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Homelessness, Alcohol, and Other Drug Abuse

Research Traditions and Policy Responses

Gerald R. Garrett

Although homeless alcoholics and other drug abusers more often elicit public scorn than sympathy, ironically they enjoy a celebrity status as research subjects. This article provides an overview of research literature on the homeless and their alcohol and drug problems. The evolution of public policies concerning control, rehabilitation, and treatment of homeless substance abusers is also traced with special attention to the interaction between scientific literature and policy responses over the past century. Although homeless populations today are more diverse than their counterparts in earlier decades, the analysis suggests that the policies and programs developed in response to the crisis of homelessness and substance abuse in the 1980s and 1990s reflect themes that are also evident in early literature.

History has not been kind to homeless alcoholics.¹ For more than a century they have collected such labels as winos, degenerate derelicts, morally inferior, and from the Victorian era, whiskey bummers.² As late as the 1960s, newspaper journalists called their habitats a “house of horrors,” their panhandling “The Touch of Terror,” and complained that a “Wave of Bums Sweeps Over Parks, Streets.”³ Nor have other drug abusers — those using cocaine, heroin, more recently crack, ice, and other illegal substances — fared better, even though their presence in large numbers does not appear in homeless populations until the 1960s and early 1970s.

As a Boston police officer complained, “These are your lowest types of homeless street people. They steal, they bum, they prey off others, they spread disease, they commit crimes and they cost taxpayers millions every year!” According to a case manager at a Connecticut shelter, “Drug abusers are our most difficult guests. They are typically on the outs with the law and are very often treatment resistant.” Alcoholics and drug abusers, thus, are probably the least likely of any group in the homeless population to elicit public sympathy. In fact, while recent surveys suggest that not only are some communities losing patience with the plight of the homeless in general, they are even more frustrated when it comes to tolerating the problem behaviors associated with homeless substance abusers.^{4,5}

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In contrast, homeless substance abusers, alcoholics in particular, have for decades enjoyed a celebrity status within the research community. Although their numbers constitute only an estimated 10 percent of the overall population of substance abusers, they have come to be one of the most studied groups in addiction literature.⁶ For more than a century, researchers from a variety of disciplines and clinical fields — psychology and psychiatry, medicine and nursing, political science and public administration, human services and social work, urban planning, education, criminal justice, anthropology, and especially sociology — have in ways elevated homeless alcoholics and drug abusers to a place in scientific literature out of proportion to their representation in the population of substance abusers.⁷

Although a number of reasons — some scientific and theoretical, others pragmatic and humanitarian — account for the disproportionate growth of this body of knowledge, collectively this literature offers policymakers an invaluable information base to inform their decision making. In fact, historically a significant number of studies on homelessness, including those concerning alcohol and drug problems, have been concerted efforts to develop and guide policymaking on urban renewal, rehabilitation services, public housing, human services, public health, law enforcement, and other policy domains.

Because alcohol and other drug problems continue to have an impact on homeless populations, the purpose of this article is to provide an overview of past and recent studies with special reference to how this research literature interfaces with policy responses. Curiously, while contemporary studies identify a “new homeless” that is more demographically diverse, more stratified in the prevalence of health problems, and perhaps even more disenfranchised than its counterpart in earlier decades, it is nevertheless clear that many of the observations and policy recommendations in current literature reflect themes that are evident in the 1950s and earlier. As Howard Bahr points out, “It turns out on inspection that the past *is* relevant after all, although from the typical report on contemporary homelessness one would be led to believe that we confront a totally new situation.”⁸

Epidemiology of Alcohol and Drug Problems

Whatever the differences in today’s homeless population compared to its counterparts in past decades, one problem in particular has remained constant: alcohol and substance abuse. Although early studies reporting prevalence rates of alcohol abuse often utilized unsophisticated methodologies by present standards, overall results have been remarkably consistent over the decades. For example, early studies by McCook (1890) in a national survey, Marsh (1900) in Philadelphia, Cook (1910) in New York, Anderson (1920s) in Chicago, Hoffer (1930s) in California, Straus in New Haven and Stearns and Ullman (both in the 1940s) at Tewksbury, Massachusetts, Caplow (1950s) in Minneapolis, and Bogue (1960s) in Chicago report prevalence rates of alcoholism ranging from a low 28 percent to as high as 57 percent of the homeless population, yet most falling within a 30 to 40 percent range.⁹ While these variations may have been due to population differences by city location, they can also be accounted for by differing methodologies and oftentimes crude definitions of alcohol abuse. Thus McCook took “arrest for public drunkenness” and Hoffer used “confirmed drunkard” as indicative of alcoholism; others

adopted definitions, such as "drink to excess," "steady, excessive consumption," or "heavy drinking."

Ironically, while modern methodologies are far more complicated, their results based on the "new homeless" populations yield almost identical prevalence rates and similar variations to those in early times. Across major U.S. cities, for example, studies of the homeless indicate alcohol abuse or alcoholism prevalence rates from 9 percent in Ohio, 15 percent in New York State, and 25 percent in Los Angeles to 32 percent in San Diego, 35 percent in Portland, Oregon, and 45 percent in Boston.¹⁰ Even within a single city, such as Boston, estimates vary from 25 to 45 percent. Fischer, who has charted and analyzed studies through the 1980s, found that nationwide results on alcohol-related disorders among the homeless show a range of 2 percent to as high as 86 percent.¹¹ As in earlier decades, most estimates cluster in the 30–40 percent range.¹²

Other drug abuse, of cocaine and its derivatives, heroin, and other illegal substances, is also a long-standing problem among homeless people, especially within the past three decades. Both Milburn¹³ and Fischer¹⁴ observed that recent studies provide prevalence estimates ranging from a low of 2 percent to as high as 70 percent (and occasionally higher, depending on study site). Most estimates cluster between 10 and 15 percent.

Current studies show that alcohol and other drug-abuse problems affect a significant number of homeless people. In fact, results from the national Health Care for the Homeless projects, which established a database on homeless clients at clinics in nineteen U.S. cities, identified alcoholism as the most frequent single disorder diagnosed.¹⁵ Moreover, collective evidence suggests that the homeless may have a prevalence rate of alcoholism at least nine times higher than the community at large.¹⁶

Yet it is also clear from recent studies that "dual diagnoses" or comorbidity, that is, the coexistence of substance abuse and mental health disorders, are also prevalent within the homeless population. Fischer and Breakey point out that current research suggests that from one half to three quarters of the homeless population have at least one alcohol/drug/mental health (ADM) disorder. Dual diagnoses, however, show prevalence rates ranging from 2 percent to 34 percent; about one fourth of these evidence an alcohol and mental health disorder and up to one third are diagnosed with concurrent alcohol and drug problems.¹⁷ Less commonly seen among homeless populations in earlier decades, comorbidity, including multiple diagnoses, creates difficult treatment circumstances, especially when alcohol or drug abuse coexists with a psychiatric disorder.

Broad prevalence estimates, however, obscure the subgroups who are most or least affected by substance-abuse and other disorders. This information has particular relevance to policymakers and program planners, since these data help define target groups more clearly. Collective evidence from a number of reports reveals important differences within the homeless population.¹⁸ For example, men are more likely than women to evidence alcohol and drug abuse, though this sex difference is least observed on drugs. The use of drugs is also more commonly seen among younger men than in older age groups (thirty to sixty-four years), who are most likely to be traditional alcoholics resembling those of past generations on skid row. If men are more likely to evidence a single diagnosis of alcoholism, women are more likely to have a single mental disorder. Still other findings document important

differences by psychosocial, race, ethnic, and other demographic characteristics and by service utilization patterns.¹⁹ Thus, while overall evidence suggests that substance abuse remains as the major health problem facing the homeless, as in earlier decades, it is also clear that homeless substance abusers today are more diverse in their composition and rehabilitation needs than ever. As a result, policy and program solutions will require a sensitivity to this diversity and a creativity in their approaches if efforts to return this population to self-supporting, independent, and especially sober lifestyles are to be successful.

Control, Rehabilitation, and Public Policy

Since homeless alcoholics and drug abusers have historically acquired unflattering labels, even public scorn, it is not surprising that efforts to control and later to "rehabilitate" them show a checkerboard evolution that includes cycles of containment to skid row districts; relocation efforts that remove them from their natural habitats into work camps, police farms, poorhouses, and county psychiatric facilities; and more recently various forms of what can be called treatment and rehabilitation. Yet throughout this evolutionary process, it has always been true that homeless substance abusers have been virtually powerless to influence, much less determine their fate at the hands of public policy. In fact, if they have wielded any influence at all over the years, it has typically come in the form of resistance to or avoidance of public programs for their benefit or of becoming uncooperative, if not unruly clients. Even today this form of resistance plagues often well-designed, even creative programs for the homeless. As a defiant homeless substance abuser in a New England city complained, "This [veteran's] program robs me of my self-respect and that paperwork makes me feel like I should get down on my knees begging for help. Never!"

Approaches to controlling and rehabilitating alcohol and drug abuse, however, are historically tied to public views on the causes of homelessness and of substance abuse, as well as to public perceptions of the degree to which the homeless themselves are responsible for their misfortunes and their misbehaviors. This latter point assigns a double stigma to homeless substance abusers, which historically has complicated efforts to formulate and implement viable policies and programs on their behalf. For close to a century, researchers and policymakers alike have debated the role of alcoholism, in particular, as a principal cause of homelessness. Put another way, is alcoholism (and other drug abuse) an antecedent, a concomitant, or a consequence of homelessness? Or is it a combination of all of these? Answers to this question have taken different forms over the past century.

Historical Background

Early policy and program approaches related to homeless substance abusers are closely tied to the issue of vagrancy, one component of which was drunkards. Initial studies by McCook, Marsh, Cook, Anderson, and others,²⁰ are careful to document the proportion of homeless who "drink to excess" or who have been arrested for public intoxication, which functioned to stratify and separate presumed alcoholics from other, more respectable homeless subjects. Regardless, vagrancy (and wanderlust), unemployment, as well as drunkenness, are treated throughout the 1800s and even after the turn of the century as vices. Public policies emphasized

repressive measures that rendered indulgence in these vices costly to the offenders. In 1895, McCook, for example, who was an authority on homelessness in Massachusetts, submitted a proposal to the National Conference of Charities and Correction that would solve the so-called tramp problem by utilizing indeterminate prison sentences, thus keeping them confined until their reformation was completed.²¹ Still others proposed or implemented labor colonies and work-houses.²² In Detroit, for example, "get tough" policies, including forced labor, were well established by the 1880s.²³

But even in this early era there were advocates of rehabilitating the homeless, including those with alcohol problems, that resembled modern understanding of this concept. An advocate for labor colonies, Edmond Kelly nevertheless observed that there must be a balance between rehabilitative and custodial objectives in institutional programs for the homeless. His proposal directed municipal lodging houses to screen clientele so as to identify the honest unemployed men, the unfortunate impoverished, and the "social parasites," which included the drunkards. Each type would receive appropriate rehabilitation.²⁴

During the 1880s, the Salvation Army also brought enlightenment to the American public with its evangelical mission of "effectual help for the drunkard," which has served as its guidepost for more than a century. As Stoil explains, "One crucial component of this effectual help was early recognition by the Salvationists that the repeated cycle of arrest for public inebriation, incarceration in a jail 'drunk tank' or an asylum and subsequent release into the same environment in which public drunkenness was commonplace did nothing to address the self-respect or long-term recovery of the alcoholic."²⁵ Although the public sector was not quick to adopt this principle, it served as a foundation for developing community-based facilities where homeless residents could address their alcoholism, simultaneously developing work skills in an environment of evangelical Christianity. Nor were Salvationists passive in recruiting homeless alcoholics into their facilities, evidenced by the outreach efforts organized by their Bowery Mission. They were conducted on Washington's Birthday and Thanksgiving Day — known as Boozers' Days — when mission officers would comb lower Manhattan in search of public inebriates.²⁶

The Depression Years

Due principally to the onset of the Great Depression, public policies concerning both the homeless and their alcohol and drug problems begin to shift in the 1920s and 1930s toward centralized, more concentrated programs of care. As Bahr notes, "The federal government had moved into the 'treatment of vagrancy' business on a large scale."²⁷ At the same time, the problem of chronic, public inebriates was more evident than ever, and while there emerged both public agencies and private charities to serve the needs of the homeless, few had little to do with alcoholics, that is, other than police and jails.

Moreover, the position of many public spokesmen remained harsh, evidenced by a 1928 paper on "psychopathic vagrancy," which held that breadlines encouraged vagrancy and that vocational programs would not keep derelicts off city streets. Despite its provisions for treatment by psychiatrists, in the end control and rehabilitation of vagrants and public inebriates were left exclusively to police, the courts, and of course jails, since there were not enough psychiatrists to handle other, non-homeless people during the Depression.²⁸

Nevertheless, massive research studies and commission investigations were also hallmarks of this era. Nels Anderson, who had authored an important work in the 1920s, *The Hobo*, chronicled the devastating consequences of the Great Depression in his *Homeless in New York City* and *Men on the Move*, which brought him to a conclusion that a permanent class of homeless people was emerging. In *Twenty Thousand Homeless Men* (1936), Sutherland and Locke observed that Chicago's homeless suffered from multiproblems, including an estimated 10 percent alcoholics and as many as 20 percent afflicted with psychotic disorders. And in 1932, a report from the Illinois Relief Commission's investigation portrayed the hopelessness and despair that cut across all homeless people of that time, pointing to a need to coordinate government efforts at intervention.

Essentially the same results were reported again in 1937, this time calling for integrated, comprehensive programs to assist all homeless, including those with alcohol and other health problems.²⁹ Collectively, these reports suggested that the public image of homeless alcoholics was gradually shifting from "morally inferior derelicts" to one that recognized them as a different type of homeless person requiring special care, even though the police and jails remained their principal caretakers in the years following.

Skid Row and Urban Renewal

Although enclaves of homeless people have sprung up in the form of "hobo jungles," shantytowns, and so-called Hoovervilles throughout the history of urban and rural America, skid row in particular has come to personify the public's image of homeless people and their lifestyles. Its emergence in American cities began in the latter decades of the 1800s, and by the end of the Great Depression, when homelessness reached a peak, virtually every major city had laid claim to a skid row district. In Boston, it became Dover Street; in Chicago it was West Madison Street; in Minneapolis, the Lower Loop; and in New York it was, of course, the famed Bowery. Smaller cities, too — Providence, Richmond, Rochester, Toledo, Sacramento, Spokane — developed skid row districts.

Skid row gets its name not from the cities that have made it infamous, but from Seattle, where it is more commonly called skid road. While its name connotes the downward social mobility associated with homelessness, its origin derives from the skidways used by Seattle's lumberjacks in the 1800s to slide logs to Yesler's Mill on Elliot Bay. Near these routes, but especially at Pioneer Square, saloons, rooming houses, single-room-occupancy hotels, cafeterias, and religious missions sprung up to serve loggers and other clientele. Over time this district collected large numbers of the unemployed, social misfits, and especially alcoholic derelicts.³⁰

While the Great Depression swelled skid row populations nationwide to all-time highs, World War II brought about significant decreases, since younger, able-bodied men went off to war, leaving others to take on jobs that contributed to the war effort. Yet this population decline was short-lived, and during the economic downturn of the 1950s, skid rows became busy, albeit problematic neighborhoods. In fact, most skid rows had become rampant with blight, failed businesses, decrepit, often unoccupied buildings, due to years of neglect and poor city services.

It is no wonder, therefore, that the 1950s helped to focus attention on urban renewal that could enhance the quality of land use. It offered opportunities to increase tax revenues, to reduce if not eliminate nuisance crimes typifying most skid

row neighborhoods, to upgrade the city's image, and especially to attract the middle class back to the city.³¹ But in order to implement urban renewal policies, something had to be done with the homeless people who lived on skid row.

To "solve" this problem, throughout the 1950s and 1960s, many cities enlisted the help of survey researchers, most of them sociologists who had long been attracted to issues on poverty and inner-city life. In Minneapolis, a team of researchers headed by Theodore Caplow began a major study of the redevelopment area and the homeless people who lived there. Supported by a coalition of private businesses in Philadelphia, known as the Greater Philadelphia Movement, Leonard Blumberg and his associates undertook a study of some 2,200 homeless residents in the inner city. Commissioned by the city of Chicago, Donald Bogue undertook a massive study of Chicago's skid row districts, giving special attention to the implications of these data for relocating homeless residents in suitable housing. Detroit, too, undertook a similar endeavor, which was headed by H. Warren Dunham. And in the mid-1960s, federal funds from the National Institute of Mental Health supported a major study of New York's homeless men with Theodore Caplow as principal investigator and Howard Bahr as project director. Later in the 1960s, Bahr and Garrett undertook still another NIMH-funded study on homelessness in New York, this time focusing on homeless women. Known as the Urban Disaffiliation Project, it was the first major study of homeless women.

In all these projects, investigators gave special attention to the problem of substance abuse among the homeless, each reporting similar prevalence rates for skid row men. While they were not the first to study homeless alcohol and drug abusers, the comprehensive scope of these studies generated large amounts of quantitative, even qualitative data that could be infused rapidly into research literature on substance abuse and other disciplines. Despite their applied research approach, these studies represent substantial pieces of scholarship that provided comprehensive, detailed information about the homeless and their substance-abuse problems. Moreover, because most of these studies were commissioned or funded by city, state, or federal government sources for specific purposes, their findings helped to inform their immediate audience comprised of policymakers, government administrators, and professional personnel about the alcohol and drug problems of homeless people.

Large survey studies were not the only pieces of important scholarship during the 1950s and 1960s. Ethnographic works by Peterson, Rooney, Spradley, and especially Rubington offered rich insights into the subculture of homeless alcoholics, including their experiences in jails, drunk tanks, and rescue missions, as well as on the group dynamics of "bottle gangs" and communal circumstances in bars and skid row hotels. Later Wiseman contributed a particularly significant work that explains how skid row alcoholics assign meaning to events in their repetitive cycles through the criminal justice system, spiritual missions, treatment facilities, and other institutions.³²

That alcohol and drug problems of the homeless achieved higher visibility during this era is also evident by professional meetings convened around the issue. In September 1955, the first annual International Institute on the Homeless Alcoholic was convened in Detroit. Its proceedings help to document a link between research and clinical literature on alcoholism among the homeless to policymakers and public administrators. Considering the emphasis on urban renewal in the 1950s, no article is perhaps more germane than that of Arthur Stine, "Rehabilitation of the Alcoholic

and What It Means to the Taxpayer!"³³ Though renamed and relocated in subsequent years, its proceedings are evidence that programmatic and treatment approaches, especially, were central concerns. Of particular note from the second conference in 1956 was the article written by Morris Chase — then a bureau director in the New York City Department of Welfare — "The Homeless Woman Alcoholic," about his concerns that more women alcoholics could be expected to enter the ranks of the homeless.³⁴ A little more than a decade later, data collected in Bahr and Garrett's study of homeless women in New York proved that he was absolutely correct!³⁵

Public Inebriates and the Police

Throughout the history of skid row, police have had a "special relationship" with homeless alcoholics! On the one side, police served as caretakers, though never in the conventional sense. During the heyday of skid row, police protected homeless people by "moving them on" so that they might avoid a "pinch" or seek safe haven from the elements at a mission, shelter, or even an abandoned building. Protecting public inebriates from victimization, especially from "jackrolling" or robbery, is still another, though rarely successful service. Even the routine police sweeps when public drunks were rounded up and jailed, known in police jargon as "preventive arrests," had its benefits during cold winter months, since it provided inebriates with a safe place to sleep off their liquor, three "square meals," and a cot!³⁶ In this respect, homeless alcoholics have enjoyed a benevolence that police have never extended to homeless drug abusers, at least in quite the same way, partly because their illicit activities more often involve felony infractions rather than the misdemeanors typical of public inebriates.

On the other side, the peace-keeping role of police served a containment function, keeping skid row residents, especially public inebriates, in their place. In virtually all skid row police precincts, unofficial police policy awarded officers wide discretion to exercise their containment role.³⁷ Curiously, as urban renewal began to achieve its development goals in the 1960s and 1970s, its success helped to disperse ecological concentrations of homeless people from skid row, thus breaking down the containment effect. This breakdown in part explains the extraordinary visibility of homeless people in most urban centers in the 1980s and 1990s.

Court Decisions

If there is a single hallmark in the history of scientific literature on alcohol and drug addiction, it is certainly E. M. Jellinek's classic volume, *The Disease Concept of Alcoholism*. Beginning in the 1940s, Jellinek's work helped set in motion the concept that alcoholism was a disease involving a configuration of social, psychological, and medical symptoms, including dreaded alcohol-related ailments such as liver disease and pancreatitis. While the disease concept has had major impact on research and clinical literature, public sentiments about alcoholism also began to change. The dramatic growth and success of Alcoholics Anonymous, which got its start in the 1930s, played a major role in changing public attitudes about the causes of alcoholism and in lessening the public stigma assigned to alcoholics.

By the 1960s, however, growing public acceptance of the disease concept served as an impetus that led to important landmark court decisions concerning public inebriates and vagrancy. In *Robinson v. California* (1962), the U.S. Supreme Court

ruled that drug addiction was not per se a punishable offense when the drug user was "diseased and lacked volition in regard to drug use." This enabled two important arguments to come into play: the cruel and unusual punishment doctrine contained in the Eighth Amendment and the precept that "a person cannot be punished for an involuntary act."³⁸

Subsequently *Easter v. District of Columbia* (1966) and *Driver v. Hinnant* (1966) ruled in favor of defendants charged with public intoxication. Although the *Easter* decision applied only to the District of Columbia, the Circuit Court of Appeals ruled unanimously that the disease of alcoholism is a permissible defense in cases involving public drunkenness. Since alcoholism involved a "loss of control" syndrome, Easter, who was a long-standing alcoholic, could not be held accountable for his crime. In the *Hinnant* decision, rendered by the U.S. Court of Appeals, Fourth Circuit, the court reasoned that Hinnant, a skid row alcoholic who had spent two thirds of his adult life in jail for vagrancy and public drunkenness, should be exempted from criminal sanctions. Although a later Supreme Court case, *Powell v. Texas*, specifically addressed the significance of the disease concept of alcoholism, the Court did not rule in favor of the defendant, largely because testimony on his behalf was "utterly inadequate." Nevertheless, this decision represents an important step in the evolution of legal changes concerning public drunkenness, since four of the five justices who upheld Powell's conviction agreed that since there was no known effective treatment for alcoholism and a deficiency of treatment facilities, a jail sentence outweighed the benefit of an indeterminate civil commitment for treatment.³⁹

The Uniform Alcoholism Treatment Act

Ironically, while the *Powell* decision seemingly upheld the traditional punishment perspective on public drunkenness, the reasoning underlying the Court's ruling can be seen as writing a script that contributed to the groundwork for legislation passed by Congress in 1971. Known as the Uniform Alcoholism and Intoxication Treatment Act, this legislation defined a continuum of medical services as an alternative to criminal justice processing of drunkenness offenders, thus encouraging states to decriminalize public drunkenness laws. This act was seen as having its greatest impact in skid row districts, where homeless alcoholics had for decades clogged court dockets and overcrowded city jails at enormous cost to taxpayers. In fact, it was not uncommon for some homeless chronic alcoholics to spend more than six months a year in jails and drunk tanks, which Pittman and Gordon described as a "revolving door" phenomenon.⁴⁰

Although there was widespread consensus in the professional community that treatment was a more humane approach than criminal justice processing of drunkenness offenders, the act did not contain concrete provisions for establishing detoxification and treatment centers. As an impetus to adopt and implement the act, Congress in 1974 passed the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act which provided federal funding to establish treatment facilities. Maryland and Massachusetts were among the first to develop this treatment-oriented model; most other states eventually adopted the act.⁴¹

Networks of detoxification and medical units for treating public inebriates are now in place nationwide. While these have ultimately helped to unclog municipal court dockets (only to be replaced by the proliferation of drug-involved offenders in the 1980s and 1990s), another form of "revolving door" seems to have appeared.

Fagan and Mauss, for example, suggest that detoxification centers have created a new version of recidivism in which patients pass from one public detox unit to the next, often at heavy cost to taxpayers.⁴² Others, too, have made similar observations. In the study of homeless women during the 1970s, for example, Garrett notes that nearly half of a sample of fifty-seven skid row women spent an average of 275 days in hospitals and medical care and residential care facilities, most in and around New York City.⁴³ Neuner and Schultz tracked forty-three chronic alcoholic recidivists from Hennepin County, Minnesota, through the treatment and criminal justice systems over a year-long period. Using outcomes from this sample to project costs for services to the county's estimated 425 homeless chronic alcoholics, they concluded that taxpayers should expect to foot a bill of *at least* \$10 million per annum!⁴⁴

Detoxification units, however, were never intended to be the ultimate treatment for alcoholics and drug abusers. Instead, they serve as one of several intercept points that provide patients with potential avenues into long-term recovery programs, that is, once sobriety is restored. For those with adequate health care insurance to defray treatment costs, the issue is more their motivation to seek treatment than their ability to pay. However, homeless substance abusers, even when they are motivated and committed to their recovery, have far fewer options, since they rarely enjoy the privileges of medical insurance. Sustaining their recovery efforts thus involves reliance either on public treatment facilities or on the generosity of state funding to support treatment in private facilities under purchase-of-service arrangements. In periods of budget decline, a reality of the 1990s in virtually every state, funding for human and health services is often among the first to be sliced.

The Stewart B. McKinney Act

The crisis of homelessness has been shaped by a combination of policy factors spanning at least three decades. Urban redevelopment policies displaced thousands of homeless people from their skid row habitats. In the 1970s, for example, as many as one million SRO units were eliminated while housing prices escalated and subsidies for public housing declined. In the 1980s, income supports were eroded by both inflation and changing policies on entitlements and welfare benefits. The Community Mental Health Act of 1963 helped to stimulate a deinstitutionalization movement that brought about a 73 percent reduction in the number of patients in state psychiatric hospitals between 1959 and 1980, a significant number of whom became homeless with no psychiatric care.⁴⁵ Collectively these policy changes, along with other social factors, played a major role in stimulating vast increases in the size of the homeless population during the 1980s, estimated by some to be as high as 3 million.⁴⁶

In response to this crisis, Congress signed into law the Stewart B. McKinney Homeless Assistance Act on July 22, 1987. Although the act does not directly address the causes of homelessness, its purpose is to provide federal leadership in implementing comprehensive assistance programs for the nation's homeless.⁴⁷ Coordinating this effort is the responsibility of the Interagency Council for the Homeless. In fiscal year 1992, McKinney appropriations total \$871.6 million; \$129.9 million is appropriated for non-McKinney homeless assistance programs.

Although numerous programs were established by the McKinney Act, including those focusing on mental health, job training, adult education, emergency food and shelter, housing, and others, the Community Demonstration Grants Projects for Alcohol and Drug Abuse Treatment of Homeless Individuals specifically addressed

the needs of homeless substance abusers. Administered by the National Institute on Alcoholism and Alcohol Abuse (NIAAA) in consultation with the National Institute on Drug Abuse (NIDA), the mission of the demonstration project was to develop and evaluate community-based approaches to treatment. Auxiliary objectives included facilitating linkages with other human service and treatment agencies, increasing access to shelter and housing, and improving the economic and quality-of-life factors for homeless people.⁴⁸

In 1988, the Community Demonstration Grant Projects funded projects in nine cities: Anchorage, Boston, Los Angeles, Louisville, Minneapolis, Oakland, New York, and two in Philadelphia. Although all these projects have common components, their approaches were guided by their individual treatment philosophies and configured around circumstances of their target populations and local treatment resources.⁴⁹

Although these projects concluded in mid-1991, detailed reports of their results are not yet available.⁵⁰ However, it is noteworthy that the demonstration projects allocated 25 percent of their budgets to carry out their evaluation plans. In addition, data from these projects were collected by a national evaluation team. Taken together, the Community Demonstration Grant Projects will yield comprehensive data about alcohol and drug abuse among homeless people, invaluable information about the efficacy of treatment approaches, and viable strategies for facilitating sober living environments and reintegrating recovering substance abusers in the community.

While the Community Demonstration Grant program represents an unprecedented benchmark in the history of research on homeless substance abusers, as well as in developing creative intervention approaches, fourteen new projects were funded by the NIAAA in September 1990. Under its Cooperative Agreements for Research Demonstration Projects on Alcohol and Other Drug Abuse Treatment for Homeless Persons, awards were made to cities located in all geographic regions of the United States.⁵¹

Housing and Sober Living

While solutions to the crisis of homelessness involve much more than generating affordable housing, the fact is that shelter is precisely what the homeless do not have. As a homeless woman in Hartford explained, "I have no shelter, no home, and no place to go!" Overall efforts to assist the homeless must therefore provide opportunities for housing.

For the homeless recovering from alcohol or drug dependency, however, locating suitable housing can be even more complicated, since sustaining sobriety often hinges on alcohol- and drug-free living environments. Historically, this need has been consistently overlooked by rehabilitation programs for homeless alcoholics and other drug abusers. As far back as 1960, for example, New York's well-regarded Camp LaGuardia offered alcoholics and other homeless men the luxuries of fresh air, exercise, work programs, three square meals, and social services. Yet with no housing opportunities to pursue after their release, more times than not these men returned to the environment most familiar to them, the Bowery, where it was next to impossible to sustain sobriety in the permissive drinking subculture. Essentially the same circumstances are true of many homeless substance abusers today, who cycle in and out of public detox centers, each time returning to the living arrangements

that supported their alcohol or drug abuse in the first place. So alcohol- and drug-free housing plays a critical role in sustaining the recovery process and establishing sober living habits.

In his extensive work on housing issues, Wittman points out that restoring the affordable housing stock is the main focus of efforts to house homeless people. There are different types of housing opportunities: regular housing, such as single- or multifamily units, duplexes, and apartment buildings; single-room-occupancy (SRO) and specialty housing; and institutional housing. Since there is "nothing special" about the first of these categories, it need only be said that single-family units are as viable for recovering substance abusers as they are for others who have been assisted out of homeless circumstances, since needed recovery services can be acquired at off-site sources.⁵²

SRO units are intended to house single adults and specialty housing is designed to accommodate groups with special needs, such as recovering substance abusers or those who suffer from psychiatric disorders. Both types of housing achieve their efficiency through shared facilities. In recent years, renovated SRO hotels have become an important, low-cost housing source that can be ideally suited to the needs of those in recovery. For example, San Francisco's Arlington Hotel is one of ten SRO hotels established by the Mayor's Task Force on Public Inebriates. Operating under an alcohol/drug management policy, the Arlington Hotel serves as an "island of sobriety" for men and women in recovery. In addition, SRO hotels and special housing in the form of a "boardinghouse" operate according to policies similar to SRO alcohol/drug-free facilities. These boardinghouses are often reconfigured from single-family houses so they can accommodate residents in communal living.⁵³

Although relatively few recovering alcohol/drug abusers require institutional housing like hospitals and nursing homes, these types of facilities offer housing options that provide relatively comprehensive care. They are part of the continuum of housing options that can benefit a small percentage of homeless substance abusers requiring supervision and domiciliary care.⁵⁴

One of the most promising programs for generating alcohol/drug-free housing is the Oxford House model. The operation of Oxford House, founded in 1975 by residents of a halfway house, is guided by democratic decision making and several straightforward, commonsense rules that must be followed by its tenants, all of whom are recovering substance abusers. Self-supported and self-managed by their current residents, more than 250 Oxford Houses are now in operation nationwide. A 1988 provision in the Omnibus Drug Act required states to develop a revolving fund for making loans to qualified applicants seeking to establish Oxford Houses.⁵⁵ In sum, while the Oxford House model may not be the singular solution to meeting the housing requirements of recovering substance abusers, policymakers must respect the importance of alcohol/drug-free living environments to sustaining sobriety and the recovery process.

This chronicle of literature about homelessness and alcohol and drug abuse offers only highlights of some of the more important benchmarks in this research tradition. Nevertheless, it is clear that the evolution of these researches interacts with policy-making concerning homelessness and substance abuse. This is particularly true beginning in the 1950s, when large survey studies were sponsored by agencies which sought answers to questions and problems that would guide their policymaking. The

NIAAA/NIDA Community Demonstration Grant Projects, however, hold unusual promise of yielding valuable information about the efficacy of intervention and treatment approaches, viable options for sustaining long-term recovery, even strategies for stimulating the housing stock. And because the Community Demonstration Projects include extensive evaluation plans enabling them to document implementation procedures and assess treatment outcomes, it should be possible to replicate approaches identified as successful in comparable agencies serving homeless alcohol and drug abusers. If so, the Community Demonstration program will have written the single most important chapter in this research tradition on homelessness and substance abuse. ☛

Notes

1. Selected segments of this manuscript are an elaboration of materials from an earlier work: Gerald R. Garrett, "Alcohol Problems and Homelessness: History and Research," *Contemporary Drug Problems* 16, no. 3 (Fall 1989): 301–32. For an expanded discussion of many of the points covered, see Russell K. Schutt and Gerald R. Garrett, *Responding to the Homeless: Policy and Practice* (New York: Plenum Publishers, 1992), chap. 5, 6; and Gerald R. Garrett and Russell K. Schutt, *Working with the Homeless*, 3d ed. (Boston: Center for Communications Media, 1990).
2. Jim Baumohl, "Alcohol, Homelessness, and Public Policy: Editor's Introduction," *Contemporary Drug Problems* 16, no. 3 (Fall 1989): 281. Baumohl notes that "whiskey bummers" functioned as a crude "social diagnosis" to distinguish alcoholic tramps from the more reputable unemployed who upheld personal virtues while down on their luck. See Baumohl's brief yet informative discussion on 282–83.
3. See Howard M. Bahr, *Skid Row: An Introduction to Disaffiliation* (New York: Oxford University Press, 1973), 58–61. Despite countless acts of charity and dozens of new state and federal programs aimed at helping the nation's homeless in the past decade, such newspaper accounts are in fact appearing again in the 1990s. During the 1991 World Series, for example, newspaper accounts document that Atlanta's police quietly swept away the homeless from city streets, especially unsightly and bothersome alcoholic derelicts. Newspaper accounts indicate that in San Francisco, former police chief Frank Jordan made his "get tough on the homeless" approach a campaign issue in the 1991 mayoral election. Newspapers such as *USA Today*, the *New York Times*, *Boston Globe*, and the *Seattle Post-Intelligencer* report that the "streets are meaner" for the homeless. See, for example, Andrea Stone, "For Homeless, Streets Are Meaner," *USA Today* (November 25, 1991), 3-A. See also note 5.
4. U.S. Conference of Mayors, *Report on Homelessness* (Washington, D.C., 1991).
5. Seattle is a good case in point. Long tired of countless homeless beggars in the downtown shopping district, merchants have taken to posting signs that inform shoppers that panhandling supports substance abuse, advising them to give instead to their favorite charities. As a merchant who owns a gift shop near Pioneer Square explained to me, "These street homeless are aggressive, they come after you. This is not 'Buddy, can ya spare me a dime?' — This is 'Gimme your change!' And if you don't, be prepared for insults or worse!" Because of assaults on pedestrians by homeless panhandlers, Seattle's police vigorously enforce "open container and public consumption" ordinances, particularly in Pioneer Square — ironically the district from which "skid road" derives its name.
Yet Seattle is not alone in expressing its public frustration over the legions of street homeless. During the latter years of Mayor Edward Koch's administration in New York, the mayor himself publicly urged New Yorkers to give to charities for the homeless, but not to panhandlers, which he and others felt supported substance abuse. In Atlanta, Denver, and Detroit, city ordinances intended to curb aggressive begging and "open-air sleeping" have been proposed or passed. Police in Santa Monica, California, which has attracted thousands of home-

less people to its oceanside park, now enforce a ban on sleeping in the park from midnight to dawn. And in recent years, Los Angeles, Detroit, and New York have closed or bulldozed shantytowns. Still other communities and their local merchants have gone so far as to offer bus tickets for the homeless to leave town!

6. Garrett, "Alcohol Problems and Homelessness," 302-3.
7. For a comprehensive review of scientific literature on alcohol and drug abuse among homeless people, see *ibid.*; Russell K. Schutt and Gerald R. Garrett, "The Homeless Alcoholic: Past and Present," in *Homelessness: The National Perspective*, edited by Marjorie J. Robertson and Milton Greenblatt (New York: Plenum Publishers, 1992); Dennis McCarty, Milton Argeriou, Robert B. Heubner, and Barbara Lubran, "Alcoholism, Drug Abuse and the Homeless," *American Psychologist* 46, no. 11 (November 1991): 1139-48; M. Susan Ridgely, Caroline T. McNeill, and Howard H. Goldman, *Alcohol and Other Drug Abuse Among Homeless Individuals: An Annotated Bibliography* (Rockville, Md.: National Institute on Alcohol Abuse and Alcoholism, 1988); Louisa Stark, "A Century of Alcohol and Homelessness: Demographics and Stereotypes," *Alcohol, Health and Research World* 11, no. 3 (Spring 1987): 8-13; U.S. Department of Housing and Urban Development, *Publications Relating to Homelessness: A Working Bibliography* (Washington, D.C.: Office of Policy Development and Research, 1989). See also Howard M. Bahr, *Disaffiliated Man: Essays and Bibliography on Homelessness* (Toronto: University of Toronto Press, 1970); V. Mulkern and R. Spence, *Alcohol Abuse/Alcoholism among Homeless Persons: A Review of the Literature, Final Report to NIAAA* (Rockville, Md.: National Institute on Alcohol Abuse and Alcoholism, 1984); Friedner Wittman, ed., *The Homeless with Alcohol-related Problems: Proceedings of the NIAAA Meeting to Provide Research Recommendations* (Rockville, Md.: National Institute on Alcohol Abuse and Alcoholism, 1985); Jim Baumohl, ed., *The Homeless with Alcohol Problems* (Rockville, Md.: National Institute on Alcohol Abuse and Alcoholism, 1986); NIAAA, *Homelessness, Alcohol and Other Drug Abuse* (Rockville, Md.: National Institute on Alcohol Abuse and Alcoholism/University of California, San Diego, Program on Alcohol Issues, 1988). At least three professional journals in recent years have devoted thematic editions exclusively to alcohol, drug abuse, and homelessness: *Alcohol, Health and Research World* 11, no. 3 (Spring 1987); *Contemporary Drug Problems* 16, no. 3 (Fall 1989); *Alcoholism Treatment Quarterly* 7, no. 1 (1990). A thematic edition on alcohol and homelessness by the *Journal of Studies on Alcohol* is in the planning stages.
8. Howard M. Bahr, "Introduction," in *Homelessness in the United States: State Surveys*, vol. 1, edited by Jamshid Momeni (Westport, Conn.: Greenwood Press), xx.
9. J. J. McCook, "A Tramp Census and Its Revelations," *Forum* 15 (1983): 753-66; B. Marsh, "Causes of Vagrancy and Methods of Eradication," *Annals of American Academy of Political and Social Sciences* 67 (1904): 2445-56; H. Cook, *Report of the Secretary of the Municipal Lodging House for October, 1910* (New York: New York Charity Organization Society, 1910); Nels Anderson, *The Hobo* (Chicago: University of Chicago Press, 1923); E. Hoffer, *The Ordeal of Change* (New York: Harper & Row, 1964); Robert Straus, "Alcohol and the Homeless Man," *Quarterly Journal of Studies on Alcohol* 7 (1946): 360-404; A. W. Stearns and A. D. Ullman, "One Thousand Unsuccessful Careers," *American Journal of Psychiatry* 105 (1949): 801-10; Theodore M. Caplow, Keith Lovald, and Samuel A. Wallace, *General Report on the Problem of Relocating the Population of the Lower Loop Redevelopment Area* (Minneapolis: Housing and Redevelopment Authority, 1958); Donald J. Bogue, *Skid Row in American Cities* (Chicago: Community and Family Study Center, University of Chicago, 1963).
10. D. Roth and J. Bean, "Alcohol Problems and Homelessness," *Alcohol, Health and Research World* 10, no. 2 (Winter 1985/86): 14-15; New York State Department of Social Services, *Homelessness in New York State: A Report to the Governor and Legislature* (Albany: State of New York, 1984); R. Ropers and M. Robertson, *The Inner-city Homeless in Los Angeles: An Empirical Assessment* (Los Angeles: Los Angeles Basic Shelter Project, 1984); J. Wynne, *Homeless Women in San Diego: A New Perspective on Poverty and Despair in America's Finest City* (San Diego: County of San Diego, Department of Health Services, Alcohol Program, 1984); Multnomah County Social Services Division, *The Homeless Poor* (Portland, Oreg.: Division of Social Services, 1984); G. R. Garrett and R. K. Schutt, "Homelessness in

- Massachusetts: Description and Analysis," in *Homelessness in the United States*, 79–90; Massachusetts Association for Mental Health, *Homelessness: Organizing a Community Response* (Boston, 1983).
11. Pamela J. Fischer, "Estimating the Prevalence of Alcohol, Drug and Mental Health Problems in the Contemporary Homeless Population: A Review of the Literature," *Contemporary Drug Problems* 12, no. 3 (Fall 1989): 333–89. See also Pamela J. Fischer and William R. Breakey, "The Epidemiology of Alcohol, Drug, and Mental Health Disorders Among Homeless Persons," *American Psychologist* 46, no. 11 (November 1990): 1115–28.
 12. Garrett and Bahr analyzed data gathered on drinking behavior from several samples of homeless men and women in New York City. Although their overall results show that women may be more "truthful" in reporting their drinking than men, they also suggest that "sophisticated" quantitative measures of drinking may not be better than simple, straightforward self-reports, or at least they do not yield substantially different results. See G. R. Garrett and H. M. Bahr, "A Comparison of Self-report vs. Quantity-frequency Classifications of Drinking," *Quarterly Journal of Studies on Alcohol* 35 (December 1974): 1294–1306.
 13. Norweeta Milburn, "Drug Abuse Among the Homeless," in *Homelessness in the United States: Issues and Data*, vol. 2 (Westport, Conn.: Greenwood Press, 1990).
 14. Fischer, "Estimating the Prevalence of Alcohol, Drug and Mental Health Problems."
 15. J. Wright and E. Weber, *Homelessness and Health* (New York: McGraw-Hill, 1987).
 16. Fischer, "Estimating the Prevalence of Alcohol, Drug and Mental Health Problems."
 17. Fischer and Breakey, "The Epidemiology of Alcohol, Drug, and Mental Disorders," 1115–16.
 18. Ibid.; Milburn, "Drug Abuse Among the Homeless"; Institute of Medicine, *Homelessness, Health, and Human Needs* (Washington, D.C.: National Academy of Medicine, 1988); Schutt and Garrett, "Homelessness in Massachusetts"; Wright and Weber, *Homelessness and Health*; McCarty et al., "Alcoholism, Drug Abuse and the Homeless"; Fischer, "Estimating the Prevalence of Alcohol and Drug Disorders"; Paul Koegel and A. Burnham, "Traditional and Nontraditional Homeless Alcoholics," *Alcohol, Health and Research World* 11 (Spring 1987): 28–34.
 19. Wright and Weber, *Homelessness and Health*; Koegel and Burnham, "Traditional and Non-traditional Homeless Alcoholics"; Schutt and Garrett "Homelessness in Massachusetts"; Fischer and Breakey, "The Epidemiology of Alcohol, Drug, and Mental Health Disorders."
 20. See note 9.
 21. Bahr, *Skid Row*, 222–25.
 22. Garrett, "Alcohol Problems and Homelessness"; Stearns and Ullman, "One Thousand Unsuccessful Careers"; Bahr, *Skid Row*, chap. 7.
 23. Bahr, *Skid Row*, 224.
 24. Ibid.
 25. Michael Stoil, "Salvation and Sobriety," *Alcohol, Health and Research World* 11, no. 3 (Spring 1987): 14
 26. Ibid.
 27. Bahr, *Skid Row*, 224–25.
 28. Ibid., 225–26.
 29. Nels Anderson, *The Hobo* (Chicago: University of Chicago Press, 1923), *Homeless in New York City* (New York: Board of Charity, 1934), and *Men on the Move* (Chicago: University of Chicago Press, 1940); Edwin Sutherland and Harvey Locke, *Twenty Thousand Homeless Men* (Chicago: J. B. Lippincott, 1936); Illinois Relief Commission, *Men in the Crucible* (Chicago, 1932); Glenn Johnson, *Relief and Health Problems of Selected Group of Non-family Men* (Chicago: University of Chicago Press, 1937).

30. Garrett, "Alcohol Problems and Homelessness."
31. Ibid.
32. James Rooney, "Group Processes Among Skid Row Winos," *Quarterly Journal of Studies on Alcohol* 22 (1961): 444-60; James Spradley, *You Owe Yourself a Drunk* (Boston: Little Brown, 1970); Earl Rubington, "The Bottle Gang," *Quarterly Journal of Studies on Alcohol* 29 (1968): 943-55; Jacqueline P. Wiseman, *Stations of the Lost* (Englewood Cliffs, N.J.: Prentice-Hall, 1970).
33. *The Homeless Alcoholic: Proceedings of the First Annual International Institute on the Homeless Alcoholic* (Detroit: Detroit Mayor's Rehabilitation Committee on "Skid Row" Problems and the Michigan State Board on Alcoholism, September 1955).
34. *Proceedings of the Institute of the Skid Row Alcoholic* (New York: National Committee on Alcoholism, March 1956).
35. Howard M. Bahr and Gerald R. Garrett, *Disaffiliation Among Urban Women* (New York: Columbia University, Bureau of Applied Social Research, 1972); Gerald R. Garrett and Howard M. Bahr, "Women on Skid Row," *Quarterly Journal of Studies on Alcohol* 34 (December 1973): 1228-43; Howard M. Bahr and Gerald R. Garrett, *Women Alone* (Lexington, Mass.: Lexington Books, 1976).
36. Egon Bittner, "The Police on Skid Row: A Study of Peace Keeping," *American Sociological Review* 32 (October 1967): 699-715.
37. Ibid.
38. For a superior summary and analysis of major court cases concerning public intoxication during this period, see N. Kurtz and M. Regier, "The Uniform Alcoholism and Intoxication Treatment Act," *Quarterly Journal of Studies on Alcohol* 36 (1975): 1421-41. During the Johnson administration, the President's Commission on Law Enforcement and Administration of Justice was established as a task force to look into issues concerning crime, delinquency, corrections, and drunkenness. See *Task Force Report: Drunkenness* (Washington, D.C.: U.S. Government Printing Office, 1967); Richard J. Driver, "The United States Supreme Court and the Chronic Drunkenness Offender," *Quarterly Journal of Studies on Alcohol* 30 (March 1969): 242.
39. Kurtz and Regier, "Uniform Alcoholism Act."
40. David Pittman and C. Wayne Gordon, *The Revolving Door: A Study of the Chronic Police Case Inebriate* (Glencoe, Ill.: Free Press, 1958).
41. Kurtz and Regier, "Uniform Alcoholism Act."
42. Garrett, "Alcohol Problems and Homelessness."
43. Gerald R. Garrett, "Drinking on Skid Row: The Case of the Homeless Woman." Presented at the annual meetings of the American Sociological Association, New York, August 1973.
44. R. Neuner and D. Schultz, *Borrow Me a Quarter* (Anoka: Minnesota Institute of Public Health, 1986).
45. Schutt and Garrett, *Responding to Homelessness*, 3-9.
46. Anna Kondratas, "Ending Homelessness: Policy Challenges," *American Psychologist* 46, no. 11 (November 1991): 1226.
47. For further information about the McKinney Act, see Garrett and Schutt, *Working with the Homeless*, chap. 7. For an analytical discussion of this act, see Kondratas, "Ending Homelessness," 1226-31, and Maria Foscarinis, "The Politics of Homelessness: A Call to Action," *American Psychologist* 45, no. 11 (November 1991): 1232-38.
48. Gerald R. Garrett and Robert B. Heubner, "Alcohol, Drugs and the Crisis of Homelessness: Challenge to the Criminal Justice System." Presented at the annual meetings of the Academy of Criminal Justice Sciences, Washington, D.C., March 1989.

49. For a brief summary of the Community Demonstration Grant Projects, see the *Alcoholism Treatment Quarterly's* thematic issue, "Treating Alcohol and Drug Abuse Among Homeless Men and Women: Nine Community Demonstration Grants," Milton Argeriou and Dennis McCarty, eds., vol. 7, no. 3 (1990), and McCarty et al., "Alcohol, Drug Abuse, and the Homeless," 1143-44.
50. See *ibid.*
51. For project locations and an overview of the Cooperative Agreement Program, see NIAAA, *Synopses of Cooperative Agreements for Research Demonstration Projects on Alcohol and Other Drug Abuse Treatment for Homeless Persons* (Rockville, Md.: NIAAA).
52. Friedner D. Wittman, "Housing: From Street, to Shelter to ———?" in Russell K. Schutt and Gerald R. Garrett, *Responding to the Homeless: Policy and Practice* (New York: Plenum Publishers, 1992), 193-98.
53. Wittman, "Housing."
54. *Ibid.*
55. *Ibid.*