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The Last Thing We Need Is Another Shelter

Jessica Segré

Segré suggests that family homelessness is merely the latest and most devastating example of America's lack of commitment to children and families. The history of human services for children is presented to show that, both at the community and at the policy levels, this population and its needs have been neglected, subjected to fragmentation, and consistently downgraded on our lists of priorities. The societal values that have led to this situation are discussed and revealed as still reflecting an individualistic, frontier outlook, which is, however, becoming an anachronism. The need for a child/family policy is stressed, as is the urgency of reexamining and modifying some of our basic tenets in order to prevent the recurrence of such inhumane outcomes as homelessness.

Our methods of care and our thinking are intimately interwoven into the fabric of society. If we look at just the warp and the woof, we will miss the design.

— Murray Levine

History and Politics of Community Mental Health

We usually think of “homeless children and families” as simply one of the groups that make up “homeless persons.” Numerous articles and reports have referred to the “different populations of the homeless,” dividing the category by age, by sex, and by family status. Also, in looking at the recent upsurge of homelessness, we can see an apparent sequence of vulnerability for different demographic groups: first single adults were most prominent, later kids and families came to the fore, still later, in some areas, the youth population is showing the largest increase in growth. Presenting information in this manner seems to imply that each group comprises a segment of an organic “homeless” whole. It suggests that the operative term in the phrase “homeless (adults) (youth) (families)” is the condition itself. It has also led to a search for the factors associated with homelessness, be they prior or succeeding, and to an emphasis on looking for similarities among affected populations as a means of identifying shared risk factors to homelessness.¹

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When we make such comparisons, we've observed that, at the most basic level, all who are homeless lack a permanent roof over their heads. By the same token, we've noted that all of us share the need for this kind of safety and security, and that a "home" implies support as well as shelter. From these and similar observations, we have constructed our public response, an effort that has taken two major directions: (1) in the short-run, to provide the needed roof on a temporary basis, since being without shelter constitutes an "emergency" (more on this later); and (2) in the longer-term, to attempt to deal with the factors perceived to be associated with the problem: the lack of low-income housing; the mismatch between available jobs and job skills; our grossly inadequate entitlement structure.

It would seem as if, while human service providers, politicians, and bureaucrats have differed in their ideas about program priorities, funding levels, and time lines, they have generally agreed on the preceding approach to dealing with homelessness. And, in the language of the day, it is this approach which has served to micromanage the issues. By focusing on the details of shelter services, transportation routes, and employment programs — all necessary — we have at the same time diverted attention from some of the more fundamental issues: What are the overarching societal factors that have allowed homelessness to occur in the first place? Why are there *any* people who are without a place to live in late twentieth-century America?

To begin to find crucially needed answers to these questions, since our goal should be not merely to get through this crisis, but to ensure that it can never happen again, it may be helpful to reformulate our concept of the problem. One way to do this, which is easy in execution yet large in import, is merely by switching our emphasis. In looking at "homeless children and families," rather than focusing on homelessness, instead pay attention to what it's like to be a child or a family in our society, then look at homelessness as it relates to these circumstances. An advantage to this approach is that it puts the people part of the equation first and forces us to confront, from the outset, our values and attitudes toward others. (By contrast, when we start with homelessness, we have to travel a long, inductive route before finally dealing with a whole person).

It's important to state that in changing emphasis, I am not suggesting that looking at the attributes of homelessness *per se* is invalid. I am, however, saying that such a focus is by nature incomplete and has perforce led to solutions that are also short of the mark. This is so because such "solutions," by and large, have dealt with homelessness as if its causes were not embedded in our deep-rooted cultural values, and as if addressing outward manifestations of the issue would somehow, magically, cause inner, endemic problems to heal.

The remainder of this article will attempt to show that the presence among us of large numbers of children and families lacking the safety and support of a home is merely another example, albeit an extreme one, of a long-standing lack of commitment to the needs of these populations in this country. To illustrate our ephemeral concern for the young and their caretakers, I examine the sorry ways in which children have fared within the human service system, the very system set up to ensure their safety and support. I also discuss the specific values and attitudes that appear to be most antagonistic to fostering the development of children and families and show, as suggested, that they constitute some of our most dearly held principles.

I'd like to begin by presenting the story of a family, disguised in detail, but real in substance. I first met the R.'s when I was the director of a large, urban child and adolescent mental health unit in the late 1970s.²

Rachel R.

Rachel R. was a tiny, waiflike six-year-old with big brown eyes. When Gwen, her future counselor, first saw her, Rachel was crouched in a school closet, looking terrified, meowing like a cat. Ms. K., her teacher, said that this kind of behavior had been going on for some time, but had recently gotten worse. Ms. K. connected the child's increasing withdrawal and tendency to use odd verbalizations (she also barked) to the recent appearance of welts on Rachel's back and legs, and the teacher was quite distressed when her call to Protective Services was followed only by a perfunctory contact with Rachel's parents and a quick closing of the case. Ms. K. was particularly concerned, she told Gwen, because the R.'s were living out of a car parked in a supermarket parking lot, and she didn't see how that situation could not be detrimental to the child's well-being.

It took Gwen many weeks of trying before Rachel would speak to her. During this time, the child's behavior deteriorated further, and she began to have what her teacher termed "fits" of frantic crying, seemingly unable to control herself. Both Gwen and Ms. K. noted new bruises on Rachel, and both contacted the Protective Services Unit with the same negative results as before.

Gwen's attempts to talk with Rachel's parents resulted in one meeting with the whole family. At that time she learned that Mr. and Mrs. R. and their two children had only recently arrived in Boston from the rural South, and that neither had finished high school or had any particular skills training. Not surprisingly, both parents were unemployed. The family was living on welfare, and anxious that DPW not learn about Father's presence on the scene. Gwen was alarmed to see that Mrs. R. was pregnant, and that everyone looked malnourished and disheveled. Most disturbing, however, was the way Mr. R. treated his wife and children, who were not allowed to speak without his permission. He also displayed no apparent compunctions about slapping the little ones in front of the counselor. Gwen's offers of counseling for the parents, or for the whole family, were rejected.

The situation came to a head when Mr. R., angry at being reported to Protective Services, withdrew Rachel from counseling and kept her home from school. At that point, with no one left to monitor the situation, a joint agency meeting was called and pressure was exerted on Protective Services to undertake a more complete investigation of the case. They demurred, but said that they would provide parenting and other services if the R.'s asked for them voluntarily. The caseworker, who was new both to her job and to the field, said she believed Mother's assertion that Rachel's bruises were accidentally caused and suggested that the child's behavior was a "stage" she was going through.

Meanwhile, fearing that Rachel's fragile functioning would finally break down altogether, Gwen had been trying to arrange an inpatient psychiatric evaluation for the child. Such a procedure would have allowed Rachel to be observed away from the family and aided in explaining her behavior. While Gwen had her doubts about getting the parents' consent for this arrangement, it turned out that she needn't have spent time worrying. With Medicaid as the only source of payment, there were so few child beds in Massachusetts that it would have meant a year's wait. A second option considered, a straight inpatient admission, was also abandoned when the only public child psychiatric hospital in Massachusetts refused even to evaluate Rachel for a possible slot.

There is no neat end to this story. After two years and the intervention of the court owing to the youngster's long-term truancy, Protective Services recommended a residential treatment facility for the child, and asked Gwen to become reinvolved as her counselor (the child had repeatedly requested this). By this time, both Rachel's younger siblings had also been reported for possible abuse. Rachel began to come out of her shell in the treatment facility, but quickly regressed when she returned home — precipitously, due to the agency's unexpected closing. The clinic was able to continue to follow this family after a fashion for many years, through successive requests for information from ever-new agencies and systems. The last we heard about Rachel, she had just been admitted to an adolescent psychiatric hospital after having tried, nearly successfully, to kill herself.

The Service System

Much has been written about the relationship between the mental health system and single adult homelessness, usually in terms of the proportion of the latter population with psychiatric illness, frequently to talk about a less-than-successful deinstitutionalization policy.³ However, there has been almost no comment on the equally strong, though somewhat more complex, connection between our mental health policies and family homelessness. There are several reasons why this might be so. In the first place, single adults constitute the most obvious of the homeless populations; they wander the streets, sleep in doorways, and otherwise intrude on our senses. Their peculiarities are frequently displayed publicly; we can almost not avoid seeing them. Homeless families, by contrast, may be quite effectively hidden from the rest of us unless we know where to look: in shelters, on food lines, inside overcrowded apartments.⁴ Homeless youth may be even less apparent than families, since they are frequently not simply "hidden," but actually hiding from others, like the police.⁵

Another reason that we may not have understood the relationship between family homelessness and the mental health system appears rooted in our unquestioning acceptance of that system's current view of its mission: to treat the chronically and seriously mentally ill population. Since studies have shown that relatively few homeless families have members with severe mental illness,⁶ we seem to have gone no further in pursuing a possible connection. This is so despite the fact that we talk quite freely about the stresses and strains of being without a home, for both children and parents, and the lack of support services available to address these issues. There is something ironic in having a mental health system which deals only with the most seriously ill. It would appear more accurate to say that what we actually have is a mental illness system, and that there is no public entity with responsibility for mental health.

A third reason for the lack of association between "mental health" and family homelessness stems from a laudable desire to avoid stigmatizing the population — a position again based on the system's narrow definition of its purview. Not only do mental health departments deal almost exclusively with chronically mentally ill clients, but they also perceive their clients' problems (read: illnesses) to be primarily biological in nature.⁷ This formulation inevitably results in treatment according to a medical model: evaluation; diagnosis; reliance on chemical remedies; and supervision by a physician (psychiatrist). There is no question as to who is the doctor and who the patient. Given this model, we would assume that a family involved with the

mental health system is "sick" and dependent, with all that these designations imply. It would be hard to fault those wishing to avoid such labels.

But the medical model, essentially a straightforward illness-and-cure-by-a-doctor approach, is only one among many ways that people try to help others. Because of its simplistic view of problems, its quick resort to drugs, and its insistence on diagnosable illness as an admission ticket, it has never been a model in much favor among people working with children.⁸ As is clear from Rachel's story, "children's" problems are far from simple, and diagnostic labels, at best, don't do justice to the complexity of developing organisms.

However, the most important reason that we have not delved further into the connection between mental health and homeless families seems to be that we've been considering the relationship between these two factors from a direct cause-and-effect perspective: either mental health problems lead to homelessness or the other way around. Having found neither proposition to be true to any great degree, and feeling that the very formulation is counter to our helping goals, we have abandoned it. But the real association between family homelessness and the mental health system is that each has evolved to its current state because of the same societal factors and processes, and that each is inimical to children and families. A crucial connection indeed.

At this point, to gain a better understanding of just what happens to children and families within the human service system, let's turn to a discussion of Rachel and then to a brief historical review.

Rachel R.: Family Issues and Response

Only three factors distinguish the R. family from the typical clients seen on the Child and Adolescent Unit in the late 1970s: (1) the family was "intact," meaning that Father was present; (2) Rachel's behavior was more disturbed at a younger age than the average; and (3) the family was literally "homeless." In all other respects, the R.'s were quite like our usual clients, that is, they were on welfare, violence was a part of family life, attempts to help involved the efforts of multiple systems, resources were limited and waning, and trying to provide some appropriate and useful service was problematic and frustrating. That the R.'s were typical belies the image that child clinics see mainly middle-class families and deal with "little" problems from a traditional psychoanalytic perspective. This is a point of view still heard,⁹ apparently a remnant from the heyday of the child guidance centers, which have also long since changed their clientele and perspective.

As suggested above, the issues presented by the R.'s were complex, and "complexity" is almost synonymous with "children's services." In the first place, the term itself is a misnomer since "Children's services are not services exclusively for children, but services to the family unit."¹⁰ Thus the interests and rights of *each* family member must be considered, although, as with the R.'s, members' interests often conflict with one another. Then, trying to protect vulnerable children can be tricky, since parents may simply stop bringing them. At the same time, having a youngster in counseling engenders some guilt in most of us as parents, so that absent danger it becomes important to counteract these feelings and reinforce parent-child alliances. It's always important to support parents' skills, and thereby to strengthen and empower them. However, the two parents' interests may also not coincide. How then to help each? To protect each? To garner for each needed services?

In addition to the family, children are also embedded within a number of other systems, such as school, welfare, protective services, and so on. Helping always involves relating to each of these systems and essentially re-creating the child's environment within the helping framework. Each agency and system has its own mandates, its own professional requirements, and its own territory; disagreements may result as much from inadvertent misunderstandings as from real differences in points of view. In the R. case, differing missions, qualifications, and turf were all involved in our poorly coordinated handling of the case. For example, the Protective Service worker later told us that she had dug in her heels about the abuse because she thought that we were trying to tell her how to do her job. The more frantic we became, the more other agencies concurred, the more she backed off. But other agencies had no mandate to pursue the violence. And time is a more precious commodity for children than for adults.

Finally, in looking at Rachel's story we can see how important it is to understand the process of development itself, without which we can't really assess what's going on. Is the behavior "just a stage" or a reasonably appropriate reaction to abuse or chronic stress? What if Rachel had been four instead of six? And so on.

I've gone into some detail about a few of the issues presented by the R.'s to illustrate two points. First, child mental health practice, as it occurs in community clinics today, is a broad-spectrum affair which, as noted, undertakes to work directly or indirectly with all the players and the agencies in the child's/family's life. As implied, the conceptualization of treatment is systemic and ecological, and internal causation, be it intrapsychic or biological, is simply one of a long list of possible explanations for behavior. Thus, it would appear as if both the form and the substance of child/family work differ from the medical model, predominant in the mental health system today, and there seems no question but that the differences would be greater were child professionals not constrained to work within that system.

Second, and clearly following from the preceding, the skills needed to help children and families are equally far ranging, and they are also *particular* skills. Being trained to see adults, and to conceptualize the needs of this population, does not qualify one either to work with children directly, or to speak about their conditions and requirements with authority. We will see later how crucial the latter issue has become.

Rachel R.: Service System Issues and Response

The saddest commentary on Rachel's story from a service perspective is that, in retrospect (only), it looks as if it took place in a time of relative plenty — before the cuts in human services implemented by the Reagan administration;¹¹ before the further cuts in children's programs in Massachusetts;¹² long before the current recession. Yet gaps and distortions in service are very much in evidence in this example. For one thing, the R.'s had no home, and living out of a car surely exacerbated everyone's level of stress and Father's tendency to violence. Mother was reluctant to pursue public housing or to get involved with any government agency more than she absolutely had to, because she feared that Father would be "discovered," and they would be disqualified from AFDC. While no longer the case in Massachusetts, there are still many states that deny AFDC to two-parent families — a good example of the antifamily bias contained in many of our official policies.¹³

Although worse was to come, we can see gaping holes in the continuum of mental health services. The one public mental health hospital for children mentioned remains the only such unit in the state, and as of this writing public hearings are under way to

determine if it, too, should close.¹⁴ Although hospitals, treatment centers, and other types of out-of-home placements are far down the line in terms of options for children, they need to be available and to be equitably distributed. As Rachel's story suggests, both these issues are relevant, and it is interesting to note that, while child and adolescent admissions to public psychiatric hospitals have decreased markedly in recent years, those to private hospitals have more than correspondingly increased, suggesting that the issue is not the treatment modality per se, but who is entitled to it.¹⁵

The need for accessible prevention, early intervention, and prompt health and social services are all highlighted by this story. In fact, the child unit would probably never have seen Rachel had it not had an outreach component in her school. But where were the pregnancy-related services? Job training? Appropriate educational opportunities? Why did it take violence to get society's attention at all? What future can we really expect for any member of this family? The thought is depressing.

However, at the time, the response of local service providers to the many Rachels we saw was actually quite optimistic. We organized. We formed an areawide Children's Committee consisting of all child/family serving agencies, and determined that we would identify and do something about the problems that we and the clients were experiencing.¹⁶ Clearly we felt that this was possible. Had we been more aware of the history of such efforts (below), I'm not sure we could have summoned the energy.

The aim of our committee was to establish a coherent, coordinated system of services to address as wide a spectrum as possible of child/family issues (recreation, day care, early intervention, protective services, education, health, mental health, substance abuse, legal problems, emergency services, and so on). We foresaw a single community entry point for a number of the services, a twenty-four-hour information and referral program, and an ombudsman or family advocate to facilitate clients' smooth passage through programs. To begin, we undertook a joint professional-community needs assessment process, and in line with this participatory ethic, we felt it important to redefine the concept of "treatment." We proposed abandoning the term itself (although we never did agree on a substitute), while at the same time vastly broadening the types of activities included under this rubric. We saw the process of helping as a collaborative, problem-solving endeavor, rather than a hierarchical, agency-driven imperative (this was pre-empowerment).¹⁷

Of all issues, that of effective interagency collaboration struck us as most crucial, since demands for service were increasing while money for programs was not. Collaboration was something that we could do, with no additional funding, which could at least plug some holes in the system and prevent the kind of interturf warfare that hampered the R. case. So we spent a lot of time getting to know one another and the mandates and missions of our various agencies. We also identified troubleshooters to mediate within our own group. We even began to develop joint protocols for service and referrals, and to wrestle with the thorny issue of client confidentiality within an affiliated network.

Finally, we approached our parent departments for money to staff our efforts. We pointed to time analyses showing savings in such areas as processing clients, negotiating with other agencies, and providing information and referral. We emphasized the preventive side to our endeavors: with good relationships and a shared knowledge of community resources, clients were receiving a package of services, and problems were being dealt with before they became intractable and enormously costly. At the other end of the service spectrum, we were also saving money, since we were

resolving difficult cases among ourselves, so that few had to go on for interdepartmental mediation. Further, as a group, we'd been successful in writing service proposals; it was staffing we needed.

We thought that we were on to something. We had actually begun to implement a planned, rational system of services in a low-income, multineed community. We felt that this accomplishment was particularly important since by that time (early to mid-1980s) we were beginning to see more and more children and families with multiple and serious needs, at ever younger ages. We made the latter point repeatedly. Without services and support, without appropriate opportunity, these children would not learn how to function independently, could not grow into responsible adults. We were setting up a time bomb.

As you've probably guessed, we did not succeed in shaking loose money for the organization from any state agency, nor did any department adopt the concept and run with it. I was baffled by the response of the Department of Mental Health, which evidenced no interest whatsoever in helping us and basically ignored our efforts. While I had no illusions that the department had any interest in children, I was surprised that it didn't pick up on a program which was helping to relieve it of unwanted responsibility. The Department of Social Services, which was more supportive and sympathetic, did entertain a proposal from us, but in the end said that they wanted to fund "new" efforts, and that ours, then five years old, was already "established" in the community.¹⁸ Established, yes, viable, no, since those of us involved could no longer put in the countless hours of unpaid time required to make it work. With much regret and some disbelief, we disbanded.

History

In the year 1991, the status of children in this country appears as dismal. One recent author, after reciting a litany of deficits in such areas as low-income housing, jobs, welfare, prenatal care, and educational opportunity, concludes that "child neglect has become endemic to our society."¹⁹ A report tells us that "our nation's children are at greater risk today than at the beginning of the 1980s,"²⁰ and goes on to inform us that 20 percent of all American children, and an astounding 43.8 percent of all black American children are now living in poverty. Yet these figures differ little from those of twenty years ago when "One-fourth of American children under age 18 live[d] in poor families. Nonwhite children [were] almost four times as likely to be disadvantaged as white children."²¹

If the status of children is depressing, the state of the service systems ostensibly designed to help them defies characterization. Quotes from local and national sources over the last two decades give the general picture:

In spite of our best intentions, our programs are insufficient; they are piecemeal, are fragmented, and do not serve all those in need. Unwittingly, we have failed to commit our vast resources to promote the healthy development of our young.²²

The Special Commission also uncovered an absence of coordination of the many different agencies providing children's services. This has resulted in agencies refusing to care for other agencies' children, identical services being offered by several agencies, and lack of consistent case management, case referral and cost-sharing policies.²³

Further, it is sad to note that, among child-serving agencies, the Department of Mental Health, the agency one would assume to be the monitor of child (and adult) well-being, has been a particularly frequent object of criticism at both state and national levels. For example:

The story of the (Mass) Department of Mental Health is one of ineptitude, misfeasance and misguided priorities. This state agency, responsible for the mental health of our citizenry, largely disclaims responsibility for children.²⁴

Like states, the federal government has paid little attention to disturbed children and adolescents. The lack of adequate targeted funding, organizational visibility . . . standards, training, or cross-agency efforts apparent at the state level is repeated at the national level.²⁵

The Early Period

To best illustrate the continuity in our thinking and responses, I'm going to begin this history with our own beginnings as a nation, in the early nineteenth century. At that time, the debate over the merits of public versus private, and institutionally based (indoor) versus individually based (outdoor) relief was already much in evidence. By and large, the history of the nineteenth century is the story of the rise of institutions and the increasing assumption of public responsibility for social problems, at least at community and state levels. However, even during this early period, there were differences in the way we structured our responses to perceived child and adult issues. These disparities, as we shall see, were to set the stage for future difficulties in creating comprehensive service systems.²⁶

In terms of public institutions, the primary kinds of facilities developed to address the needs of the poor, including the indigent mentally ill, were state psychiatric hospitals for adults (usually males), orphan asylums and reform schools for children, and almshouses for the poor. Since the concept of child mental health did not yet exist, there were obviously no institutions to deal this problem; therefore our incipient public mental health system was one focused on adults. And, as mental health historians have chronicled in detail, the system components, state hospitals, proliferated in number and expanded in size throughout the 1800s. By the end of the century, the hospitals had evolved from relatively small institutions practicing humane therapy to "cure" their charges into huge holding operations for patients felt to be chronically ill and virtually "incurable." And the administrators of these facilities, male psychiatrists educated in elitist universities, had even by then succeeded in institutionalizing their own role as experts in the treatment of psychiatric patients. The psychiatrists were able to accomplish this feat, despite not curing their patients, owing both to their monopoly of high-level positions in the field and to the growth of their own professional organizations.²⁷

Public institutions for children, as noted, were first established to deal with two groups of youngsters: those who had been orphaned or abandoned (orphan asylums) and those who were either already delinquent or thought to be in danger of becoming so (reform schools). In addition to publicly funded programs, private philanthropy provided a major source of support for children's services and was to continue in this role long after analogous efforts for adults were supported primarily by public funds (see Child Guidance Movement, below).²⁸

Social services for children and welfare services in general were predicated on an Anglo-Saxon (Puritan) philosophy that equated poverty with laziness and other personal vices. Hard work and inuring privation were seen both as preventive measures against poverty and as antidotes to the condition itself. Care was taken in social programs neither to give too much, lest the recipient lose the incentive to work, nor to give to those not seen as "deserving," or capable of working themselves. The righteous horror of poverty was such that youngsters living with their families in almshouses were actually removed to orphan asylums so that they would not be corrupted by their surroundings (including their indigent parents), and could be trained according to proper moral principles.²⁹

With the turn of the century came new efforts at reform. In the mental health arena, the mental hygiene movement emerged and made a valiant attempt to modify the state hospital system, in part by advocating the addition of outpatient services. However, as late as 1935, a national survey found that only half the state hospitals had developed even token outpatient departments. According to David Rothman, the institutions and their administrators had become a self-reinforcing system, with the psychiatrists loath to agree to any changes they saw as reducing their growing influence and power.³⁰

Children's reform efforts shifted focus at this time from the individual child to the child-within-a-family-and-community. New coalitions of advocates and professionals were formed to deal with such issues as child labor, slum conditions, and maternal and child health. Two landmark accomplishments of the new groups were the establishment of the Federal Children's Bureau in 1912 and the passage of the Sheppard-Towner Maternal-Infancy Act in 1921. The latter, which provided grants to states to establish departments of maternal and child health, was soon allowed to expire, such was the opposition from state governments and the American Medical Association (AMA) to this "imported socialistic scheme." The Children's Bureau, however, set up with the broad mandate to "investigate and report . . . upon all matters pertaining to the welfare of children and child life,"³¹ survived in one form or another in the federal bureaucracy until the 1960s. Undoubtedly, the height of its influence was in the early years, when its comprehensive plan to address child health and welfare issues became the basis for Title V of the Social Security Act. Enacted in 1935, this legislation served finally to validate the role of the federal government in child welfare, by establishing the Aid to Dependent Children program, which also institutionalized the concept of the deserving poor at the federal level.

The Child Guidance Movement

The Child Guidance Movement, probably the single most innovative effort ever in the "child mental health" field, and the effort that launched the term itself, began in the second decade of this century. The movement was an outgrowth of reforms in the juvenile justice arena, and it built upon the interdisciplinary team method developed in the new juvenile court clinics. Its ambitious agenda was summed up in 1934: "Historically, [the Child Guidance Clinic] owes its existence to the broader concern . . . with the age-old and overwhelming problems of delinquency, mental disease and dependency."³²

Conceived and supported by the Commonwealth Fund, child guidance was initially a preventive effort in which child-and-family outpatient clinics collaborated with schools, health, and social service agencies to "study" and treat children's prob-

lems before they led to more serious acting-out behavior. Eight demonstration clinics were set up in as many U.S. cities, and money was allocated for staff, training, research, and a cadre of affiliated school social workers. The emphasis on delinquency prevention was short-lived, however, and the clinics quickly began to deal with middle-class, garden-variety problem children. In 1927 the fund revised its priorities in favor of training and set up an independent professional institute for this purpose. In so doing, it extended its influence well beyond support of the program, which ended in 1945. It is therefore significant that a retrospective study of the training effort showed two important features: a psychoanalytic theoretical orientation, which also viewed psychiatrists as "in charge," and a pattern of discrimination against women and Jewish candidates (who were statistically more interested in this field) in favor of "elitist males."³³

Thus, by the eve of World War II, several critical characteristics of the human service system are discernible: (1) in terms of mental health, virtually all efforts, both public and private, child and adult, were controlled and run by male psychiatrists; (2) adult mental health services, publicly funded and hospital based, focused on individual clients; (3) children's mental health services, privately funded and outpatient based, targeted children and their family/community contexts (as child services had become increasingly dominated by male psychiatrists, they, too, had become more individually focused); (4) children's health and welfare programs, under the Children's Bureau and Title V, also systemically conceived, overlapped in purview with the guidance clinics; and (5) our welfare services continued to view giving in moralistic terms.

World War II and Beyond

The war itself had two important consequences for our chronicle, the first enduring, the second not. The enduring outcome (to date) was a change in the perception of mental illness as incurable, partly as a result of successful emergency treatment practices on the battlefield. The "discovery" that psychiatric conditions might be cured led in rapid succession to the passing of the National Mental Health Act of 1946 and to the establishment of the National Institute of Mental Health (NIMH) in 1949.³⁴

The pertinent temporary outcome of the war effort was the Emergency Maternity and Infant Care program, the most comprehensive federal effort in this sphere ever undertaken. The government, asking for no state matching money and no means tests for participants (as required by Title V), launched a program of total maternal and infant care services for soldiers' wives. This program lasted "for the duration" and was withdrawn immediately after hostilities ceased, when the prescription for women changed abruptly from "helping our boys" to "getting back to normal" at home.³⁵

However, the emphasis on helping those who had fought the war remained. In fact, it is Murray Levine's contention that

in the immediate postwar period, the Veterans Administration mission to care for the returning veteran dominated mental health efforts. Because so much was concentrated on the[se] . . . young and middle-aged males, the development of programs for . . . other populations [women, children, the aged] was neglected. Th[is] emphasis . . . led to a whole generation of mental health workers without training or encouragement to service other populations. It was the war . . . that defined the mental health problem, and . . . the solutions the federal government [would] support.³⁶

While Levine's thesis fits with the events that were to follow (below), the focus on the veteran was really only an extension of the system's historical concern with adult men. It's probably truer then to say that the war had merely provided a stronger rationale for continuing with the same emphasis.

And continue it did. NIMH allocated money for training, as noted above, and for research, and the 1963 Community Mental Health Centers (CMHC) Act provided funds to build facilities. The research yielded new groups of psychoactive drugs, hailed as miraculous, which ameliorated symptoms sufficiently to allow for early discharge from hospitals. Since the hospitals themselves had recently been scrutinized and found wanting, there was renewed call for reform: clean up the facilities; provide services in the community.³⁷

In 1955 Congress authorized a "nationwide analysis . . . of the human and economic problems of mental illness."³⁸ The study, conducted by the Joint Commission on Mental Health and Illness, was directed by Jack Ewalt, past commissioner of mental health in Massachusetts. "Action for Mental Health," published in 1961, summarized the group's recommendations. It called for greatly expanded outpatient and community consultation programs, standards of care, and continued research and training, all to revolve around chronically and seriously mentally ill adults. Not a word about children and families.³⁹

Actually, progress on social issues seems to have regressed during this period, as women had returned to the home, literally and figuratively. The decennial White House Conference on Children, initiated in 1910, had continued to meet and issue reports. However, "No one listened, and . . . the White House Conferences seem to have functioned as encounter groups and little else."⁴⁰ One thing that did occur was a postwar baby boom. There were soon more children flooding schools, hospitals, welfare agencies, and society. There was also considerable structural economic change after the war as industry moved to low tax areas and farms decreased in numbers and increased in size. And, a portent of things to come as the "boys" came home and families grew, was the enormous pressure on the housing market.⁴¹ The resulting U.S. Housing Act of 1949 established the goal of "a decent home . . . for every American family"⁴² and launched a number of federal efforts in pursuit of that goal. The language of the legislation seemed to imply that housing was a right for all Americans.

Then came the 1960s. First President John F. Kennedy and then President Lyndon B. Johnson led us to believe that something could actually be done about poverty and discrimination and inequity — and that they would lead the way. Suddenly people "saw" the problems that had been there all along; a spate of federal legislation ensued. We owe to the 1960s Medicaid, Medicare, comprehensive neighborhood health centers, and Head Start. A less fortunate legacy of this decade was the breakup of the Children's Bureau, transferred and demoted due to the reorganization of the Department of Health, Education, and Welfare (HEW) in 1967. The move was symbolic of two trends: increasing fragmentation and categorization of services and reliance on a "vertical" approach to service delivery, that is, having programs target all age groups under the same aegis.⁴³

Nowhere was this inclusive thrust more evident than in the CMHC Act and its subsequent amendments. President Kennedy, going beyond the recommendations of the Joint Commission, called for a "bold new approach," with an emphasis on prevention, community care, and service continuity. He specifically linked mental health problems to poor social, educational, and welfare conditions, and called for a gradual

depopulation of state hospitals.⁴⁴ As a requirement of the act, each state had to develop its own implementation plan. Reading through the Massachusetts plan, one is struck with the excitement engendered by the opportunity to reorganize a state system. Certainly the conceptualization was global.

Mental health is an issue with which every institution in our society is involved; the family, the school, the church, the employer, organized labor, the hospital, the settlement house, the police, the drug store, even the poolroom and the bar . . . The community mental health program must relate to and direct its efforts toward other significant institutions . . . The various services must be linked in such a manner as to assure continuity of care.⁴⁵

One area in which opinion did differ here was how best to include the required citizen participation in mental health activities. The plan records two points of view: (1) programs should be decentralized, with local communities maintaining control; and (2) programs should be left in the hands of professionals as "citizens would only get in the way." The compromise position left services largely in the hands of the Department of Mental Health (DMH), with a plethora of lay boards and committees to "advise" various administrative levels.⁴⁶

In all, the federal CMHC Act was amended fifteen times — in 1970 to include services for children.⁴⁷ Because the Joint Commission, and the CMHC Act itself, had so conspicuously omitted children and families, leaders in the child welfare and mental health fields had convened a commission of their own, the Joint Commission on the Mental Health of Children. Their 1969 report, "Crisis in Child Mental Health: Challenge for the 1970s," was the first of what was to become a long series of local and national publications outlining the disastrous state of children's services. It was also influential in adding children to the CMHC priority list.⁴⁸

Conceptualizing mental health in the broadest possible terms, "Crisis in Child Mental Health" talked about the effects of poverty, racism, social change, and a spotty educational system, and provided evidence to show that mental health services for children were actually less available in 1967 than they had been in 1930. The tone of the report was outrage. The solutions offered were a multitiered child advocacy system; a comprehensive community service program emphasizing prevention; and a whole series of programs to ameliorate poverty and social conditions, including a long section on housing. The latter stressed the need to undertake a massive program of construction and repair and cautioned that urban renewal efforts should not disturb families and communities. Noting the federal emphasis on adult services, the report expressed concern that "many child guidance clinics are currently the nuclei for mental health programs . . . their activities in behalf of children steadily declining. Supposedly, this diversion is temporary, but . . . it may not be unlikely that less services for children will be available within so-called comprehensive programs than was provided for children previously."⁴⁹ A prescient comment.

The Last Twenty Years: United States

We are now back to where we started this history. And, as the quotes at the head of this section suggest, the last two decades have seen steadily decreasing opportunity, steadily worsening conditions for children and families. These years have also produced considerable comment on this situation.

The marker event of the recent past was the election of Ronald Reagan. Unabashedly committed to giving to the haves, he immediately set about disman-

tling housing and human service programs, thereby increasing both the numbers and the plight of those who had fewer resources to begin with. Reagan also vetoed the 1980 Mental Health Systems Act. This product of the Jimmy Carter administration had called for a recommitment to the community aspect of community mental health, including increased collaboration between health, housing, and human service systems.⁵⁰ For children, the act had incorporated one of the recommendations of Carter's 1978 Presidential Commission on Mental Health, by authorizing funds to improve services to severely disturbed youngsters.⁵¹

The president's commission itself had actually outlined a much broader set of needs. Noting that few of the recommendations of the 1969 Commission on Children had been implemented, it had designated youngsters as one of several "underserved" populations entitled to priority services.⁵² At about the same time, the Select Panel for the Promotion of Child Health, created by Congress to assess the status of maternal and child health, issued its own report, listing the following "major concerns": (1) known interventions were not reaching consumers; (2) there were wide gaps in health status by income and ethnicity; (3) emotional health needs were not being addressed; (4) health systems were unsupportive of families; and (5) programs were split, fragmented, and competitive with each other.⁵³

However, the most damning national report on children's services was Jane Knitzer's "Unclaimed Children," published in 1982. Utilizing data from all fifty state mental health departments and from the federal system, she concluded that "of the three million seriously disturbed children in this country, two-thirds are not getting the services they need . . . Only seven state departments of mental health have taken the first limited steps to create a range of . . . services for troubled children."⁵⁴ Her report was replete with depressing facts: both federal and state funds targeted medically restrictive care to the detriment of community programs; only 17 percent of federal CMHC dollars were spent on children, although they comprised 32 percent of the population; few state mental health departments contained children's units; other children's agencies, such as welfare and protective services, had virtually ignored mental health issues; coordinated service systems were few and far between. Unlike previous exposés, Knitzer's did produce changes. NIMH responded by allocating money for the Child and Adolescent Service System, an effort to establish comprehensive systems of services for seriously disturbed adolescents. While an important undertaking, the program was limited in scope and addressed itself only to those with the severest problems.⁵⁵

Massachusetts: The Recent Past

What about Massachusetts? How well had we succeeded in implementing the far-reaching, community-focused aims of our mental health planning process? The Massachusetts Comprehensive Mental Health and Mental Retardation Services Act was passed in December 1966, with the following three purposes:

- to establish a complete range of services in each community, so that every person requiring help, regardless of age or economic condition, can be cared for appropriately and quickly . . .
- to cooperate with other community agencies to provide continuity of care, especially to families being served by more than one agency
- to give people a strong voice in determining programs for their own Areas⁵⁶

A 1970 DMH brochure had this to say about children's services:

The long-range plan of the DMH is to offer a complete range of services to children, from birth to adolescence, that would include early home training for pre-school children, out-patient and day-time services, residential care, halfway houses for adolescents, and consultation, education and research. Recognizing that children 17 years of age and under constitute 40 percent of the Commonwealth's population, and services to this dependent and voiceless constituency are at present fractionated and inadequate, the DMH recommends a Child Advocate in each Area . . . [and] 1970-71 has been designated "The Year of the Child."⁵⁷

In 1972, the Task Force on Children Out of School, chaired by Hubie Jones, issued *Suffer the Children: The Politics of Mental Health in Massachusetts*. Its Foreword begins, "The report which you find . . . developed out of outrage and frustration."⁵⁸ Indeed, what follows is a searing condemnation of the DMH as mismanaged, duplicitous, and utterly uncommitted to children. Utilizing staff interviews and the department's own statistics, the report points out that only 5 percent of the DMH staff and 3 percent of its budget had been allocated for noninstitutional children's services. The document goes on to cite numerous instances in which citizen board priorities for children had been ignored and circumvented by the department. It states flatly that the DMH, "from its highest level [central office] to its lowest [areas] is controlled by psychiatrists whose training focuses them on adults . . . in institutions."⁵⁹ The report recommends an immediate investigation of the DMH for subverting the 1966 Mental Health Act and suggests numerous measures to ensure that child/family needs will be acknowledged and met.

Within five years of *Suffer the Children*, three additional groups, representing the state administration, the legislature, and a major child advocacy organization, had each surveyed the spectrum of agencies serving child and family needs.⁶⁰ All three groups issued reports citing fragmentation and duplication of services, absence of accountability, and lack of uniform standards of care. Two groups stressed the need for preventive programs and bemoaned the historical absence of priority for children in the state, as measured both fiscally and politically. They cautioned that unless the issue of priority was addressed, cosmetic organizational changes would come to naught. *The Children's Puzzle*, the report commissioned by the state legislature, put it succinctly:

There is a demonstrated ambivalence in state policy toward children. Landmark legislation enacted by the Massachusetts General Court is either underfunded or not implemented. Legislation is not implemented because of the diffusion of responsibilities between agencies or because the agencies charged with implementation are incapable of, or resistant to, following the expressed intent of the Legislature.⁶¹

Incredibly, in 1984, just seven years following the above, the state Senate felt it necessary to undertake yet another investigation of children's services, and its findings read like a carbon copy of previous efforts. It's especially interesting to see that DMH's budgetary commitment to children and families has remained the same as twelve years previously: 4 percent of total expenditures. A new and ominous note, however, is that children's services are being cut back. The governor has slashed DMH's meager budget request for children in half; DMH Central Office has reduced

its children's staff 70 percent in the previous three years.⁶² One concrete reform that did result from the Senate's efforts, however, was Executive Order 244, mandating separate hospital units for adolescents.⁶³ Like the response to Knitzer, the focus was on the most restrictive, medical — and oldest — end of children's services.

Now something funny happens. In December 1984, the secretary of Human Services had initiated the Mental Health Action Project to look into the needs of chronically mentally ill persons. The project's final report, issued in August 1985, included a detailed description of needs and available resources, as well as a set of specific recommendations. The 103-member project committee prefaced the document by stating,

The Mental Health Action Project represents an important attempt to focus attention on the needs of chronically mentally ill citizens. *It in no way diminishes the other target populations for whom the Department has statutory responsibility. Services to children and adolescents and to mentally retarded citizens continue to be areas of concern as well.* [Italics added]⁶⁴

The report goes on to articulate a mission statement for the department "in serving chronically mentally ill persons" — guiding principles, in other words, to be utilized while dealing with this population. However, the new mental health law, the State Comprehensive Mental Health Service Plan Act of 1986, limited the department's mission to the seriously and chronically mentally ill. And the Mental Health Action Project's findings were cited as the basis for this official change in direction.⁶⁵ In line with these developments, the Governor's Special Message on Mental Health (December 1985) called for major improvements in adult services, with huge amounts to be spent on renovating the state hospital system.⁶⁶ Having ignored children, families, and preventive strategies for years, contrary to statute, finally there was a legal basis for this position.

Homelessness

The other big news of the last decades, of course, has been homelessness. While the R. family was unusual in the 1970s, their counterparts became commonplace in the 1980s. In trying to figure out why this was so, we have uncovered a whole new set of gaps and declines: federal support for low-income housing dropped from \$32.2 billion to \$9.8 billion in the ten years between 1978 and 1988;⁶⁷ the median income of young parents fell 36 percent between 1974 and 1987;⁶⁸ the percentage of children growing up in poverty rose 25 percent between 1979 and 1989.⁶⁹ The job market has continued the changes begun after World War II, losing the high-paying manufacturing jobs that had provided career ladders for generations of new workers, gaining service-sector jobs that pay less yet frequently carry higher educational requirements.⁷⁰ Entitlement benefits, such as AFDC, low to begin with, have not kept pace with inflation and now average, nationwide, only 68 percent of the poverty level.⁷¹ Rents have skyrocketed. No wonder that in 1990, in 74 percent of cities surveyed, more families were requesting shelter than the year before. Or that families now comprise 34 percent of the homeless population.⁷²

And what has been our response to homelessness? Across the nation we have built shelters: emergency, short-term, longer-term, "transitional." Also, we have called for "homeless services": health care, day care, parenting programs, G.E.D.

classes, job training, counseling. While warning ourselves not to create a "homeless system,"⁷³ that is just what we've done. Not that it's a profligate enterprise. As the National Coalition for the Homeless reminds us, the sum total of expenditures under the Stewart B. McKinney Homeless Assistance Act constituted only 0.05 percent of government spending last year.⁷⁴

Nonetheless, we did at last respond where we had long been turning a deaf ear. And in so doing, we recapitulated the R. family scenario on a national level: one's plight must reach virtually ruinous proportions before we intervene. In St. Louis, for example, a Human Services Network was established, with the city planning, coordinating, and at least partially funding a continuum of residential and human services.⁷⁵ In Chicago, a large Public-Private Task Force of advocates, providers, and bureaucrats worked hard to accomplish the same goal.⁷⁶ In Portland, Oregon, existing settlement houses became large multiservice centers, blanketing city neighborhoods and attempting to maintain and provide for homeless families within their own communities.⁷⁷ Here in Massachusetts, Governor Dukakis, in his January 1983 Inaugural Address, declared homelessness to be his "number one priority,"⁷⁸ at the same time as the state was decreasing other services to families. The very year that our interagency project, the product of five years' work on the part of a city's entire child service system, couldn't scare up a dime.

Analysis

I doubt that anyone would admit to being *against* children and families. Quite the contrary, we think of ourselves as a family-centered society; we talk constantly about loving and doing for our children. By the same token, it's hard to imagine anyone being pro-homelessness, saying that there should be people without roots or a place to live. Yet our actions belie our concept of ourselves: we tolerate homelessness; it's a struggle to get any children's programs validated and funded. Even more significant, repeated attempts at reform of the child and family service system seem to go nowhere, since the same issues arise continuously, and the same kinds of recommendations keep being made. It is these two factors, the disjuncture between belief and behavior and the enduring tenacity of the behavior itself, which suggest that we must find a new way to understand what has been going on in order to be able to effect change.

Two thoughts occur to me. If it hasn't worked simply to look within the child/family system, to identify lacks and ask for redress, perhaps we need to begin by comparing children's issues with other, seemingly more valid ones, to identify the pertinent characteristics of each. What would emerge from this kind of analysis would be a set of risk factors for problematic issues; the more factors any situation contained, the less likely it would be to be addressed well, or even at all.

For example, we might juxtapose our handling of child/family issues with the way we dealt with the recent savings and loan crisis. In the latter instance, we appeared unhesitatingly willing to commit huge sums of money to correct the mistakes and misdeeds of financial entrepreneurs. Granted, there were large societal costs to consider, but there are obviously also societal bills to pay for neglecting children's health or allowing people to live in squalor. From this example, it would seem that we validate issues that involve men and/or attributes that we see as inhering in men: independence, competitiveness, action orientation, and so on. By contrast, children's issues focus on populations seen as dependent and involve interconnected groups of

people rather than individual adults. There are also ways in which the examples are similar, the most important being that we typically allow situations to fester, no matter what the specific issue. Once we do respond, however, there are vast differences in the quality of that response, depending on the problem addressed, as can be seen by comparing the amounts spent on the savings and loan bailout with the dollars we've committed to dealing with homelessness.

Because we are talking about risk factors, rather than causal relationships, as noted above, we can assume that those issues containing more negative features will be handled less well than those with fewer (and vice versa), although both will suffer to some extent. We can see this process at work by looking at the experience of different populations within the mental health and homeless systems. While all people involved with either system have been stigmatized, along with other "needy" groups, in both cases adult men were recognized and received help first. And, at least within the mental health system, men have also achieved a virtual monopoly on services.

The "risk factors" we've been discussing are really equivalent to our cultural values. In saying that the same set of beliefs underlies our treatment of children and the presence of homeless families, we are clearly implying that without some change in these attitudes and beliefs, conditions such as homelessness will continue to exist. Therefore, it seems to me that our second task is to reexamine some of these values in more detail and, using our history, to show the ways in which they appear to be affecting our policies and programs. Tenets that are laudable in theory lead to quite unexpected consequences in practice. Values that made cultural sense for a new nation may well be outmoded today.

On the eve of the twenty-first century, it appears that the frontier mentality is still with us. It is also an anachronism, but I'll come back to this later. Basically, our public ethos seems to consist of about three parts rugged individualism and one part Puritan ethic. At the top of the list is our focus on the individual. But what exactly constitutes individualism? At a minimum, that we're responsible for ourselves; that we respect those who "go for it" even at the expense of others; that we want government to leave us alone, and vice versa. Conversely, individualism implies that we don't think much of those whom we label dependent, or not responsible; that we are loath to regulate, and in fact admire people who take advantage of others; and that we resist public solutions for problems involving people. By definition, glorifying the individual means that we are less interested in families. And a focus on individual causation serves to absolve society. If fault is strictly personal, we don't need to look for societal factors and we don't need to change the way we do business. Instead, we can build asylums, and when that solution fails, we can erect hospitals. Or we can put up emergency shelters, and when they don't suffice, we can devise transitional housing.

There are two underlying implications to individualism: that the individuals in question are male and that they are also adults. Women, always by culture and usually by choice, are caretakers in society, and can rarely act independently of others. Children as well do not function on their own. Thus, we have adopted a standard that can really only apply to men, without, however, appearing to take this fact into account. And, circularly, since the ability to function independently *is* our standard, we also accept that society should focus first on the needs of those who best meet this criterion, men.

When individuals go about pursuing their interests with minimal government interference, the result, of course, is the free competitive system, the second peg in our

set of values. Once again, there is an implication to competition that we seem to lose sight of: where there are winners, there must also be losers. By stressing competition, we are ensuring that there will always be groups of people who have less than others. We are saying both that we expect losers, and that it's okay with us if they exist. And because we believe that a person's fate is within his or her own hands, when people lose, we blame them. These processes have allowed us to tolerate and rationalize disadvantaged populations among us. Taken together with our reluctance to seek government solutions, they have permitted inhumane outcomes, such as homelessness, to evolve and persist.

However, when we do create public structures, we can see the effects of competition in these as well. Nowhere is this more evident than in the perpetuation of fragmented, duplicative service systems. As we have seen, agencies and government departments are frequently assigned similar or overlapping mandates, then left to work out the details themselves, at staff, client, and citizen expense. It seems contrary to human nature, and to logic, to then expect these same entities to cooperate. Our overwhelming emphasis on competition really precludes effective collaboration and system building. It also overtly encourages splits and disagreements between people and agencies, as programs vie with one another for money and status. Having to prove continuously that they're better or more innovative in order to stay alive, agencies which should be natural allies, since they're working with the same clients and concerned about the same issues, end up as enemies. The existing system, able to offer rewards to first one and then another, emerges the constant victor.

Finally, free competition assumes a level playing field, which in fact is seldom to be found. A good example is the way in which we assign priorities to issues. We act as if all interests were equally present in the political arena, slugging it out for monetary-program prizes. Actually, some interests, such as children, cannot represent themselves at all, and others, including the poor, ethnic minorities, and women, have a diminished presence due to cultural perceptions and attitudes. When the needs of the latter populations are constantly reclassified downward, we conclude that they were simply not as pressing — each time, year after year — without stopping to look at the process.

A third fundamental precept stems from our Puritan background, adding a moralistic tinge to individualism. It holds that, just as success is the result of essential goodness, badness, or sin, underlies failure. Thus we frame solutions that are punitive: we exclude those not really deserving; we give as little as we can get away with; we try to catch people cheating. An unfortunate legacy of Puritanism is our refusal to offer true entitlements. We're so afraid of giving to a "wrong" person, thus abetting sin, that we spend countless dollars creating bureaucracies to play the role of church deacon. Unlike most of Western Europe, we have neither universal maternal and child health benefits,⁷⁹ nor a right to housing assistance.⁸⁰ Even when we enact legislation which seems to imply that right ("the general welfare and security of the Nation . . . require . . . the goal of a decent home"),⁸¹ it just doesn't happen. How ironic that the only time women were entitled to receive maternity benefits was to further the cause of war! Not for themselves, their children, or the future. It is a lesson in our real priorities to examine the life and death of this World War II program.

The last frontier principle I'd like to discuss is the need for quick, easy solutions, an imperative with great relevance for our response to homelessness. Shooting first and thinking later may have been serviceable in the Wild West when, on balance, it

was better to react quickly to an emergency, but adopting the same style in settled life distorts the sequence of events: now it takes an emergency *in order* for us to react. All kinds of consequences follow from this: we neglect issues until they turn into crises; we reinforce the squeaky-wheel approach to operating; we give time-limited responses, since attention itself relieves the emergency, and soon there's another issue whose noise level is higher. As with our other values, continuing to believe that a quick and easy style is effective and appropriate means ignoring alternative evidence and implications.

Easy solutions imply simple problems, a formulation in line with our individualistic thinking. While in fact problems involving individuals are not simple, those pertaining to families are even less so. Holding to the construct of easiness has led us to devise solutions that focus on single factors while ignoring side effects and other issues. In giving priority to homeless people over others for housing, as in New York City,⁸² we inevitably create more homeless persons. In constantly funding demonstration projects, we ensure an unstable system with lapses in service, staff turnover and unemployment, and maximal administrative and societal costs.

Quick responses share many of the characteristics of easy responses, but faith in their efficacy has an additional, critical implication: that we don't really need to plan for the long term, and therefore don't need to devise *policies*. Our lack of a child and family policy has been noted repeatedly, as has our inconsistent treatment of these populations in current laws and regulations. Refusing welfare to two-parent families is one example; splitting families to enter shelter is another. All family homelessness is a third, since no policy could possibly countenance the absence of the most basic structures for stability and growth. Without policy as our guide, each decision is ad hoc, and may or may not be consistent with the next, or the last, ad hoc solution.

Finally, there are important connections between our reliance on an emergency approach and the political process. In the more obvious sense, the two factors are mutually reinforcing, since politicians keep needing new issues, and the issues and their advocates frequently require a politician's clout. However, there is also a way in which believing that a crisis response pattern is sufficient denies the more lasting effects of the political system and ignores the degree to which politics infuses all decisions.

The history of the mental health system is testimony to the ways in which enduring vested interests maintain control over the long haul. True, there are pauses to respond to periodic crises in other spheres, as for example homelessness or even children, but the default position is clear: the system always reverts to the concerns of its male medical establishment. Depending on our figure-ground position, we can either see this as success for a crisis approach or, as I've indicated, monopolistic control by the predominant political group. Although an extreme example, because interests are rarely so narrow, the mental health system may be likened to society. We as providers may approve the crisis-oriented mode of operating simply because it seems to have worked for us, with no clue that there is also a long-term process and a more inclusive perspective. The purpose of my article is to help to provide that broader point of view and to show the very real and persistent effects of our belief system.

It has become a truism to say that those who ignore history are doomed to repeat its mistakes. Believing this, I've tried to cover enough of the past to show patterns, but clearly the account is sketchy. It's sketchy both because it's hard to encompass two hundred years in a few pages and because children's issues, like children themselves,

don't quite fit into our adult-based, vastly disjointed frameworks. The latter fact, of course, is a problem in and of itself. Since adults create the frameworks, unless they are attuned to children's issues, and the need to evolve systems that fairly reflect these factors, any "new" system will be as inadequate as the old ones.

I started with the thesis that the issue which we have named "homelessness" is not really about the condition itself. Instead, it is concerned with the ways in which we perceive and treat people, in this case children and families. I have therefore tried to chronicle and document the latter picture and present homelessness as one act in that long-running play. In another sense, homelessness more closely represents the final act, since it's hard to conceive of a condition that could encompass and symbolize neglect and devaluation more fully. As Sally Ann Hewlett has put it, we are committing national child neglect.

The first question is *Why?* Absent an overt tenet calling for the mistreatment of children and families, my answer has been that our evident and enduring behavior in this regard may best be explained as a by-product, or artifact, of other important values to which we do explicitly subscribe. This formulation would account for both the tenacity of the issue and the fact that we continue to say one thing (we love our children) and do another (neglect them).

If it is true that the problem lies in the practical workings of our basic values, then the answer to the second question, *What can we do?* begins to take shape. We, as a society, must raise our awareness of the issues involved by undergoing a sensitization process similar to that initiated some years ago by the women's movement. Sensitization differs from mere "education," or the imparting of facts. The latter is appropriate when we all start from a commonly understood base. Sensitization, rather, refers to the process by which we reach that starting point.

By raising awareness I think we will also discover that in many ways our image of ourselves is vestigial: it applies to earlier times and circumstances. It has lingered past the age that it may have been appropriate and serviceable both because of its mythic properties and because belief systems, in general, change more slowly than circumstances. Further, the demographic composition of the American populace is also changing; as early as the next century, we'll have to revise the very concept of majority and minority groups. Not only will white people be in the minority, but the people of color who constitute the majority population will consist of several quite disparate groups: blacks, Hispanics, Asians, and so on, all with different cultures, customs, and religious backgrounds. It is probable that there will be no one dominant culture in the country. Certainly, as fewer and fewer of us have any Anglo-Saxon roots at all, the Puritan ethic will become a thing of the past. To the extent that we start now to become empathic with others' issues, the imperative that has been missing thus far, we'll be ahead of the game in adjusting to such a society.

The same kinds of endemic neglect issues noted have been cast as "juvenile ageism" in an article by Jack Westman, who has also proposed another important remedy. Stating that "ageism has the virulence of racism and the pervasiveness of sexism," Westman goes on to assert that the best way to address the individual and institutional discrimination involved is through the identification and promotion of children's and parents' human rights. He calls for a new civil rights movement with a focus on children and, as I have tried to do, predicts continued dire consequences for both children and society if nothing is done.⁸³

As part of both sensitization and civil rights processes, we must also examine our

laws and policies for their real effects to children and families. We will need to continue with this procedure for each new law and regulation passed, not simply those dealing with our groups of interest, but all legislative efforts. For real decision making, we need the complete balance sheet in front us: exactly which children's programs will be cut if we spend 97 percent of our money on adults; precisely how many fewer low-income units will be available, and how many people we are agreeing should be homeless, if we cut the housing budget. Of course, impact statements have been proposed before, but at this point it has become critical to follow through with comprehensive efforts at both local and national levels.

The latter point brings up the issue of leadership. There has been considerable comment of late on the lack of dynamic leadership in the human service area. Particularly now, when a recession has been added to already deteriorating conditions, it's hard to understand the lack of outrage being expressed. It's equally difficult to account for the absence of spontaneous organizing. In the past, there have been many such efforts, as for example, welfare rights or patient liberation groups, notable now by their absence. It's almost as if we've become collectively numb from repeated blows and the lack of past success. It is my hope that the appearance of books such as Hewlett's and articles such as Westman's will begin to coalesce the necessary energy for change.

Most important, we need to develop a comprehensive policy for children and families, one which addresses all the various issues faced by this population — education, welfare, housing, social services, child care, maternity, mental health, nutrition — and fits them into a coordinated whole. A policy based on developmental need, framed in the direction of health and growth. One that will serve as the basis for our impact statements. Fortunately, we have plenty of partially used models left from the past to draw upon, since our problem has not been lack of vision, but impediments to carrying it through. Since these barriers are primarily attributes within ourselves, our job now is to face them squarely. If we don't, homelessness will be just another in a long line of catastrophic consequences for children, and for our future. ♪

Notes

1. See, for example, Interagency Council on the Homeless, *A Nation Concerned* (Washington, D.C.: 1988); National Coalition for the Homeless, *American Nightmare: A Decade of Homelessness in the United States* (Washington, D.C.: December, 1989); U.S. Conference of Mayors, *A Status Report on Hunger and Homelessness in America's Cities: 1990*.
2. Director, Child and Adolescent Services, Somerville Mental Health Clinic, 1978–1984.
3. See, among others, Karin E. Ringheim. "Estimating A Population at Risk of Homelessness." Dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy (Sociology), University of Michigan, Ann Arbor, 1989.
4. Ibid.
5. Falcon Baker, *Saving Our Kids* (New York: Cornelia and Michael Bessie Books, 1991).
6. Good account of percentages in Coalition for the Homeless of Houston Harris County, *Addressing the Problem of Homelessness in Houston and Harris County*, December 8, 1989.
7. See, for example, the illness concept underlying the Massachusetts Executive Office of Human Services (EOHS), Department of Mental Health (DMH), *Comprehensive Mental Health Service Plan*, January 1989, and the predominantly biomedical research priorities outlined in Institute of Medicine, *Research on Children and Adolescents with Mental, Behavioral, and*

- Developmental Disorders* (Washington, D.C.: National Academy Press, 1989). Also, Thomas J. Scheff, "Medical Dominance, Psychoactive Drugs and Mental Health Policy," in *Mental Health Care and Social Policy*, edited by Phil Brown (Boston: Routledge & Kegan Paul, 1985), 255–72.
8. Joint Commission on the Mental Health of Children, *Crisis in Child Mental Health: Challenge for the 1970s* (New York: Harper & Row, 1969), 278–79.
 9. As a consultant to the Massachusetts DMH in 1990, I heard this point of view expressed by DMH managers at every level of the state system.
 10. Massachusetts Commission on Children and Youth, *Putting Children First: A Reorganization Proposal for Children's Services in Massachusetts*, Boston, June 1973, 73.
 11. For a good discussion of these cuts as they affect children's services, see Sylvia Ann Hewlett, *When the Bough Breaks* (New York: Basic Books, 1991).
 12. Massachusetts Office for Children (OFC), *Mass Childwatch '90*, October 1990.
 13. As of 1985, only half the states covered two-parent families when the principal earner was unemployed. Children's Defense Fund, *A Children's Defense Budget*, Washington, D.C., 1985.
 14. Summer 1991.
 15. Between 1970 and 1980, admission rates (per 100,000 children) to public hospitals decreased from 37.8 to 26.1, and to private hospitals increased from 9.3 to 26.3. Office of Technology Assessment (OTA), *Children's Mental Health Problems and Services* (Durham, N.C.: Duke University Press, 1987), Table 3, 25.
 16. Cambridge-Somerville Comprehensive Emergency Services Coordinating Committee.
 17. Jessica Segré, "Evolution of a Community Systems Approach." Paper presented at the American Association of Psychiatric Services to Children (AAPSC) Annual Meeting, San Francisco, 1981.
 18. Personal communication from John York, regional director, Department of Social Services (DSS), Spring 1983.
 19. Hewlett, *Bough Breaks*, 11.
 20. Center for the Study of Social Policy, Anna E. Casey Foundation, *Kids Count Data Book*, 1991.
 21. Joint Commission, *Child Mental Health*, 185.
 22. *Ibid.*, 1.
 23. Massachusetts Senate Special Commission on Mental Health, *Interim Report*, June 1984.
 24. Task Force on Children Out of School, *Suffer the Children*, Boston, 1972, 9.
 25. Jane K. Knitzer, *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services* (Washington, D.C.: Children's Defense Fund, 1982), 82.
 26. Good historical discussions in Robert H. Bremer, *The Public Good* (New York: Alfred Knopf, 1980), and Murray Levine, *The History and Politics of Community Mental Health* (New York: Oxford University Press, 1981).
 27. Levine, *ibid.*; David Rothman, "The Enduring Asylum," in *Mental Health Care and Social Policy*, 41–70.
 28. Bremer, *Public Good*.
 29. *Ibid.*
 30. Rothman, "Enduring Asylum."
 31. Quoted in William M. Schmidt and Helen M. Wallace, "The Development of Health Services for Mothers and Children in the United States," in *Maternal and Child Health Practices*, edited by Helen Wallace, Edwin Gold, and Allen Oglesby (New York: John Wiley, 1982), 18. This chapter is also the source for other data in this paragraph.

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33. Ibid., and George S. Stevenson, *Child Guidance Clinics, A Quarter Century of Development* (New York: Commonwealth Fund, 1934).
34. Levine, *Community Mental Health*.
35. Schmidt and Wallace, "Development of Health Services."
36. Levine, *Community Mental Health*, 35.
37. Ibid.
38. Ibid., 46.
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40. Joseph D. Noshpitz, "Toward a National Policy for Children," *Journal of the American Academy of Child Psychiatry* 13, no. 3 (Summer 1974): 385-401.
41. Ringheim, "Estimating a Population."
42. Confluence St. Louis Task Force, *Housing for Low Income Families: The Crisis and the Challenge*, October 26, 1988, 2.
43. Schmidt and Wallace, "Development of Health Services."
44. Levine, *Community Mental Health*.
45. Massachusetts Mental Health Planning Project, *Final Report*, June 30, 1965, 45.
46. Ibid.
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52. Levine, *Community Mental Health*.
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58. Task Force, *Suffer the Children*, 5.
59. Ibid., 87.
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62. Senate Commission, *Interim Report*.
63. EOHS, *Comprehensive Plan*.
64. Mental Health Action Project, *Report*, August 26, 1985, 4.
65. EOHS, *Comprehensive Plan*, 12.
66. Ibid.
67. Hewlett, *Bough Breaks*, 46.
68. Ibid.
69. Social Policy, *Kids Count*, 9.
70. For an excellent analysis of structural change since World War II, see Ringheim, "Estimating a Population."
71. Social Policy, *Kids Count*, 9.
72. Conference of Mayors, *1990 Status Report*.
73. See, among many others, The Task Force for the Homeless, *Homeless in Metro Atlanta*, June 1987, 4.
74. National Coalition for the Homeless, *The Closing Door, Economic Causes of Homelessness*, December 1990, 2.
75. Personal interview with Dorothy Dailey, coordinator, Homeless Services, city of St. Louis, November 10, 1989.
76. Personal interview with Jackie Edens, director, Homeless Services and Programs, city of Chicago, November 7, 1989.
77. Personal interview with Vaughan Albanese, past chair, Coalition for Homeless Families, Portland, Oregon, January 24, 1990.
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