Reprinted from SOCIAL WORK, Vol. 25, No. 5, September 1980

Engaging the disengaged: proposals on madness and vagrancy

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Urban areas have become host to young chronic ex-mental patients who often live on the street or in single-room occupancy hotels. The authors analyze obstacles to humane community care and suggest future policies and programs.

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YOUNG ADULT males will be the most difficult mental patients of the 1980s. Although the rate of residence in mental hospitals for the overall population has declined markedly since 1955, the rate for young adult males has changed little in this time. Moreover, the size of this population has grown enormously and is projected to grow further during the 1980s.[1] As elderly patients are removed to nursing homes and similar institutions, state and county hospitals will contend with a growing population of young patients, many of whom will become familiar, periodic guests. In this era of community care, most will receive only "revolving-door" treatment: they will be briefly hospitalized, treated with major tranquilizers, and discharged.

After discharge, some of these young people will return to parents or spouses; others will find congenial halfway houses or board-and-care settings. Some will gravitate to cults or other communities of believers and, in retrospect, may view their madness as a necessary religious awakening.[2] A significant number, who have lost or exhausted their kin or who place autonomy before the refuge of home, will pursue independent lives. Perhaps they will never again need treatment.

Unfortunately, many of these young, primarily male ex-patients will simply disappear into the tenderloins, youth ghettos, and skid rows of America. Between hospitalizations, they will live on the street and, in time, become "career" mental patients and middle-aged urban nomads. Most probably, they will drift through run-down welfare hotels and be repeatedly involved with the police and mental health agencies as a result of public complaints.[3]

This article is concerned with the dilemmas of this group of ex-mental patients—the so-called space cases. The authors discuss six major obstacles to their humane care in the community and describe approaches to social support that might prevent the worst consequences of madness and disaffiliation.

In this article the authors use the terms "ex-mental patient" (or "ex-patient"), "street person," and "space case" to describe the subjects of their inquiry. These terms are not synonymous, and the authors will be remiss in their obligation to those who participated in the research if the distinctions are not clear.

The term "street people" is a gross, imprecise term that is applied to a heterogeneous population with only a few characteristics in common. Street people hang out on the street, using the sidewalks and parks of the city as the living rooms that most cannot afford; they participate in the various social and economic activities associated with street life the world over. However, there is no widely accepted "code of the streets" in this country. If there is an encompassing tradition among street people in predominantly white, university-dominated Berkeley, California, rather than sets of expectations adhering to specific roles (such as that of the drug dealer), it is a vague legacy of the "psychedelic left" that is, today, more veneer than substance.[4]

The term "space case," however, is specific and grounded in the authors' field research on social boundaries among street people. Space cases are those judged by other street people to be delusionary, unpredictable, and unreliable—in the lexicon of the street "burned out," "fried," or "spaced." Space cases have invariably been hospitalized, but not all street people who have been hospitalized are space cases.[5]

The term "ex-mental patient" refers to all individuals of such status, space cases included. Since the space case is a particular sort of street person, he or she is also a special kind of ex-mental patient.

PRESENTING PROBLEM

In addition to psychiatric status, two dimensions of the ex-mental patient's life are of primary importance to caretakers: social functioning and propensity to violence. Kears, although referring to the whole population of young male ex-patients in his area, provides a description that fairly represents the mental health professional's view of space cases. He finds that space cases are "chronically dysfunctional" or "violent and destructive."[6]

0037-8046/80/2505-0358 $0.50

The chronically dysfunctional have long histories of unemployment and minimal occupational skills. They show consistently poor judgment in the management of their finances and social relationships and have long-standing psychological problems that have resulted in multiple hospitalizations and frequent minor entanglements with the law. They are often said to be drug or alcohol abusers and are described as "minimizing," "denying," and "projecting" responsibility for their problems. Characteristically, they do not follow through on treatment plans.

The violent and destructive ex-patients share most of the characteristics of the chronically dysfunctional. However, they have a pattern of criminal behavior that is more pronounced than their psychiatric illness. Although these young men are rarely considered dangerous enough to require long-term hospitalization, mental health professionals regard their histories as promising continued belligerence. It is thought that their violent or destructive behavior is most often a result of the stresses and pressures of everyday life and that they cope better after brief institutional treatment.[7]

There are six significant obstacles to providing humane community care to space cases: (1) transience, (2) burden to the chosen community, (3) inappropriate services, (4) negative public attitudes, (5) violence, and (6) chronicity.

TRANSIENCE

Many young people wander for a time, some as domestic or international "drifter-tourists," others as members of a mobile pool of superfluous labor. Among this latter group, variously called "road people," "street people," or "truckers," are numerous mental hospital veterans.[8]

The extent of such wandering is difficult to measure, but two studies bear on this question, one by Baumohl and Miller and one by Travelers Aid Society (TAS) of Greater New Orleans. In a survey of 295 Berkeley street people, Baumohl and Miller found that 69 percent of the respondents, regardless of their hospitalization experience, "never spent an appreciable length of time [6 months or more] in any one place" after leaving home.[9]

TAS randomly selected names of 85 "obviously disturbed" clients from its active files for a seven-year retrospective study.[10] These names were sent to 74 TAS offices across the country, 68 of which responded. Despite aliases, which confused identification, these offices identified 62 (73 percent) of the individuals as clients in common. These 62 clients, typically aged 20–30, accounted for 214 cases nationwide, totaling 325 recorded office contacts. Most responding offices commented that the "mobile mentally ill" were a substantial problem in their communities.

Why do mentally disordered young people wander, and why is such wandering a problem? Conventional psychiatric wisdom, with some empirical support, calls the problem a "flight syndrome." The mentally disordered person "in flight" is running from the commitments and obligations of close relationships and leaving behind failures and pejorative social judgments. Such movement appears to be stress reducing and a temporarily effective defense against anxiety and conflict.[11] In short, when faced with stressful, difficult situations or relationships, many mentally disordered individuals leave town. In time, they become well traveled.

The cyclic nature of this movement leaves these young people isolated and dependent. Inevitably impoverished, mentally disordered transients must rely on human service programs wherever they go or resort to the most debasing means of survival. In the first instance they often become involved in a struggle of manipulation and countermanipulation, finally rejecting services. In the second instance, they risk humiliation, illness, injury, or apprehension as a public nuisance. For the transient madman, life is a series of defeats and Pyrrhic victories.

At the local level, homelessness undermines the coherence of treatment planning, since clients disappear even within a radius of several blocks. Thus cases are repeatedly opened and closed, efforts are duplicated, and funds are ill spent.

A complex of problems affect the relationship between space cases and the communities they pass through or settle in. A consistent finding in the mental health literature has been the association between so-called lower-class status and admission to a state mental hospital. Early studies found rates of admission to mental hospitals for persons diagnosed as schizophrenic to be higher in areas with little familial or formal social organization.[12] These areas were presumed to promote or allow for isolated life-styles because of their many single-room occupancy hotels (SROs) and the disaffiliation and transience of area denizens. It is not clear, however, whether the stresses of life in socially isolated areas precipitate disorder or whether the mentally disordered drift into these areas because of their downward mobility. In any case, it appears that social and financial pressures and affinities with unconventional life-styles promote the ghettoization of young, frequently chronic mental patients in skid rows, tenderloins, and the youth ghettos surrounding major universities.[13]

The financial pressures on ex-mental patients are legion and obvious. Even if ex-patients fully participate in the various income-support programs available to them, they are hard pressed to pay rent, buy food, or enjoy much entertainment. Their inability to pay high rent is probably the most significant factor in their ghettoization. They may live only in areas where inexpensive forms of housing are available. Typically, these are areas where SROs, rooming houses, and various other forms of group quarters have survived urban renewal. Thus, ex-mental patients compete with other abjectly poor people for the cheapest housing.

Within this context of limited choice, it is important to note that some environments are more congenial than others to individuals with different tastes and habits. Some areas have a counterculture ambience derived from the Bohemianism of the 1950s and the social experimentation of the 1960s. Others have a "bright lights" atmosphere that is dependent on the local sex industry. Others offer what denizens of skid row call "a drinking man's plea-

sures." People settle where they find others like themselves.

These observations are illustrated by the experience of Survivor, a space case who migrated to Berkeley, California, from a small town in the Midwest when a judge warned him that another arrest would draw significant jail time. When asked how he came to Berkeley, he answered:

> SURVIVOR: The truth, well, one night I got up and left. Everyone I met on the road suggested I go to Berkeley. They said, "You'll make it there, it's a good place to be."
>
> INTERVIEWER: They suggested you could make it in Berkeley? Did they say why?
>
> SURVIVOR: Anybody who has been there has had a good trip—not a lot of hassles—and they pass the word that it is a good place to be. I spent my first day wandering on the Avenue wondering where the hell I was, but everything felt familiar. Someone said, "Go to Telegraph." I asked about its locale and when I got there, I knew damn well I had been there before. I said to myself, "Man, you've found a home, all your brothers and sisters. . . ."
>
> INTERVIEWER: What makes you feel like Berkeley is home?
>
> SURVIVOR: I can walk down the street and smile at someone and say "hi," and they'll say "hi," back. Other places they will bust you in the mouth.[14]

If an area's economy is based on a mental hospital industry, the area may be able to absorb the settlement of a large number of ex-mental patients. However, such a settlement most often places new and heavy burdens on social service and control mechanisms. Costs related to the provision of welfare, food stamps, and medical insurance to chronic ex-mental patients in the community have been estimated at over $7,200 per patient per year.[15] Other costs are difficult to measure because they involve the interaction of different service systems in aid or in control of the multiproblem client. The interaction of these systems—for example, criminal justice and mental health— requires complex and usually expensive programs devoted to intersystem coordination.

There are additional social costs. Ex-mental patients, space cases in particular, pose a threat when they are visible and radically different from the rest of the community. Fearful community members avoid areas frequented by street people or ex-patients. This contributes to the segregation of deviance and magnifies the instability of the area. When a community becomes one of the "chosen," it comes to bear the combined economic and social burdens of its congeniality.

INAPPROPRIATE SERVICES

Service systems in many communities, especially those with some experience with other disaffiliated populations, are absorbing a growing number of space cases, although they are ignorant of these clients' specific needs. In skid row areas, for example, many programs serving vagrant alcoholics are now confronting populations of young ambulatory schizophrenics whose primary problem is not alcoholism. These programs are not, by and large, solving the problems inherent in serving mixed client populations who are different in age and functioning. Similarly, police officers, court officers, and judges are processing new and strange cases of petty offenders whose overwhelming problems appear to be psychiatric and whose legal transgressions are trivial in comparison. Few adequate and systematic responses to such cases have been designed or implemented, and the funds for such design or implementation are not readily available.

Current services to space cases, whether in jail or hospital or by community-based agencies, face five specific problems. First, is the nature of the clientele: many are running from social contacts of any kind.

Second, is the involuntary nature of services: most services "offered" to these individuals are imposed. These services must realistically be accepted to avoid incarceration or involuntary hospitalization.

Third, is the type of service or the means by which it is offered: many space cases consider traditional or involuntary services to be demeaning and a threat to their self-esteem, perhaps to their very freedom. Even those who have acknowledged the label of mental illness as a means of receiving categorical aid deny that they are sick—they admit some emotional problems but deny madness. Survivor explained with characteristic whimsy:

> SURVIVOR: I still don't believe I am crazy, you know. I mean, even if I get paid for it. Now that I am a professional at it, anytime you get paid for what you do you are a professional, right? So I am a professional nut, but I really don't believe I am.
>
> INTERVIEWER: Is this why you were originally reluctant to apply for SSI [Supplemental Security Income] because they would think you are a professional nut?
>
> SURVIVOR: I was sure they were going to put me away after I obtained it. I couldn't believe they would pay me to stay alive—that's what they are doing. Tomorrow is payday!

Fourth, is the reluctance of law enforcement or mental health personnel to become involved with individuals who undermine professional efficiency. Police officers on the beat who transport people to the hospital or crisis clinic and then must sign papers and confer with psychiatric personnel greatly reduce their capacity to respond to other events that are far more important in the hierarchy of police concerns. They are under great pressure to resolve the immediate problem in the field while simultaneously being available for other calls. Furthermore, police officers complain bitterly about "revolving-door" care. As one officer put it: "I take a guy in [to the hospital] because he's a menace or he needs help, and what happens? He's back here [on the street] faster than I am!" Thus officers often ignore space cases except in extreme situations or "move them on" to areas where their presence is less disturbing to residents.

Mental health workers spend a great deal of time on space cases and achieve little success. Aftercare workers soon learn that two weeks of work come to nothing on the day a client leaves town. And the agency evaluated by standardized client outcomes sees palpable evidence of its inefficiency: a large group of costly, chronic patients

who fail to improve by conventional criteria.

Fifth, is the conflict between the bureaucratic expectations of the service agency and the norms of street life. For the bureaucracy, the client must produce identification, a life history, and personal information, but in the world of the street, anonymity is valued and respected, and information traditionally gathered at intake by bureaucratic agencies is shared only with one's closest friends, if at all. Sharing such information with an unknown and powerful official is antithetical to street sense; it requires a trust in authority that street life discourages. Furthermore, bench warrants are sometimes out on these clients; thus the clients are often reluctant to contact any agency until they know they will not be subject to arrest.

NEGATIVE PUBLIC ATTITUDES

Negative public attitudes effectively inhibit the social integration of former mental patients in three ways. First, they result in direct exclusionary activities by the general community. Aviram and Segal discussed the use of zoning ordinances, fire safety codes, and general bureaucratic maneuvering to keep former hospital patients out of many neighborhoods.[16] More recently, "anti-impaction" ordinances have been passed to prevent the concentration of large groups of ex-mental patients.

Second, negative public attitudes often block access to community resources. The argument is often made that communities will become less attractive to ex-mental patients if resources are withheld, since the provision of services only makes areas more attractive and consequently more burdened. Although this argument has some merit, it has only marginal relevance in communities with other special characteristics. For example, in university towns the presence of the university and the set of institutions that surround it will inevitably create a hospitable environment. This situation is unlikely to change as long as university students remain young and university areas comparatively permissive.

Third, the negative attitudes held specifically by mental health professionals inhibit the social integration of ex-patients. Tringo showed that, among the general population, individuals labeled as mentally ill are subject to more severe negative attitudes than those labeled as ex-convicts. This clearly obtains on the street, where being an ex-convict can enhance social status and increase social involvement. However, both Tringo and Bolton et al. found that although the general public has a more negative attitude toward the mentally ill, rehabilitation workers have more negative responses to ex-convicts.[17] These professional biases can cause rehabilitation workers to close off resources to ex-mental patients who are also involved in the criminal justice system. In describing his application for SSI, Survivor, a diagnosed paranoid schizophrenic, recalled:

> It was an uphill battle. We went as far as reconsideration and we had to take it to an appeal. They did some things, like when we went in for this examination, one of the assigned shrinks wanted to look at my arm which had puncture holes from having given plasma and assumed I was shooting up. He didn't do a routine urine test, though I was clean. All they wrote down was that I had puncture holes. That's why they turned me down originally and said nothing was wrong with me. [This account was confirmed by Survivor's paralegal advocate.]

VIOLENCE

Street people live outside the law in an environment where conflicts are often resolved by force or the threat of force. Arguments about property, women, sleeping space, and the like are settled between complainants who muster friends as witnesses, seconds, and potential retaliators. Space cases, who are usually social isolates, are most often the victims rather than the successful prosecutors of such claims. Bingo, a drug dealer who called himself a "purveyor of imported goods," explained the situation this way:

> BINGO: I hate to say this for the record, you know, but a lot of people out here will sell their mothers. I mean, it's cold, but it's true. So, like when you get something going with a few people, you know, when you hang out with them all the time, and maybe you do some business together, you know [*laughing*], you watch their backs, and they watch yours. . . . So like Ace knows he can't fuck with me or Jane without fucking with Slug and Pete and like that. . . . I'll tell you what it's like, man, it's like playing Risk or one of those war games. You've got to have some allies in the game or you're gonna get your ass kicked.
>
> INTERVIEWER: What about space cases? Who watches their backs?
>
> BINGO: [*Laughing*] Nobody. I mean, you want something from Alonzo, say, you just ask for it and nine times out of ten he'll just give it to you for the asking. But if he don't, you could just take it. Who cares?

The common abuse and neglect of space cases may underlie some seemingly senseless violence, for space cases are not always docile victims. The paranoid, for instance, may have real enemies; although these enemies may not be covertly organized against him, they may act to exclude him from their company and treat him with contempt.[18] The reaction of the repeatedly excluded or victimized person may be expressed in "looking for trouble." The following incident involved Billy, a 21-year-old paranoid schizophrenic who had been hospitalized for ten years as a child, and one of the researchers and his wife, both of whom had known Billy for three years at the time of the meeting. The account is from the researcher's field notes:

> After a movie, we were walking on the avenue at about midnight. The street was deserted except for one young man, hunched over with his hands in his pockets, walking rapidly and cursing loudly to no one in particular. We recognized Billy at about twenty feet, but he paid us no attention. I put my hand on his shoulder as he passed. As I said "hello," he whirled around, a little unsteady from drinking, and scowled at us. The white handle of a revolver was visible above his belt.
>
> Upon recognizing us, Billy produced the weapon that would "take care of any punk motherfucker that

fucks with me anymore." He was "tired of being shit on and kicked around by every motherfucker on the avenue," and "let them just come and fuck with me now."

Encouraging him to "tell me about it," I guided him, alone, toward the dark campus, away from people. He agreed to "take a friendly walk," but only if I understood that he had to get back to the avenue "in case anyone's looking for me."

He told me of his recent eviction, a sordid homosexual "trick" and robbery, and several additional humiliations for which he intended to even the score "with anyone who fucks with me from now on." I questioned the wisdom of setting himself up for a "bad bust." He emphasized that he wasn't scared, didn't care. He only wanted to "get even with all of them."

We sat silently and smoked my cigarettes on the terrace level of a university cafeteria. Billy fingered his weapon, a relatively harmless .22 caliber pellet pistol. Every so often he cursed someone's hardheartedness. I commiserated. The world was full of "assholes" who treated you like "shit."

After a while, I asked him to give me the gun until he cooled off. He shrugged noncommittally, but when he got up—to "piss" over the railing into the plaza below—he left the pistol sitting in front of me. I took it. When he returned, he still spoke of "getting even," but didn't ask for the gun.

We continued to talk, mostly about mutual acquaintances. After half an hour or so he stalked off toward a hotel where he was "crashing," and, in great relief, I went to a cafe to meet my wife.

Based on the authors' knowledge of Billy, it seems unlikely that he would have gone on the sort of rampage the public often associates with pistol-packing ex-mental patients. That his "cannon" was, by street standards, little more than a toy, suggests a symbolic rather than a malevolent intent. Still, the repeated frustrations of incompetence and humiliation, combined with crude subcultural norms of how to resolve conflicts and the aleatory play of events, could produce serious, if not fatal injury—probably to Billy—if he pulled his gun on someone bigger or better equipped than he. The control of this sort of violence would appear to require not only the on-site diffusion of volatile situations but, in the long run, a reduction of the stresses that accompany a vagrant life-style (and a strictly enforced program of gun control).

CHRONICITY

What does the future hold for space cases? Given the current helplessness of mental health professionals faced with treating chronic mental disorders, it seems reasonable to assume that today's space cases will be marginal for the rest of their lives. Although their situations may stabilize, their psychiatric problems will not change dramatically. It is likely that they will follow the pattern common among single homeless men who find themselves, in late middle age, less transient, less volatile, and more likely to settle among the "home guard" of a community that includes others like themselves.[19]

SSI can be an important inducement for some space cases to leave street life, especially those who frequently have been victimized and have a conventional view of the culture. In Kears's terms, they are among the "chronically dysfunctional" rather than among the "violent and destructive." Alonzo, a space case with a long history of hospitalization and several drug arrests, described his recent departure from the street:

> I left the street scene to get away from these [other street] people. I couldn't stand the emotional stress that they put on me. A guy [who wants a "loan"] would say: "Hey man, what is it to you, man? You could go out and buy a ton of this or a ton of that." I know, but what would happen if I got a crap load of that and I was in a freak house or something and all of a sudden . . . they [other street people] knock on my door and I don't know who it is, so I answer the door and they open up the door, and "wallop," there I go.

Some space cases are motivated to move into the "normal" world. As Alonzo put it:

> I've been around here too long, being in all those freak places. . . . The normal world is . . . maybe direct family. I had no idea that most people go out only Friday and Saturday nights or whatever. I had no idea that's what people really did because at that time of my life, I was a little bit screwed up. I don't really know why I moved to where I moved, but the way I figured it, I moved to Jones Street because this is halfway between my family and the street. Also, it was the last stop on the bus line.

Alonzo moved out of street life at age 27. He still visits one "avenue," but has settled into a rooming house with much older individuals as housemates. He aptly describes his current residence as the last stop on the line, for this type of environment will ultimately become home. Although he may break down under stress and move in and out of such stable situations, his social life has changed significantly with income and a more stable environment. To be sure, he may at times drift back into a pattern of transience, taking "vacations" in places out of the area, and during such periods he will risk apprehension by the police or mental health personnel. He is especially vulnerable because he will use skills acquired as a transient to live on these vacations.

The so-called violent and destructive members of this population appear to have embarked on an irreversible and reciprocal break with conventional society. They are not only outcast, but are confirmed in their outsider's status. Many are likely to wind up in prison. Those who avoid serious mayhem may survive on the street. In time, they may become less transient and less hostile, but most seem committed to life on the fringe and will depend on the availability of cheap hotels and the like as they get older.

RECOMMENDATIONS

What follows is a series of recommendations to the mental health professions and relevant governmental agencies for changes in policies and programs. The focus of these recommendations is on the effective engagement of space cases in humane community care. The recommendations are related to the six obstacles to such care just described.

Transience Social supports to ex-mental patients must be provided that engender stability, which is greatly enhanced by income and housing. First, inappropriate obstacles to receipt of SSI must be removed. It is imperative that mental disability grants not be denied to former criminal offenders or transients because of prejudice or the glacial movement of bureaucratic welfare organizations. People who are homeless find it difficult to wait around while SSI's bureaucratic machinery grinds out its decisions. One can safely sleep in the same doorway only for so many nights before having to move on.

- Recommendation 1: Previous mental hospitalization should be accepted as reasonable justification for presumptive eligibility for SSI.

Lindsey and Ozawa argued that the higher benefit levels of SSI compared to those of other income support programs induce people to feign mental illness—to become, as Survivor puts it, a "professional nut."[20] The authors believe that the label of mental illness is still so onerous that only the most desperately poor single men will present such a problem. This is a trivial matter compared to the unconscionable problems created by the lengthy screening process of the existing categorical aid system. Thus the authors prefer a system of presumptive eligibility with subsequent status review.

Second, to help stabilize this population through the use of housing supports, it is desirable to focus on environments where its members are most likely to reside—SROs. Such facilities might become centers of service (see Recommendation 3 under "Chronicity"). To become functional, however, such facilities must be rehabilitated and financially accessible to this group.

- Recommendation 2: Additional funds under P.L. 93-383—the Housing and Community Development Act of 1974—should be made available to preserve and rehabilitate existing SRO units (Section 202), and to provide rent subsidies for low-income mentally disabled residents (Section 8).
- Recommendation 3: Coordinated services to the transient population must be developed to reduce the negative consequences of their movement (see Recommendation 1 under "Attitudes").

Burden on the Community When young mentally ill vagrants concentrate in a community, funds should be used to develop new social service agencies and to augment current services. Although the magnitude of the problem is considerably smaller than that which occurred during and after World War II, an impact program could be modeled on those developed by the National Housing Agency (in 1942–51) to cope with the influx of defense workers and veterans in coastal areas or by the Veterans Emergency Housing Program to help provide community facilities and services in critical defense housing areas.[21] In the 1970s, the state of Alaska received large amounts of federal money to provide services made necessary by the influx of pipeline workers. Any receipt of funds from such a grant program should be contingent on an area's ability to mount a coordinated effort. Planning and start-up funds should be made available to resource-poor communities.

- Recommendation 1: Through existing federal agencies, additional financial resources must be provided to areas with a great many transient and homeless people.
- Recommendation 2: A special grant program should be developed for areas affected by problems derived from extralocal sources.

Inappropriate Services The type of agency most successful with space cases seems to be one that becomes a surrogate for natural helping networks. Such agencies facilitate the attainment of public welfare and provide an address for checks and for correspondence with the "normal" community. Free local telephone service helps people find lodging, food, or a job and provides a point of phone contact for relatives and friends.

Experience suggests that space cases use such services when they are provided on a voluntary basis and as part of the informal patterns of helping they are accustomed to using. The elimination of threats stemming from the immediate disclosure of personal information greatly facilitates service contacts, as does a multiracial staff and the drop-in, blue jeans, first-name-basis style of the typical "street agency."

- Recommendation 1: Funding should go to projects operating from an understanding of the community's street subculture and demonstrating an ability to work within it.
- Recommendation 2: Priority should be given to agencies that function as substitutes for unavailable or destructive natural helping networks. Although natural helping networks offer "counseling services," they are most important in the distribution of real goods and services among resource-poor people.[22] Agencies providing emergency housing and assistance in obtaining social resources (in addition to other forms of help) should be given priority over agencies providing only psychotherapy.
- Recommendation 3: To engage this population, intake procedures that require detailed personal information in the initial interview should be changed to require a minimum of information. "Gradual disclosure settings" should be instituted.

Such settings (that is, "coffee houses" or "community living rooms") allow for informal interaction between clients and workers. They are typically open to anyone and are unencumbered by intake and assessment protocols that ritually confirm clienthood and are perceived as threats or create formality and social distance.

Negative Public Attitudes Mental health professionals must alter public perceptions that this population is a threat to the community. High public visibility reinforces this perception.

- Recommendation 1: A system of hostels should be developed for this population. Giving localities an emergency shelter will reduce both the negative effects of public visibility and the nuisance potential of this group.

In the past, areas that served large groups of mentally ill persons were rewarded for their services by the economic benefits accruing to areas with such a specialized industry. (The best examples are small cities housing large mental hospitals or Geel, Belgium, where the major industry is providing

family care to patients.) The economic benefit was such that communities bid for mental hospitals.[23] Now, however, many communities shoulder a significant social burden without benefit of economic support.

- Recommendation 2: If an area organizes to provide services to and can demonstrate that the services have brought about greater social acceptance of this population, it should receive funds (possibly increased revenue-sharing money) for community improvement unrelated to the service needs of the target population.

Violence There is no method of accurately predicting the occurrence of violent behavior. Short of violating the civil rights of many to prevent violence among a few, violence per se cannot be prevented. However, it is possible to prevent or mitigate violence in specific instances, especially when the violence is a result of subcultural norms that encourage combative means of resolving conflicts.

- Recommendation: Activities to prevent violence must be undertaken by trained, experienced workers whose street knowledge and continuing relationships with street people allow them to effectively resolve disputes before they become violent.

Resolving disputes has been a traditional activity of street workers, who are often able to use personal influence to calm combatants and whose non-law enforcement status permits them to respond to disputes that arise from illegal activities.

Chronicity Since it is not likely that cures for all mental disorders will be discovered in the near future, it seems that, with respect to space cases, three policy options are open to society. It could (1) make use of long-term institutionalization either in mental hospitals or prisons—the increased use of mental hospitals brought about by broadened psychiatric discretion and the increased use of prisons by the imposition of harsher criminal sentences, (2) ignore the problem and allow space cases to fend for themselves until they drift into a more stable pattern of living, perhaps ending up in a sheltered-care arrangement, or (3) attempt to shape a more stable life for them through the use of various programmatic interventions.

The response of space cases to an increased use of hospitalization will be flight from mental hospitals. Prevention of flight will involve security measures that will have substantial negative effects on long-term outcomes. The use of jails or prisons to contain space cases will, in the vast majority of cases, violate basic constitutional freedoms and jeopardize the safety of the imprisoned space cases. Ignoring the group and allowing them to work out their problems with age is inhumane and does not help communities that must put up with them in the interim.

The initial cost of attempting to shape a more stable life for them will be greater, but, over the long run, should be beneficial for the communities and individuals involved. This third option involves the creation of long-term housing arrangements and innovative programs. Specific recommendations follow:

- Recommendation 1: Funds from P.L. 93-383, Sections 202 and 8, should be used to create long-term housing arrangements.
- Recommendation 2: State and federal subsidies should be added to individual SSI grants to pay for such special program innovations as mental health consultation to communal living arrangements.
- Recommendation 3: Programs should be developed through the U.S. Department of Health and Human Services geared to work with SRO hotel managers to make such hotels quasi-therapeutic environments safe from victimization and predators. The locus of service activity should be the hotel, not a mental health agency.[24]

CONCLUSION

Although specific communities serve space cases, the problem is national in scope. The inadequacy of community care can be traced, in part, to the ambiguous responsibility of localities that have become either home or way stations to large numbers of ex-mental patients, including space cases. The problem is not merely a matter of mental illness, but an old and nagging question of managing migration.

Recommendations outlined in this paper are intended to promote—at the national level—an effort to enhance the social integration of space cases through the development of stabilizing social supports that will function in lieu of disrupted social networks. Without such unconventional alternatives, conventional treatments will fail. Without federal leadership and support, local neglect will prevail.

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