness, the needs of homeless families, and the impact of homelessness on children. In 1988 she became president of The Better Homes Foundation in Chestnut Hill, Massachusetts, a new organization created to help homeless families.

WILLIAM R. BREAKEY, M.D., is currently the director of the Community Psychiatry Program at the Johns Hopkins School of Medicine as well as associate professor in the Department of Psychiatry and Behavioral Sciences. He has carried out research on homeless persons suffering from mental illness and alcohol problems and has provided clinical care for them.

A. ALAN FISCHER, M.D., is professor and founding chairman of the Department of Family Medicine at the Indiana University School of Medicine. A practicing family physician since 1953, Dr. Fischer is active in educating students and young physicians to meet people's primary health care needs.

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JUDITH R. LAVE, Ph.D., has been a faculty member at Carnegie Mellon University; director of the Division of Economic and Quantitative Analysis, Office of the Deputy Assistant Secretary for Planning and Evaluation, Department of Health and Human Services; and director of the Office of Research in the Health Care Financing Administration. She is currently professor of health economics at the Graduate School of Public Health, University of Pittsburgh.

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NATHAN J. STARK, a lawyer, is senior vice chancellor emeritus for Health Sciences, University of Pittsburgh, and president emeritus of the University Health Center of Pittsburgh. He served as undersecretary of the U.S. Department of Health and Human Services in 1979–1980.

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PHYLLIS B. WOLFE, M.S.W., A.C.S.W., developed a prototype mental health care program for the homeless in Washington, D.C., and was its project director from 1981 to 1985. In 1984–1985 she designed and implemented the Public–Private Partnership Health Care for the Homeless Demonstration Project in Washington, D.C., sponsored by the Robert Wood Johnson Foundation and the Pew Memorial Trust; she continues to serve the Project as its executive director.

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