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**A Study on the Dynamic Relationship of the Risk
Factors of Homelessness**

by

Eun-Gu Ji

**A dissertation submitted to the Graduate Faculty in Social
Welfare in partial fulfillment of the requirements for the
degree of Doctor of Social Welfare. The City University of
New York.**

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This manuscript has been read and accepted for the Graduate Faculty in Social Welfare in satisfaction of the dissertation requirement for the degree of Doctor of Social Welfare.

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THE CITY UNIVERSITY OF NEW YORK

Abstract**A Study on the Dynamic Relationships of the Risk
Factors of Homelessness****By****Eun-Gu Ji**

Adviser: Professor Michael Smith

What is the most crucial determinant of homelessness? Is there any order among the risk factors to explain becoming homeless? Although there are many studies about the number, cause, or the personal characteristics of homeless people, the studies focusing on the dynamic relationships between variables to explain becoming the homeless are few.

This study is a quantitative assessment of the influence of risk factors on the rates of homelessness. Correlations among these factors and homelessness rates precede multiple regression analysis. The objectives of this correlation analysis are to obtain values that indicate the relationships between risk factors and to

determine if a relationship exists between risk factors. In order to describe the further nature of the relationships and to assess the degree of accuracy of prediction achieved by the regression equation, regression analysis was used to assess the relative importance of the risk factors in their contribution to variation in the rates of homelessness.

The findings of this multiple regression study that employed three major models show that the poverty rate, among structural/societal risk factors, is strongly associated with homeless rate in model I. Individual risk factors explaining the cause of homelessness do not have correlations with homelessness and do not affect homelessness in model II. The rate of AFDC recipients was the only factor among ten indicators including individual and societal/structural risk factors that was highly correlated and associated with a high level of homelessness in model III.

The findings of this study provide meaningful considerations for policy. First, policy makers focus not only on particularly psychological or individual issues of alcohol and drug abuse and mental health of homeless people, but also on the root causes of homelessness such as permanent poverty, economic conditions, a low level of welfare benefits, or the lack of affordable housing units

drawn from societal/structural bases. Second, the findings of the study indicate that the reducing poverty rate is the priority in reducing the number of homeless people. Third, policy makers should identify that TANF families with no extra earnings are the most vulnerable subgroup for becoming homeless.

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I. Introduction

There is no single or correct answer to explain the homeless problem because it is a multifaceted problem (Hopper & Hamberg, 1984; Erickson & Wilhelm, 1986). There are many different kinds of homeless people for many different reasons. This makes the study of the homeless problem extremely difficult (Lang, 1989). However, homelessness is a major social problem that emerged as a central domestic policy problem in the 1980s. Since the 1990s, the size of homelessness has grown significantly. As a major social problem, many studies describe the size and personal characteristics of the homeless and the demographics of homelessness. There are also many studies that seek to understand and explain the cause, determinants, or risk factors of homelessness. However, the results of studies on homelessness vary according to the theoretical or ideological perspectives of researchers or investigators.

Generally, there are two main theoretical streams to explain homelessness: structural functionalism and conflict theory. These theories suggest that homelessness stems from structural, societal, or personal factors. Lack of affordable housing, lack of low-income housing units, change of economic structure, unemployment, poverty, lack of a

social safety net, and lack of opportunity are all included in societal or structural factors to understand the causes of homelessness.

On the other hand, Mental illness, substance abuse, lack of a family safety net, domestic violence, and family dysfunction or breakdown are all included in individual factors to explain the causes of homelessness based on structural functionalism.

Some of the studies are based on structural/societal factors to explain homelessness, but some have looked more at personal factors. There is no one risk factor to explain why people become homeless and why the number of homeless people is continuously increasing regardless of the growth of the economy. Also, there may be no one exact answer to explain why some of poor people are homeless but some not. And there may be no one answer to why some of mentally ill persons are homeless but some not. All risk factors to cause homelessness may be interrelated with each other. A combination of any of these risk factors may lead to homelessness. It is possible that there is a particular order among the factors explaining the cause of homelessness and that is also possible to estimate the relative impact of each and all the risk factors on the homelessness rates.

In this study, homelessness as a major social problem is historically reviewed and the risk factors that cause homelessness are analyzed in terms of theoretical and ideological perspectives. Then, the dynamic relationships between the risk factors and homelessness are examined. In order to examine the dynamic relationships between variables representing the hypothesized risk factors and homeless rates, the study observes the cross-sectional variation of the risk factors including both personal and societal/structural reasons on the rate of homelessness across states and communities. For this purpose, multiple regression analysis is basically used to examine the significance of each risk factor to predict the rate of homelessness as well as the significance of the entire models to predict the homelessness rate.

II. Historical Context

1. Definition of Homelessness

The definition of homelessness has changed. Before 1980, homelessness was usually interpreted to mean detachment from a family-type living arrangement. People living by themselves in skid row hotel rooms were considered homeless, even though they spent every night in shelter paid for with their own resources. Solenberger's study in Chicago (1911) defined homeless men as those living in rooming house and low-cost residential hotels who sought assistance from a local office of the Chicago Board of Charities. Wallace (1965) has defined a homeless person as one who wanders about and lodges in taverns, groceries, alehouse, watch or station house, outhouses, marketplaces, sheds, stable, barns, uninhabited buildings, or out in the open, and who does not give a good account of him or herself. Bahr (1973) defines homelessness as disaffiliation, a condition of detachment from society as evidenced by the absence of affiliate bonds that link settled persons to a network of interconnected social structures.

Today, the definition of homelessness, in contrast, varies. Depending on theoretical or ideological backgrounds,

the definition of homelessness is classified as three types: literal homeless, shelter and street homeless, and the precariously housed homeless.

Literal homeless persons are literally "without shelter" at the time they are identified as homeless (Burt, 1992). This is the simplest definition of homelessness. Someone using a shelter for the homeless on the night of measurement is assumed to be "without shelter." Most of the homeless studies use this definition of the homeless. However, this literal homeless definition does not include the homeless people living on the streets, welfare hotels, and kin or friends' house (doubled up). HUD (1984) estimated the number of literally homeless population ranged from 250,000 to 350,000.

The definition of the shelter and street homeless includes the homeless who are using shelters, welfare hotels, or public areas such as bus or subway stations, abandoned buildings, or the streets. According to the official government definition taken from the Stewart B. McKinney Act, a homeless person is one who lacks a fixed permanent nighttime residence or whose nighttime residence is a temporary shelter, welfare hotel, or any public or private place not designed as sleeping accommodations for human beings. Most of the homeless studies from a liberal

perspective are using this broader definition to count the number of homeless population. The Urban Institute (1989) reported that the number of homeless population categorized with this definition ranges from 500,000 to 600,000.

Lastly, precariously housed homeless is the broadest definition for the homeless. According to this view, the homeless include people who are doubled up or might lose their housing. Rossi (1989) calls "the precarious housed" those who may live in a conventional dwelling but whose hold on that home is precarious. And Jencks (1994) describes this "precarious housed" definition as "doubled up homeless." However, it is very difficult to count the number because precariously housed homeless are less visible. According to this definition, the National Coalition for the Homeless (1983) estimated the homeless population about 3 million in the United States.

2. Homelessness as a Social Problem

What is a social problem? How can we define it? More specifically, is homelessness a social problem? According to McWhinney (1992), homelessness is not a social problem but a social issue because it consists of unbounded, ill-defined, and an overwhelming complex of problems. And then what about

poverty or crime? Are they social problems? According to McWhinney's definition for social problems, poverty and crime are not also social problems because they do not have well defined definitions and are very complex. What is poverty? Who are the poor? Does the government poverty line or the number of poor fit the adequate criteria to define it as a social problem? The poverty line is still arguable and is only used as a convenience for implementing poverty policy. Nevertheless, most Americans believe that poverty, crime, and homelessness are major social problems in the United States.

The Gallop poll periodically samples the American population with an open-ended question asking respondents to identify "the most important problem facing the country today." The percentage of Americans identifying "poverty and hunger" or "poverty and homelessness" as the most important problem has more than doubled between 1985 (5%-6%) and 1992 (13%-15%) (Gallop, 1985 and 1992). Although concern with the economy nearly always overwhelms other issues in times of economic distress, "poverty and homelessness" topped the list of "noneconomic" problems in the poll. In 1992, this was the most important problem to more Americans (15%) than was health care (12%), education (8%), crime (5%), drugs (8%), or AIDS (3%) (Gallop, 1992).

A social problem is a condition affecting a significant number of people in ways considered undesirable, and about which it is felt something can be done through collective social action (Horton and Leslie, 1970). Maris (1988) defines social problems as general patterns of human behavior or social conditions that are perceived to be threats to society by significant numbers of the population, powerful groups, or charismatic individuals, and that could be resolved or remedied. According to Barker (1991), social problems involve conditions between people leading to social responses that violate some people's values and norms and cause emotional or economic suffering. As a result, a social problem is a condition affecting a significant number of people, threatening to society, and leading to social responses. Therefore, homelessness is a social problem because the increasing number of the homeless population threatens the public and makes the social policy a public policy concern to reduce the homeless people.

3. Changing Definition of Homelessness as a Social Problem

1) The Root of Homelessness

Homelessness is not a new phenomenon. It has a unique history in American society. The situation of homelessness has been endemic in the human family from the beginning of civilization. Often the result of natural disasters, war, and economic failure, homelessness has been experienced over the centuries by a great variety of people. However, the destitute, disabled, and antisocial have typically made up the core of those for whom homelessness has been a way of life (Caton, 1990). In preindustrial society, slaves and prostitutes were also among these outcast groups (Hotton, 1860; Ribton-Turner, 1887; Aydelotte, 1913; Smith, 1970; Pound, 1971; Grice, 1977). When the Industrial Revolution encouraged migration from rural to urban areas and across continents, the ranks of the homeless were swelled by seasonal laborers and migratory workers (Culver, 1933; Cross and Cross, 1937). New opportunities to obtain work as sailors, miners, or loggers demanded that men be uprooted from their families, isolating them from familiar social worlds (Bahr, 1970).

Early attempts to control the problem of homelessness have focused on distinguishing the "worthy poor" from the criminal or irresponsible element. In general, the disabled or truly impoverished have been viewed with greater compassion than the able-bodied wanderers with no permanent home or employment. An English law of 1388 required that all persons moving from place to place, including the destitute poor, laborers in search of work, members of religious orders, and university scholars, should obtain letters from town officials to authorize their travel. The absence of letters was punished by imprisonment or involuntary return to one's birthplace (Wallace, 1965).

In 1547, Edward VI ordered that all persons loitering, wandering, and not seeking work be taken before a justice of the peace, branded with a "V", and placed with a master to work. Despite harsh punishments, the problem of vagrancy did not disappear. The punitive measures of Edward VI were overturned by the Poor Law Act of 1601, which called for the return of all homeless persons to their place of birth. Taxes were levied for the relief of helpless and needy persons. Overseers of the poor were appointed to ensure the proper administration of relief. Work was provided for the able-bodied, but those who refused to work were imprisoned (Caton, 1990).

Early English attitudes toward poor and dependent persons were transported by English colonists to the New World. The Elizabethan Poor Law Act of 1601, which provided the model for poor relief in the American colonies, formalized the practice of placing the support of dependent persons in the hands of the local community (Deutsch, 1937; Grob, 1973). However, many communities avoided supporting the poor by making it difficult for beggars, vagabonds, and other nonworking persons to settle within their boundaries. The financial status of strangers was closely checked before they were allowed to settle in a community.

Institutions for the homeless began to appear in the U.S. in the eighteenth century. From 1725 to 1750, houses of correction, workhouses, and almshouses sprang up in the larger towns. One of the first was the "Poor-House, Work-House, and House of Correction of New York City," established in 1736. Paupers and petty offenders were treated alike in the workhouse, and thus it served as a combination poorhouse and jail (Caton, 1990).

Nineteenth-century Americans were no more sympathetic to the homeless than were their ancestors. The post-Civil War period saw a considerable increase in homelessness and transience. The construction of the railroads, their subsequent continual maintenance needs, and the rise of

large-scale commercial agriculture created a strong demand for transient workers who could supply seasonal and episodic labor. The skills needed were often based on strength and endurance. These transient homeless of the post-Civil War period were predominantly young, unattached men with low levels of education and job skills. Their employment took them all over the country (Rossi, 1989). Industrial change and practices, immigration, economic crises, and the Civil War all contributed to homelessness after mid-century.

Though industrialization came later to the United States than to England, the effects were similar. Rapidly expanding after 1865, manufacturing and construction created a huge demand for workers. Many came from rural and small-town America. They filled lodging houses in every major city. But cheap labor was still needed. A steady stream of British, Irish, and Germans filled this void, followed by Italians, Greeks, and Eastern Europeans at the end of the century (Daly, 1996).

Though many were rural peasants, immigrants frequently remained in the ports where they disembarked. Men were recruited for casual labor pools, joined work gangs on railways or canals, or found jobs in factories, while women and children labored in sweatshops or at home in tenements. Immigrants generally had no savings, no urban experience to

draw on, and often did not speak English. As a result, they were vulnerable to economic crisis and to the wiles of speculative tenement owners (Daly, 1996). In the second half of the nineteenth century, there were several severe economic downturns, each accompanied by surges in homelessness and the demand for public relief. Homelessness per se was not so much the central concern as was the general need for food, fuel, and clothing. In terms of economic distress some people became "tramps," searching for employment across country. Those who remained in the city were put up overnight in police stations. Jacob Riis noted that New York City's police station furnished lodging to 435,000 people annually (Riis, 1902).

The post-Civil War era also witnessed the development of "skid rows," named for Seattle's Skid Road, a street along which horses skidded logs to a sawmill. Skid Road was inhabited by lumberjacks who lived in the flophouses lining the street and who frequented its saloons and brothels. After the panic of 1873, skid rows sprang up in many American cities. The thousand men who lost their jobs during that economic depression were forced to move from town to town searching for temporary jobs as loggers, miners, farmhands, or construction workers. Without families, the hub of their work and social ties revolved around their

existence in skid rows (Leepson, 1984; Siegal and Inciardi, 1982). Unemployment exceeded 30 percent in 1873, and, in the panic of 1893, it was estimated that 900,000 were jobless (Ringebach, 1973).

The skid rows that grew up consisted of a concentration of enterprises catering to the needs of transient, poor, and familyless workingmen. The core businesses that defined skid row were hotels, lodging houses, and restaurants providing inexpensive housing and food, where meals and a bed for the night could be had for pennies. Bars, brothels, pawnshops, and cheap clothing stores also served the men who ate and slept on skid row.

With the advent of the Great Depression in the 1930s, local and transient homelessness increased dramatically. The Great Depression caused many people to lose their jobs, farms, and homes. Although no definitive counts were made during the Great Depression, we can get some notion of the magnitude of homelessness from the activities of federal relief agencies: in 1933 the Federal Emergency Relief Administration housed 125,000 people in its transient camps, and a 1934 survey of social agencies in seven hundred towns and cities estimated 200,000 homeless. Other estimates went as high as 1.5 million in the worst years of the Great Depression (Wickendon, 1987). For example, in 1933, a

nationwide census taken by the National Committee on Care of the Transient and Homeless found that about 1.2 million persons (1 percent of the population) in the United States were homeless (Blair, Jacobs, and Quiram, 1999). Most people of the period did not regard the homeless as vagrants, but rather as victims of unemployment and the resulting social disruption of the Depression.

With the recovery of 1936 and the advent of World War II, the skid row populations in the U.S. nearly disappeared, reaching a low point in 1944, when the New York City Municipal Lodging House reported an average of only 550 lodgings per day, compared with 18,000 in 1935 (New York City Welfare Council, 1949). The homeless were absorbed into the armed forces and into mushrooming war industries. Social welfare programs for veterans such as the G.I. Bill of Rights, the Veterans Administration, and a series of benefits ranging from education to psychiatric treatment enabled most World War II returning service men to reenter society, unlike the aftermath of other wars, and few ended up on skid row. An estimate made in 1950 placed the number of skid rowers in 41 cities at less than 100,000 (Bogue, 1963). Most of the social scientists studying the old skid rows thought they were declining in size.

In the 1950s and 1960s large-scale action-oriented surveys of skid row residents were taken in cities such as Sacramento (McEntire, 1952), Minneapolis (Caplow, Lovald, and Wallace, 1958), Philadelphia (Blumberg, 1961), Chicago (Bogue, 1961) and New York (Bahr, 1968). All presented the same picture of three dire conditions: extreme poverty arising out of low earnings and low benefit levels; disability through advanced age, alcoholism, and physical or mental illness; and disaffiliation or tenuous ties to family and kin with few or no friends (Rossi, 1989). Most homeless people were viewed as old white males with the addiction problem of alcohol in this period.

2) The Rise of Homelessness

Beginning in the late 1970s, observers of the American social scene began to note with increasing frequency the presence of people without homes, wandering city streets, and sleeping in doorways and depots (Klerman, 1977; Segal, Baumohl, and Johnson, 1977; Reich and Siegel, 1978; Talbott, 1979; Baxter and Hopper, 1981). Some were mentally ill persons or substance abusers, and others were the unemployed who had exhausted their relief benefits and experienced loss of rental housing or foreclosure on their home. Some were

welfare mothers and their children unable to find affordable rental housing on a relief allotment.

The unrelenting increase in the number of homeless people in the United States has marked homelessness as a serious social problem of the eighties. Although there were no annual national statistics to count the number of homeless people in the 1980s, the range of the number of the homeless population was placed from 250,000 - 300,000 (HUD, 1984) to 3 million (The National Coalition for the homeless, 1983). Urban Institute (1987) estimated that 500,000 to 600,000 people were homeless at any given time. As a result, homelessness has emerged as a national problem of serious proportions in the 1980s.

For example, in New York City the number of person in shelters grew considerably during the 1980s, from 5,000 in December 1983 to about 9,000 in January 1988. In many cities, welfare departments provided temporary housing for families by renting rooms in hotels and motels. For example, in 1986 New York city housed 3,500 homeless families a month in "welfare hotels" (Bach and Steinhagen, 1987).

There are possible risk factors to explain the growth of the homeless population in the 1980s: economic recession; a decline in affordable housing for the poor; the reduction of social benefits; and deinstitutionalization. In the early

1980s, when the problem of homelessness began to accelerate, economic recession was endemic, producing the worst levels of unemployment since the 1930s. In mid-1984, 8.5 million were jobless (Joint Economic Committee, 1984). During 1982 and 1983, the national unemployment rate exceeded 10 percent for a period of ten months.

At the worst point in the recession, nearly 12 million people or 10.7 percent of the workforce were unemployed. This represented a 40 percent increase in unemployment over a period of two years. Significant unemployment occurred at a time when double-digit inflation had markedly reduced the buying power of the dollar, an occurrence particularly harmful to those on fixed incomes but affecting all whose incomes did not keep pace with inflation. Therefore, unemployment significantly affected homelessness.

In contrast to the previous recession of the post-World War II era, the economic downturn of the early 1980s coincided with a sharp decline in the availability of low-cost housing because of disinvestment, abandonment, and conversion. Disinvestment is the refusal or inability to repair and keep up the rental property, so that over time it falls into decay and becomes uninhabitable. In extreme cases, property owners have been known to burn down buildings rather than continue their upkeep. Abandonment is a

situation in which the owner of the property defaults on ownership, refusing to pay mortgage payments, taxes, or other civic fees. Because of these defaults, the property reverts to the mortgage holder or the government, which may or may not be able or willing to continue operating the property as low-cost housing. In some cases, the property may sit empty for a long time before being sold or reopened for housing. Conversion can come in several forms. A property can be converted from a rental to other purposes, such as condominiums, offices, retail stores, or warehouses. It can also be refurbished or restored to become more upscale housing that is no longer affordable to the low-income renter. This is called gentrification (Blair, Jacobs, and Quiram, 1999; Burt, 1992).

Although incomes in general rose during the decade between 1970 and 1980, as evidenced by a 53 percent drop in the number of renter households with incomes below \$3,000 per year (from 5.8 to 2.7 million), the number of affordable rental units (requiring only one-third of the annual income) to those households in this income range dropped by 76 percent, from about 5.1 to 1.2 million (Low Income Housing Information Service, 1984). According to Guliotta (1992), from 1970 to 1989, the number of low rental units for the poor declined 14 percent to 5.5 million while the number of

poor renters who made less than \$ 1,000 in 1989 dollars increased from 7.3 million to 9.6 million. This shortage of 4.1 million rental units for the poor could be a reason for the dramatic rise in homelessness in the 1980s.

The loss of low-income housing units was particularly high among the substandard housing that once sheltered poor single adults, such as rooming houses and single room occupancy (SRO) hotels. Between 1974 and 1983 alone, some 896,000 housing units in the United States renting for less than \$200 a month, most of which were SROs, were demolished or converted into co-ops (Blair, Jacobs, and Quiram, 1999).

According to Dolbeare (1996), from 1970 to the mid-1980s, one million SROs were demolished, especially in large cities. New York City lost 87 percent of its \$200 per month or less SRO stock; Chicago experienced the total elimination of cubicle hotels; and Los Angeles lost more than half its downtown SRO housing. Another study showed that, in the period from January 1975 to April 1981, New York City experienced a 62 percent decline in SRO (single room occupancy) and low priced hotel rooms (Kasinitz, 1984). In a similar period of time, San Francisco lost one third of its residential hotel units through conversions, while Detroit lost 17.7 percent between 1980 and 1982. Loss of low cost

residential hotel housing occurred in other cities as well (Cuomo, 1983).

Therefore, the worsening of the affordable housing shortage stemming from two occurrences, a drop in the number of unsubsidized or subsidized low cost rental units and the growing number of low-income renter households, had a particularly severe impact on homelessness in the 1980s.

Another factor suspected of contributing to the homeless problem was the reduction of the social wages including SSI, AFDC, GA, Food Stamps, and so on (Fabricant, 1987). For example, 20 percent of the beneficiaries (about 200,000 people) of disability benefits lost their benefits because of reform of SSDI (Social Security Disability Insurance). Between 1980 and 1984, there was an intensified drive to make across-the-board cuts in all social welfare programs. AFDC and child Welfare programs fell 13 percent (Horowitz et al., 1984). Food Stamps were cut 14 percent. It is estimated that, overall, cash benefits declined by 17 percent. More specifically, these cuts eliminated one million people from Food Stamps coverage. Additionally, 90 percent of the working families on AFDC had their benefits reduced or eliminated (Coalition on Women and the Budget, 1984).

According to Gugliotta (1992), in thirty-nine of the forty-four cities surveyed, housing costs alone normally exceeded the entire grant for a family of three receiving assistance from the Aid to Families with Dependent Children (AFDC) program. Stagner and Richman's study (1985) of Chicago General Assistance (GA) recipients showed that half of GA recipients in the city are presently housed mainly through the generosity of relatives and friends because of the shortage of the social wages to pay their living expenses; and an additional one-third receives economic assistance from them. According to Hopper and Hamberg (1984), the amount of public assistance ranged from 20 percent to 60 percent of local fair market rent.

As a result, GA and AFDC payments were simply not sufficient to meet the urban rent levels throughout the country, and, further, this circumstance served to place those people who were receiving entitlements in a particularly vulnerable position (Fabricant, 1987). In addition, through the 1980s and into the 1990s, already paltry AFDC grants were reduced by the effects of inflation. The national average combined payments for AFDC and food stamps was \$10,169 in 1972 compared to \$7,471 in 1991, a decreased of 27 percent (DeParle, 1992).

Therefore, in the 1980s, the reduction of the social wage had dramatic consequences for the poor in addition to the shortage of low-income housing units. In short, substantial cuts in entitlement allowances combined with the shortage of low-income housing units placed low-income people in the position of being unable to afford urban rental housing. The reductions or loss of government benefits thus contributed to the rapid expansion of homelessness in the 1980s.

Deinstitutionalization of state and county mental hospitals is the commonly cited risk factor to explain the growing number of homeless in the 1970s. The goal of deinstitutionalization has been the phasing out of the state mental hospital as the primary locus of care of the chronically mental ill in favor of community-based treatment. Deinstitutionalization was carried out by discharging long-term patients from state mental hospitals and tightly controlling the admission of new patients. This policy was based on several factors, including the discovery and use of psychotropic (mind-altering) drugs, concern for an individual's civil liberties, an awareness of the dehumanizing nature of the institutional environment, and increased financial demands on federal, state, and local governments. As a result, this policy has resulted in a 70

percent drop in the inmate population in state and county mental hospitals, from 559,000 in 1955 to 150,000 in 1980 (Department of Health and Human Service Steering Committee on the Chronically Mentally Ill, 1980). The number of psychiatric beds fell from 524,878 in 1970 to 272,293 in 1990. These reductions led to considerable savings in the operating costs of state and county mental hospitals. Because local and federal governments generally supported deinstitutionalization because it saved money, government agencies generally did not invest in halfway houses and other medical and counseling facilities necessary to make deinstitutionalization work. Many citizens refused to permit halfway houses in their neighborhoods, fearing a loss of property values and dangerous behavior from the mental ill.

Consequently, many of these people have been left to take care of themselves. Without supervision, they often no longer take the medicines necessary for them to function properly. Without guidance, they generally cannot hold jobs. Without counseling, they often cannot manage in a world outside the institution. Without jobs, money, and the necessary medication, they are alone, disoriented, and abandoned (Blair, Jacobs, and Quiram, 1999).

Therefore, many homeless studies indicate that mental illness and insufficient mental health services are the

major reasons causing homelessness. Some of homeless studies also have established that a portion of the homeless on the streets and in shelters is suffering from psychiatric disorders or have a history of mental hospitalization. As one example, Bassuk (1984) estimated that 90 percent of homeless people at a shelter in Boston were mentally ill.

In brief, the loss of the low cost housing units in the private market and diminished SRO hotels are the major cause of the rise of homelessness along with reduction of welfare benefits in the 1980s. Deinstitutionalization of the chronically mentally ill during the 1960s and 1970s also could be a cause of the rise in homelessness in the 1980s.

There were distinguishable demographic changes in homeless people in the 1980s. According to the findings of Urban Institute (1989), unlike homeless people were viewed as old white males with the problem of alcohol addiction in the 1960s and the 1970s, the homeless population in the 1980s was generally characterized as the followings: most of the homeless adults in the 1980s were male (81 percent of the sample); the majority was nonwhite (54 percent); and the homeless adults between 18 and 50 years of age were 81 percent. Rossi's Chicago homeless study (1989) also shows that about 65 percent of homeless population were under 45; 76 percent were male; and only 30 percent were white. In

short, the age of the homeless people decreased, and homelessness prevailed among minorities such as black and Hispanic people in the United States during the 1980s.

3) The New Homeless

Since homelessness was captured by the public eyes in the 1980s as a serious and viewable social problem, the growth of homelessness has not stopped, but still been growing. Link et al. (1994) estimated rates of five-year prevalence of homelessness in the United State. According to their estimation, 5.7 million people were literally homeless. Based on the nationally conducted survey by Interagency Council on the Homeless (1999), Urban Institute (2000) estimated the number of homeless persons, as ranging from at least 2.3 million to 3.5 million in 1996. In the 1990s, the age of the homeless decreased (Helvie, 1999). The mean ages of the homeless population range from 34 to 37 and 65 percent are in their late 20s to mid 30s. Most are under age 45. According to the national survey of homeless providers and clients, seventy-six percent of the total of sampled homeless people are under the age of forty-five (Interagency council on the Homeless, 1999).

However, the most important change of homeless characteristics in the 1990s is an increasing number of homeless families, especially female-headed families. Whether in urban or rural areas, families with children are the fastest growing segment of the homeless population (Burg, 1994 and Nord & Luloff, 1995). In order to discuss consequences of homeless families, a "family" is defined as one or more adults caring for one or more children under the age of eighteen (McChesney, 1992; Shinn & Weitzman, 1996).

According to Bassuk (1991), children and members of families make up between 34 percent and 38 percent of the estimated 3 million homeless people in the United States. In addition, Bassuk (1993) estimated women made up about 20 percent of the homeless population, up from 3 percent in the 1950s. Homeless family studies in Los Angeles and New York also report that homeless families represent 40% of the sample in Los Angeles (Wood, Valdez, Hayashi, and Shen, 1990) and 40 percent to 45 percent in New York City (Institute of Medicine, 1988). Homelessness is no longer the exclusive province of single adult men.

In recent studies about homeless families, it has been estimated that homeless families constitute anywhere from 21 percent (Nord & Luloff, 1995) to 37 percent (Lindsey, 1996) of the homeless population. Lindsey also estimated that

about 80 percent of these families are headed by single parents, primarily women.

A report by the U.S. Conference of Mayors estimated, at the beginning of the 1990s, approximately one-third of the homeless consisted of such families. In its 2000 survey of 25 American cities, the U.S. Conference of Mayors found that homeless families composed 36 percent of the homeless population; 44 percent were single men and 13 percent single women. In a 1985 survey of the U.S. Conference of Mayor, the proportion of homeless families was 27 percent of the homeless population (The U.S. Conference of Mayors, 2000).

Homeless families are often less visible than homeless individuals, because homeless parents may fear that the state will take their children from them if they are found to be homeless. They may choose to double up with friends or relatives or live in cars or abandoned buildings, rather than go to shelters for the homeless where their desperate situations would be publicly visible. In addition, many homeless families lost their homes through family conflict and many have entered shelters for battered women, rather than shelters for the homeless. These factors may lead to conservative estimates of the number of homeless families at any given time (Butler, 1997). Many women and men in shelters for single adults are parents whose children

are no longer with them. If all these people were included in the count of homeless families, the proportion of families among the homeless would be substantially larger (Shinn and Weitzman, 1996).

Wagner, Menke, and Ciccone (1995) say families are the fastest growing subgroup of the homeless. Some possible reasons to explain the growth of homeless families in the 1990s are: the expanded number of single-headed families under the poverty level; reductions or lack of welfare benefits; the increasing of housing or rent cost based on structural/societal risk factors of homelessness; and domestic violence based on individual factors (Choi & Snyder, 1999; Williams, 1998; Butler, 1997, Shinn & Weitzman, 1996; Browne, 1993; Bassuk, 1993; Goodman, 1991; and Hagen, 1987).

Most fundamentally, poverty is the major risk factor in explaining the growth of homeless families. Between 1976 and 1996, the percent of married couples decreased from 80.9 percent in 1976 to 68.4 percent in 1996. And single-headed families increased from 19.1 to 31.6 percent (Stuart, 1998). Among the single-headed families in 1996, about 64 percent were mother only families. According to the National Commission on Children (1991), approximately 43 percent of families headed by women are living below the poverty level. In 1999, 3.5 million female householders were living below

the poverty level and among them 67.9 percent had no workers in their families (U.S. Census Bureau, 2000). Census data (2000) also show that poverty rates were higher for people who lived in female householder families than for those who lived in married-couple families. Poverty rates were at least four times higher for people in female householder families. The problem is not only the increased number of poor single mothers with children but also the erosion of incomes and worsening poverty among this group over the years. In 1996, about one-third of the poor minority female headed families with children under age 18 were living on incomes 50 percent below the poverty level (The U.S. Census Bureau, 1997).

The reduction of welfare benefits, especially according to the Personal Responsibility and Work Opportunity Reconciliation Act (PL104-193) in August 1996, is a factor forcing single-headed families living with AFDC (cash benefits) to leave their homes. The 1996 welfare reform replaced AFDC with Temporary Assistance to Needy Families (TANF), which is a block grant to each state with a stipulated 5-year lifetime limit for welfare receipt. Because of this, all states experienced at least a five percent drop in AFDC recipients from 1994 to 1996, and 20 states realized a 25 to 41 percent decline (Cook and Dagata,

1997). The reduction or loss of welfare benefits may create more homeless families who are unable to meet rent, utility, and food expenses. The National Coalition for the Homeless and the Children's Defense Fund (1998) analyzed the 1996 Act's impact on the welfare recipients. They found that only 8 percent of the former welfare recipients had jobs paying wages above the poverty level and two-thirds of former welfare recipients had lower income than during the three months before they left welfare. A survey of the International Union of Gospel Missions (1998) shows that 20 percent of the sampled homeless people became homeless due to losing their government benefits in the last 12 month in 1997, and 22 percent became homeless because of the same reason in 1998.

Poor single mothers with children who lack education and job skills inevitably depend on cash benefits such as AFDC or GA as a major income source. But the real dollar value of AFDC had declined by almost half since the mid-1970s. The median value of state Aid to Families with Dependent Children benefits for a family of four, adjusted for inflation, fell from \$799 in 1970 to \$435 in 1992 dollars (the U.S. Conference of Mayors and Burt, 1994). And, in 1995, no single state paid benefits high enough to allow those families to reach even 75 percent of the poverty level.

Even combining the values of food stamps and AFDC benefits, the assistance income for a family of four reached only about two-thirds of the 1992 annual poverty line of \$14,335 for a family of four (Blair, Jacobs, and Quiram, 1999).

The 1996 welfare reform poses another threat. In 1998, the state average monthly aid payment for TANF recipients was \$479. It was \$545 in 1996 (The California Department of Social Service, 1998). The grant was decreased by \$66. On the other hand, the average fair market rent (FMR) for a one-bedroom apartment is increasing every year. The median state fare market rent for a one-bedroom apartment was \$462 and FMR for two bedrooms was \$585 in 1998 and will be \$481 for a one-bedroom apartment in 2001 (National Low Income Housing Coalition, 2000). As a result, The FMR for a two bedroom apartment (\$585) was more than the entire TANF grant (\$545) for a three-person household. There are only 5 states (Alabama, Arizona, Mississippi, Oklahoma, and West Virginia) where the entire TANF grant is enough to cover the FMR for a 2-bedroom unit in 1998 (National Low Income Housing Coalition, 1998). In short, families who receive TANF cannot afford FMR housing without additional income unless they are in subsidized housing.

Reductions in AFDC or TANF benefits since the 1980s, coupled with the decrease in low-income rental units, have

made evictions and homelessness an ever more likely event for families who are trying to survive on meager welfare benefits. By April 1999, fewer people, 7.6 million, were on welfare than at any time in past 30 years. Welfare caseloads have dropped 38 percent since the most recent welfare reform went into effect. All 51 states have reduced their welfare rolls since January 1993, with 29 states cutting their rolls by more than 50 percent. According to Butler (1997), fifteen percent of the AFDC families in Maine in 1994 had recently been homeless. Therefore, the welfare reform cuts that took effect in 1996 and replacement of AFDC with state grants have even more severely limited federal benefits to the very poor.

The gap between expanding number of low-income households and low-income housing units is a major explanation of homelessness. Between 1985 and 1995 the number of very low income (with incomes less than 50 percent of area median) renter households jumped by 13.5 percent to a total of 14.4 million, and the source of much of this growth was the increase in the number of very low income, single-parent families. On the other hand, new federal commitments to provide assisted or subsidized housing averaged a little more than 100,000 units in the period between 1988-1995, down from 300,000 to 400,000 units in the

late 1970s; moreover, 1996 marked the first time in the history of federal housing programs that the number of assisted units actually fell (Joint Center for Housing Studies, 1997). In most major cities, the waiting lists for Section 8 housing subsidy and public-housing units stretch for years. The number of low-cost unsubsidized rental units has also declined below 1974 levels, which is inevitable given that between 1973 and 1983 alone, the United States permanently lost some 4.5 million affordable rental units through demolition or structural conversion to higher priced housing. In 1993, only 26 percent of very low-income renter households lived in federally assisted housing (Dolbeare, 1996). The mismatch between the decreasing supply of affordable low-income rental housing units and the increasing demand for these is one of major reasons for homelessness in many cities (Shinn & Gillette, 1994; Ringheim, 1993; McChesney, 1990)

As a group, minority women and women living in poverty are at especially high risk for victimization by violence (Williams, 1998; Belle, 1990; Hawkins, 1986; Steele et al., 1982; Merry, 1981). Recent studies have suggested that violence against women may also be a critical subtext of homelessness, based on documentation of the extremely high prevalence of current abuse and battering among this group

(Williams, 1998; Browne, 1993; Bassuk, 1993; Goodman, 1991). Williams (1998) found that women interviewed for her study emphasize the impact of divorce, battering, and other family disruptions in combination with economic insecurity and primary responsibility for their children on their paths to homelessness. A history of family violence as a child or an adult was positively correlated with homelessness in multivariate analysis of the data (Browne, 1993). Wood, Valdez, Hayashi, and Shen (1990) found that 34 percent of homeless, versus 16 percent of housed, mothers in Los Angeles reported spousal violence; and 31 percent of the homeless, versus 21 percent of the housed, reported experiences of physical or sexual abuse by relatives in childhood. Women once remained in the home and suffered physical or verbal abuse but now may leave the abusive situation and enter shelters to be counted among the homeless.

In brief, three major differences in the demographical changes of homelessness drawn from the historical background are; mostly old white-male homeless people with substance abuse (mostly alcohol) until the 1960s; younger male and female homeless people with diverse ethnicity until the 1980s; and dramatically increased homeless families, mostly female headed parent families, after the 1980s. Even though

the demography of homelessness is changing, the cause and risk factors are drawn from the same roots. Severe poverty, lack of affordable housing units, reductions or loss of welfare benefits, and economic conditions are all based on structural/societal risk factors that in turn are linked to the causes of homelessness. On the other hand, family disorganization drawn from domestic violence or divorce, substance abuse, and mental illness are all individual risk factors associated with homelessness. The risk factors provide much of the explanation for the growth in homelessness regardless of the characteristics or demographical changes of homelessness for the past decades.

III. Literature Review

1. Theories Understanding the Risk Factors of Homelessness

Homelessness is a multifaceted social problem. The many different kinds of homeless people become homeless for many different reasons. To figure out what those risk factors are, many observers have contributed their valuable efforts to this complex phenomenon of homelessness.

According to homeless studies, the reasons to becoming homeless are categorized by two key factors: personal reasons and societal/structural reasons. In the homeless studies, the most often cited personal reasons in becoming homeless are mental illness, alcohol and drug abuse, family violence, and the lack of a family support net. And the most cited societal/structural reasons are poverty, economic conditions such as unemployment, the lack of affordable housing, and the low level or reduction of welfare benefits. These two key factors (risk factors) in becoming homeless are drawn from different theories and ideological perspectives.

Theories to explain or understand social phenomena or social problems vary: structural functionalist theory,

conflict theory, interpretive theory, systems theory, feminist theory, and so on. Among these theories, mental illness, alcohol and drug abuse, family violence, and the lack of a family support net causing homelessness are explained by structural functionalism and also possibly by systems theory including ecological systems theory. And the most cited societal/structural reasons which are poverty, economic conditions, the lack of affordable housing, and the low level or reduction of welfare benefits are explained by conflict theory.

Systems theory provides a way of understanding that human beings interacting in a family or in a group often stimulate each other to maintain or strengthen relationships, which build up bonds within the family and make it stronger. These bonds could not be achieved without the interaction within the system (Payne, 1997).

Ecological systems theory focuses on the nature of the person-environment interrelatedness and the person-situation transactions. Ecological systems theorists believe that the person is observed as a part of his/her total life situation; person and situation are a whole in which each part is interrelated to all other parts in a complex way through a complex process in which each element is both cause and effect (Panyne, 1997; Toro, Trickett, Wall, and

Salem, 1991; Compton and Galaway, 1989; Germain and Gitterman, 1980). The ecological systems theory provides an adaptive, evolutionary view of human beings in constant interchange with all elements of their environment. Therefore, according to ecological systems theorists, human beings change their physical and social environments and are changed by them through processes of continuous reciprocal adaptation (Germain and Gitterman, 1980).

Therefore, according to systems theory and ecological systems theory, family disruption or dysfunction, which is drawn from the lack of interaction within the family or maladaptive interpersonal problems in families such as individual deficits of a member of the family, partner's physical or sexual abuse, a job loss of a parent, and so on, is one of main reasons for a member of family to becoming homeless because all members of a family can affect one another.

However, the family disruption is also well explained by structural functionalism because systems theory has been developed from or based on structural functionalism, especially that of Talcott Prasons (Ritzer, 2000; Payne, 1997).

Parsons's structural functionalism focuses on four functional imperatives that are necessary for all systems:

adaptation, goal attainment, integration, and latency or pattern maintenance. Parsons believes that; systems have the property of order and interdependence of parts; the nature of one part of the system has an impact on the form that the other parts can take; systems maintain boundaries with their environment; and systems tend toward self-maintenance involving the maintenance of boundaries and of the relationships of parts to the whole, control of environmental variations, and control of tendencies to change the system within (Ritzer, 2000). That is, the way of understanding how all members of a family can affect and influence one another has been drawn and developed from Parsons's structural functionalism. Thus, I will focus on two main theoretical streams, structural functionalist theory and conflict theory, for this study because the most risk factors are basically rooted in these two main theories.

In brief, there are generally two types of explanations based on two main theories concerning the risk factors that cause or increase homelessness: structural functionalism and conflict theory. These theories view that homelessness stems from structural/societal or personal reasons. On the one hand, structural functionalism points out that individual factors such as mental illness,

substance abuse, and family disorganization are the main factors causing homelessness. On the other hand, conflict theory argues that the risk factors that cause homelessness stem from societal or structural problems such as poverty, unemployment, lack of affordable housing units, and the reduction or loss of welfare benefits. Some of studies are based on the personal factors, but some are structural/societal factors to explain homelessness.

1) Structural Functionalism

Structural functionalism pays more attention to individual vulnerabilities or deficits understanding the cause and growth of homelessness rather than the institutional or structural factors of homelessness. Homeless persons are seen and treated as a problem population such as delinquents, criminals, and the mental ill. Functionalists usually ignore the structural factors of homelessness.

Structural functionalism assumes that society is a system of related parts and subsystems that function in ways that promote the survival of the whole system. For example, the body as a whole cannot survive unless each part does its job, and none of the parts can survive except as part of the

whole body. The initial focus of functional thinking is to define activities that are necessary for the survival of the entire system. According to Mack and Bradford (1979), there are five functional activities that every social system must be concerned with: the replacement of individuals by reproduction or recruitment; socialization enabling individuals to participate in the social system; the production of goods and services; the provision of social order; and the maintenance of common symbols, values, and motivations (Harper, 1993).

Functionalists also argue that society persists by maintaining "equilibrium," that is, the various structures and institutions are viewed as operating in concert in a mutually reinforcing way to maintain stability in the way that each functions and in the relationships between them. Society thus is viewed as a "homeostatic" system, which is a system that operates to perpetuate itself (Harper, 1993). Therefore, structural functionalism is sometimes called a theory of order and stability.

Structural functionalism views a system as consisting of two concepts: statics and dynamics. Statics is the classification of structural regularities in social relations (dominant role and status clusters, institutions, etc.). Dynamics is the study of goal definition,

socialization, and other functions which maintain system balance.

For functionalists, a key concept to explain social problems is anomie. According to functionalists, social problems both result from and promote anomie. Anomie means system imbalance or social disorganization, which is a lack of, or breakdown in, social organization reflected in weakened social control, inadequate institutionalization of goals, inadequate means to achieve system goals, inadequate socialization, etc. (Horton, 1966). At a social psychological level of analysis, anomie results in the failure of individuals to meet the maintenance needs of the social system.

Explaining Durkheim's concept of anomie, Merton's anomie theory of deviance argues that people can understand nondeviance, or conformity, and deviance by considering two key concepts: *the goals* that a culture defines as worth pursuing and *the means* to achieve those goals that a society defines as legitimate.

Merton (1957) identified five possible modes of individual adaptation to reach cultural goals and means: conformity, innovation, ritualism, retreatism, and revolution. He explained homelessness with retreatism. According to Merton, retreatism describes a person who

rejects both cultural goals (e.g., obtaining a high income) and the socially legitimate means to achieve them (e.g., getting a good job and working hard), such as a chronic alcohol abuser. This type of deviance rejects the cultural goal of appearing respectable and requiring material possessions (e.g., house, car, etc.). He or she also rejects the legitimate means of reaching the goal (e.g., working at a job, being honest, etc.) (Newman, 2000). As a result, Merton explained, retreatism occurs in response to acute anomie, when an individual accepts the culturally prescribed norms and goals of the society but is nonetheless barred from success or a private adaptation to society. Forced by the expansiveness of the prevailing social system to make a private adaptation, the individual retreats to drugs, psychosis, or skid row (Blau, 1988).

Structural functionalism also emphasizes consensual and adjustment definitions of social health and pathology, of conformity and deviation. The standards for defining health are the legitimate values of the social system and its requisites for goal attainment and maintenance. Deviation is the opposite of social conformity and presents the failure of individuals to perform their legitimate social roles. Therefore, deviation is out of adjustment (Horton, 1966). As a result, functionalists stress an anomie

theory of societal discontent and an adjustment definition of social deviation. That is, anomie, maladjustment, and deviation are all important concepts to explain social problems for functionalists.

Structural functionalists thus look for the cause of social problems in the personal characteristics of the individuals concerned and search for individualistic solutions to cure anomie, maladjustment, deviation, and furthermore social problems. In brief, functionalists see social problems primarily in terms of deviation, disorganization, and hereditary inadequacies. As a result, functionalists see homelessness as maladjustment or deviation at the individual level of society.

Reasons and Perdue (1981) explain social problems at the individual level, the family level, and subcultural level. At the individual level, deviant behavior is the key to understanding social problems. According to George and Wilding (1985), deviant behavior covers both non-conformist behavior and aberrant behavior - a distinction between, on the one hand, behavior which is open, unselfish and esteemed by its practitioners and, on the other hand, behavior which is concealed, practiced for personal gain, and which is even felt to be stigmatizing by the practitioners themselves. According to them only aberrant behavior is seen as leading

to social problems though it is acknowledged that there is no definitive and permanent dividing line between the concepts of aberration and non-conformism. Stealing, drug addiction, poverty, homelessness, and so on are forms of aberrant behavior at the individual level, and they are social problems. On the other hand, unusual hairstyles, unorthodox religious beliefs, and so on are non-conformist forms of behavior, and they do not constitute social problems.

At the family level, disorganization (or the disorganization deviant) also can lead to aberrant forms of deviance, as, for example, in the case of children brought up in families whose socialization practices are faulty due to group characteristics such as gypsies, large impoverished families, and so on. Family disorganization or breakdown also results from the disorganization deviance in the family system. Rather than blaming social problems on some defect of the person, social problems are attributed at the family level to poor parenting, undeveloped communication skills, divorce, family violence, and the like.

In short, disorganization deviance views social problems as having little or no connection with the unequal distribution of resources in society. As a result, it seeks solutions in the treatment of individuals, families, or, at

most, neighborhoods, rather than in any major changes to the prevailing unequal socio-economic conditions (George and Wilding, 1985).

Functionalists also focus on various categories of people who are distinct from the larger majority population by human reason of such as race, ethnicity, and class to explain social problems at the subcultural level of society (Mullaly, 1997). Subcultural theorists believe that these distinctive groups have distinctive subcultural values that put them at a disadvantage or in conflict with the larger or dominant culture (Reasons and Perdue, 1981). Social problems are not blamed on the individual or the family at the subcultural level, but are attributed to one's culture. The culture of poverty and the underclass are the examples of a subcultural theory to explain poverty (Mullarly, 1997).

Based on these theoretical frameworks, Baker (1965), Bahr (1968), Caplow (1970), and Bahr and Caplow (1975) described the homeless as typically older, alcoholic, and unemployed. Also, the homeless were disaffiliated. Disaffiliation of the homeless was not regarded as a subculture because they lacked leaders, fixed goals, and a status hierarchy. In the absence of any social glue to hold them together, one would not ordinarily perceive them as a threat. Yet functionalists often imagined them as a threat

because they withheld themselves from conventional society (Blau, 1988). Bahr and Caplow(1975) reflected this view:

The homeless man poses a threat because he has moved out of the reward system; he is a man out of control. Being functionally, if not actually, devoid of significant others, property, and substantial responsibility, he is not subject to the usual social constraints... He may go along with the rules, but there is no guarantee that he will do so, and because he is not part of the system, he has no important stake in its continuity.

Psychiatrists or psychologists frequently stand for a structural functionalist perspective to explain the risk factor or the rate of homelessness. Through extensive interviews with sheltered homeless people, regional surveys on single point-in-time, or cross sectional studies, Bassuk (1997, 1986, 1984), Gelberg, (1988), and Fischer & Breakey (1991) emphasized homelessness as the problem of personal factors such as mental illness or substance abuse. Bassuk and Rosenberg (1988), Browne (1993), and Wood, Valdez, Hayashi, and Shen (1990) also explained homelessness as a result of family disorganization or dysfunction. They view divorce or family violence as two of the main factors in becoming homeless.

In brief, according to structural functionalism, homelessness results from anomie, specifically individual

deviation, family disorganization, and a subculture of the poor or minority groups.

2) Conflict Theory

Conflict theory suggests that the risk factor causing homelessness can be traced to structural reasons including poverty, economic conditions such as unemployment, lack of low-income housing units, and reduction or loss of social benefits.

Conflict theory rejects order models of contemporary society. Conflict theorists interpret order analysis as the strategy of a ruling group, a reification of their values and motivations, and a rationalization for more effective social control. For the conflict theorists, society is a continually contested political struggle between groups with opposing goals and worldviews (Horton, 1966).

Conflict theory has always been centrally concerned with understanding change. In the functionalist perspective, strains emerge when there is malintergration, but such strains are viewed by conflict theory as being inherent in the social structure. In other words, conflict theory makes dialectical assumptions about society and change. Conflict theorists generally argue that the inherent scarcity of

certain goods and values is the source of strain and contradiction in a capitalist society. Thus, inequality is the source of conflict, and the struggles of actors and groups in society to control scarce resources are viewed as the engines of change. Exactly what is scarce, and what is unequally distributed is a matter of controversy. Functional theory focuses on broad evolutionary change, primarily with growth and differentiation within the social system. Rather than a focus on the elaboration of systems and how they function to promote survival, conflict theorists focus on the accumulation of contradictions and the transformation of systems, often with concrete historical referents (Harper, 1993).

According to Horton (1966), conflict analysis is synonymous with historical analysis. The interpretation of intersystem deals with bringing about the transformation of social relations. A key concept in the analysis of historical and social change (as new behavior rather than deviant behavior) is alienation - separation not from the social system as defined by dominant groups, but separation from man's universal nature or a desired state of affairs. Change is the progressive response to alienation. Concepts of disorganization and deviation in functionalism have no real meaning within conflict theory.

Conflict theory turns the light away from the individual and toward society in general in the search for the causes of social problems. The roots of social problems lie not so much in personal inadequacies but in the economic and social conditions. Further, conflict theory views social problems as the product of conflicts and values among the various groups in society (George & Wilding, 1985). Social problems and social change arise from the exploitive and alienating practices of dominant groups. They are responses to the discrepancy between what is and what is in the process of becoming. Therefore, social problems reflect not the administrative problems of the social system, nor the failure of individuals to perform their system roles as in the order explanation of functionalism, but the adaptive failure of society to meet changing individual needs (Horton, 1966).

Conflict theory concerning social problems raises serious questions about the structure of society. Conflict theorists view individualistic issues of deviance or inadequacy as structural issues of inequality, oppression, or alienation. In conflict theory, individual deviance will be explained in terms of the capitalist system of production, because all forms of individual behavior are

influenced and even determined by economic structure under capitalism (George & Wilding, 1985).

Rule (1971) states that social problems such as race, pollution, poverty, or homelessness amount to contests between various groups over the control of desirable resources, including wealth, privilege, and the application of political power. He thinks that these issues turn on clashes of interest, and thus represent political conflicts.

Conflict writers view poverty as largely the result of low wages or low social security benefits, and, further, is the inescapable outcome of the ownership of the means of production. Under capitalism, it is very clear that the ruling class which has the means of production, needs the surplus value to get more profit. Therefore, capitalists invest their capital to make profit and try to secure more surplus value through additional means of production, additional capital, and the extension of the production process in creating profit such as commodity production.

According to Marx's theory called "the absolute general theory of capitalist accumulation", the concern of the capitalist is but to extract the same amount of labor from less workers, not to draw out the same amount of labor or less labor from more workers. Therefore, along with processing of capital accumulation, more variable capital

could create more labor without gathering more workers; or the variable capital of the same size could create more labor with the labor power of the same amount.

Development of capital accumulation, the centralization and concentration of capital, and the high growth of the organic composition of capital accompany an increase of the number of worker and an advance of the labor product power. The increase in the number of workers and the advance of the labor product power create as much as possible the relative surplus population, that is, the industrial reserve army. As a result, according to Marx, the increase of the relative surplus population creates more poor at the bottom of society. Because variable capital could make more and cheaper labor power by the labor power of the higher rank. This kind of labor fluidity, making cheaper labor or decreasing wages, is possible through technological change of the means of production and the product process. The revolution of science and technology is stirring up labor fluidity. Labor fluidity is the most important reason for the creation of the relative surplus population under capitalism. Therefore, under the labor fluidity, the living condition of the working class is devastated more and more. As a result, the increase of the relative surplus population, called the industrial reserve

army, creates more poor or homeless at the bottom of a capitalist society (Walker, 1989).

In short, capitalists invest their capital to make more profit, and workers sell their labor for their livelihood with the cheap wages because of labor fluidity. The interaction of capital accumulation with ownership of the means of production thus brings about the devastation and deterioration of the living conditions and spreading poverty to the working class.

Therefore, according to conflict framework, homelessness is understood as, not individual behavior, but a structural problem in a capitalist society. Like poverty, homelessness is also the inescapable outcome of the ownership of the means of production. In this structurally determined conflict situation, the level of wages not only affects the level of profitability but also takes no account of the individual worker's family needs. It is therefore inevitable that many working-class people will have incomes insufficient to meet their basic family needs, including meals, clothing, and housing expenses. As a result, they may lose their housing because they cannot pay increasing rents with their incomes and finally become homeless in a capitalist society. So poverty and economic conditions are

the main factors causing homelessness in a capitalist society.

Furthermore, conflict theorists locate the primary risk factors causing homelessness not only in severe poverty based on the reduction of wages or unemployment but also the reduction or loss of social benefits such as SSI, AFDC, food stamps, GA, and so on. They also focus on the relationship of the national shortage of affordable housing units with wage reduction or unemployment.

Some conflict theorists explain homelessness not only in the relationship between the fiscal crisis and marketplace wage reductions but also in the dramatic decline in the real value of the social wage (Fabricant, 1987). Underlying inflation, job loss, unemployment, and migration of the 1970s is a crisis of capital accumulation. During the crisis of capital accumulation, new technology and labor saving devices were rapidly introduced into the workplace and provided a basis for recreating the accumulation process and restoring earlier profit margins for the capitalists. New technology and labor saving devices drawn from the revolution of science and technology make more profits for the capitalist on the one hand. However, on the other hand, they make the industrial reserve army because new technology and labor saving devices replace the worker and also affect

the reduction of wages. Therefore, they critically view the reduction of wages as not accidental but rather part of a dynamic process that is fundamental to the properties of capital. In addition, they also argue that the failure of the social safety net resulting from the reduction or loss of the social wage intensifies the life circumstance of the poor living on welfare benefits and contributes to the growth of poverty and homelessness.

Since the 1980s, the U.S. has experienced dramatic reductions of entitlement benefits and services. Concurrent with marketplace wage reductions, entitlements are also being reduced. These reductions have both freed resources for alternative investments and substantially diminished the living standard of the poor people. In addition to the wage reduction in the marketplace, the social wage reduction creates a new subclass of poor, the homeless. By April 1999, fewer people, 7.6 million, were on welfare than at any time in the past 30 years. Welfare caseloads have dropped 38 percent since the most recent welfare reform went into effect. All of 51 states have reduced their welfare rolls since January 1993, with 29 states cutting their rolls by more than 50 percent (Blair, Jacobs, and Quiram, 1999). Many homeless people have been eligible for and have benefited from general low-income assistance programs such as SSI,

TANF, GA, food stamps, Medicaid, and Medicare. Therefore, any reductions or loss in these programs can affect homeless individuals and families, as well as other poor people and low-income people.

As a result, conflict theorists believe that one of the underlying risk factors of homelessness is the increase in the number of welfare recipients whose benefits were discontinued or reduced (Halter, 1992; Hopper and Hamburg, 1984).

Conflict theorists (Timmer, Eitzen, and Tally 1994; Lang, 1989; Wright 1989) also point out that a primary risk factor causing or increasing homelessness is the failure of a housing delivery system, which is based on a free market ideology. They argue that the free housing market serves class interests and believe that the bulk of the population functions as passive consumers and a resource to be manipulated to further the profit making ends of the capitalist class (Lang, 1989). In the capitalist markets, expensive new housing is constructed for the affluent, and older housing is supposed to become available to the less affluent as it sharply drops in price when the increasing supply of new housing lessens its desirability (Smith, 1975 & Grigsby, 1973).

O'Flaherty (1996) in his book *Making Room* offers two reasons why people become homeless. According to him, there are more households than houses, and they can't afford it. He assumes that higher prices for constant housing qualities and the disappearance of the lowest and cheapest qualities of housing imply a rise in operating costs of housing and increase less in low rent housing. Then, rising operation cost from gentrification, for instance, which is accompanied by a decrease in low-rent and low-quality housing, makes middle class people become homeless. As a result, for him, fewer middle class (or the smaller middle class explanation) and many poor (or the more people explanation) imply high rents and much homelessness.

In essence, conflict theorists connect the risk factor causing homelessness with a housing problem such as O'Flaherty, Timmer, Eitzen, Tally, Lang, and Wright's view that housing is competed for like any other good in a capitalist society, and the poor get the existing older housing units that are often highly degraded. In a free housing market, housing is viewed as a commodity to be sold to the highest bidder, and the issues of equity or justice are largely ignored. Indeed, housing is viewed as an investment more than as a means of shelter for them.

Housing units are built and maintained. Maintenance is an investment; thus houses are maintained if and only if the investment is profitable. The profit on this investment is the difference between the value of the houses with maintenance and the value without. For high quality housing units, this difference is great since big differences in building costs cause big differences in price. This makes the profit from investment big, and a big profit makes people invest. Since high quality housing units are all maintained, the only way they can be supplied in the first place is through construction. So building is done in the higher part of the quality distribution.

However, below some quality housing units, maintenance is not profitable and so neither is building. This is because the construction-cost gradient is flatter for low quality housing units, and a flatter gradient implies that maintenance is less profitable.

Therefore, above some degree of quality, houses are both built and maintained; below that quality, they are neither built nor maintained. Since poorer people take lower quality housing, this means that poor people get their housing as hand-me-downs from richer people. In brief, housing built for the middle class becomes housing for the poor and then is abandoned (O'Flaherty, 1996). Thus,

homelessness is a housing problem for the conflict theorists.

As a result, the older housing units exist so long as their owners can make a profit on the units. The owners attempt to cram the poor in these units and charge the highest possible rents in order to increase their profits. If the owners no longer can make a profit on the housing, they then abandon it or renovate it for making more profits.

Frequently, conditions of market disequilibrium occur when a condition of excess housing supply exists simultaneously with a shortage of low cost housing. When there are not enough rental units to house the rising number of the poor-- a phenomenon common to many of our older urban areas today-- then the final indignity of homelessness results (Achtenberg & Masrcuse, 1983; Hartman, Keating, & LeGates, 1982). In this light, the problem of homelessness is that there are too many extremely poor people competing for too few affordable housing units. This is called affordability gap (the gap between the cost of housing and the incomes of growing number of households). Some conflict theorists explain the risk factor causing homelessness with this phenomenon. They suggest that a risk factor causing homelessness is based on the relationship between the housing availability or low-income housing and low income or

extreme poverty (Koegel, Burnam, & Baumohl 1996; Timmer, Eitzen, & Tally, 1994; Burt, 1992; Lang, 1989; Wright, 1989; Rossi, 1989).

Some of them emphasize the affordability gap in explaining the cause of homelessness (Dolbeare, 1992; Appelbaum, 1989; Wright & Lam, 1987). They point out that the cost of housing is beyond the means of growing number of households. This affordability gap is the underlying cause of homelessness. Therefore, they recommend that housing assistance programs, including a housing allowance to low-income families, is a logical solution for homelessness. For example, O'Flaherty suggests a shelter allowance, \$10 or \$15 a day, would be paid to anyone who housed anyone else. According to him, shelter allowances have several advantages. First, they concentrate resources on minimum accommodations for the homeless people. Second, shelter allowances make money useful again in the housing market for very poor people. Third, allowances level the playing field among nonprofit shelters, commercial establishments, and families. Fourth, allowances improve the incentives of U.S. public housing authorities by making the poorest people generate as much income as better-off people. Fifth, shelter allowances give a large number of agents a reason to compete among themselves and to try to design the most attractive

accommodations to lure homeless people in. Finally, allowances eliminate some temptation to violate the nondiscrimination principle in the current shelter system. However, housing assistance programs like housing allowances are a big challenge for conflict theorists because most functionalists believe that welfare programs including housing programs mean more money to the undeserving poor.

In essence, conflict theory views that homelessness is drawn from changing economic conditions based on the labor fluidity under capitalism, poverty, housing problems including the lack of affordable housing units and affordability gap, and the reduction or loss of social wages.

2. Theoretical Backgrounds of the Homeless Studies

1) The Studies Based on Conflict Theory

Conflict theory says that the risk factors that cause homelessness can be drawn from structural and societal context in society. Logically, conflict theorists focus little on individual factors such as substance abuse, mental illness, or family disorganization to explain the causes of homelessness, because most of them agree that individual

risk factors are not the main reason but rather secondary factors, which have a severe impact on inferior living conditions of homeless people or extend the duration of a person's homelessness. Furthermore, some conflict theorists suggest that some homeless adults experience individual problems after, rather than before, becoming homeless, and homelessness itself causes these problems.

Therefore, the findings of risk factor studies based on conflict theory generally show that poverty, unemployment, lack of low-income housing units, or the reduction of social welfare benefits play major roles in homeless issues. In order to support their emphases on the risk factors causing homelessness, the findings about the characteristics of homeless people generally show the low prevalence of substance abuse or mental illness among homeless people. Conflict theorists' estimates have put the incidence of mental illness or the prevalence rate of substance abuse among the homeless population as low as 20 percent. For example, Cohen and Burt (1990) describe the characteristics of homeless people with experiences of either mental hospitalization or substance abuse treatment. The data come from 1,704 in-person interviews in March 1987 with a three stage random sample of homeless adult users of soup kitchens and shelters in U.S. cities that had

populations of 100,000 or more in 1984. In this study, only 9 percent of the homeless population had a history of both mental hospitalization and treatment for chemical dependency. They found that 19 percent of the homeless population reported a history of mental hospitalization. Thus, they suggested that the prevalence of mental illness and chemical dependency is not an important factor in becoming homelessness.

In short, they believe that substance abuse or mental illness is not a primary factor causing homelessness but a casual factor that deepens severe or extreme poverty resulting in homelessness.

For some conflict theorists, the affordability gap is one of the main factors causing homelessness. Dolbeare (1992) points out that the cost of housing is beyond the means of a growing number of households. According to him, this affordability gap is the underlying factor to cause homelessness. Appelbaum (1989) also supports this view. He believes that the affordability gap is the basic cause of homelessness because current shifts in the economy are producing a growing number of people who cannot pay enough in rents or mortgages to make low-income housing investment profitable.

From 1970 to 1989, the number of rental units for the poor declined 14 percent to 5.5 million while the number of poor renters - those who made less than \$ 10,000 in 1989 dollars - increased from 7.3 million to 9.6 million (Gugliotta, 1992:A6). In 1997, an all-time record high of 5.4 million very low income families - those who have incomes below 50 percent of the local MSA (Metropolitan Statistical Area) median - paid more than half their income for housing or lived in severely inadequate housing. This is a situation that HUD classifies as "worst case needs" (HUD, 2000). This represents a 12 percent growth in "worst case needs" households since 1991, a pace nearly twice as fast as the 7 percent growth of all households over the same period (HUD, 2000). In addition to the growing number of very low-income families, the number of affordable housing units is shrinking just when it needs to expand. Between 1991 and 1997, the number of units affordable to extremely low-income families dropped by 5 percent, a decline of more than 370,000 units. As a result, according to HUD data, in 1997, for every 100 extremely low income households, only 36 units were both affordable to them and available for them to rent (HUD, 1999). The extremely low-income families have incomes below 30 percent of median MSA income.

Rent inflation is another problem in making wider the affordability gap. In 1997, rent increased at 3.1 percent while the overall Consumer Price Index (CPI) increased by only 1.6 percent. In 1998, rent increased at 3.4 percent while the overall CPI increased at 1.7 percent (HUD, 1999).

The impact of the housing market on homelessness was shown in a regression study by Tucker (1990). Using the HUD estimates of the number of homeless in each of fifty cities to compute a homelessness rate for each city, Tucker shows a negative correlation ($r = -.39$) between housing vacancy rates in 1980 and homelessness rates in 1984 across the cities. This relationship between them means that the higher the vacancy rate in a city, the lower its homelessness rate. He also shows that the vacancy rate is highly sensitive to the presence of rent control measures. In the findings, he points out that the tighter the housing market from the renter's point of view, the greater the housing burden on poor families, and the more difficult it becomes for the extremely poor to obtain housing, and consequently the easier it is to become homeless.

Between 1986 and 1988, Timmer, Eitzen, and Talley (1994) conducted a longitudinal and ethnographic study. They interviewed 20 homeless people who lived on the streets and another 20 homeless people who lived in two different

shelters. The interviews were characterized as semi-structured and open-ended. Through this qualitative research study, they showed that people are homeless not because of their individual flaws but because of structural arrangements and trends that result in extreme poverty and a shortage of affordable housing in U.S. cities.

They found that homeless population is made up of the mentally ill, the physically handicapped and disabled, alcoholics, and drug users and addicts that results from their being more vulnerable to the kind of impoverishment that excludes them from the urban housing market. They conclude that as the supply of low-income housing is being reduced, increasing numbers of Americans, especially women, children, and minorities, are becoming more and more economically marginal. Just as too much money chasing too few goods causes inflation, so, too, does too many poor and marginal people chasing too few affordable housing cause homelessness.

Wright (1989) shares this view. In his book *Address Unknown*, he stresses the fact that the problem of homelessness is that there are too many extremely poor people competing for too few affordable housing units. After reviewing the studies about the prevalence rate of mental illness and substance abuse among homeless people, he

suggested that not more than about a third of the homeless are mentally ill by any meaningful clinical standard, which means that two-thirds are not, and thus he concluded that the homelessness of a large majority must result from other factors. He also says that about half are substance abusive and this leaves another half who are not. So, while substance abuse is certainly a part of the homelessness story, it is far from the whole story.

Wright and Lam (1987) also suggest that lack of low cost housing is the main factor in becoming homeless. They point out that gentrification, whereby low-income housing is converted to middle and upper-middle class housing, condominium conversion, and abandonment exacerbates the housing problem by removing rental housing from the market, driving up rents in the remaining apartments, and uprooting tenants from their communities. Gentrification typically includes buying up older and sometimes rundown property in poor and working-class neighborhoods and rehabilitating it into middle-class condominiums, townhouses, single-family dwellings, and upscale lofts and apartments. Often, the original residents of the area are displaced because they cannot afford the increased rents, purchases process, and insurance and property taxes associated with the neighborhood's rising property values (Timmer, Eitzen, and

Talley, 1994). As a result, the poor, who once had housing, are left out due to this opportunity cost including insurance, property tax, and so on.

Some conflict theorists focus more on poverty than other structural risk factors in explaining the cause of homelessness. After the surveying the condition of the homeless in Chicago in 1986, Rossi (1989) suggests that extreme poverty is the root of homelessness. He describes the extremely poor constituting the pool from which the homeless are drawn. According to him, the pool of extremely poor persons that the homeless are drawn from has increased since 1970. There were 4 to 7 million extremely poor people, whose income was two-thirds below of the official poverty line derived from the 1987 Current Population Survey, and who were thus at high risk of becoming homeless. Of course, all of these extremely poor people do not become homeless. Rossi suggests that vulnerability to homelessness is affected by living arrangements such as the level of welfare benefits and the family safety net, the amount of inexpensive housing available, and personal characteristics such as mental illness. In his Chicago homeless study, he found that the homeless are different from most of the domiciled extremely poor in having much a higher incidence of these vulnerabilities. The joint impact of the

disabilities produces a situation in which the overwhelming majority of the homeless have at least one disabling condition, and most have more than one. As a result, among the extremely poor, those with disabilities are the most vulnerable to homelessness. Extreme poverty is the main reason for becoming homeless and, jointly, those with more than one disability are secondary reasons.

Belcher, Scholler-Jaquish, and Drummond (1991) conducted a study of urban homeless persons in Baltimore, Maryland and found that homelessness is often composed of three stages. The first stage consists of living with family or friends and is often a result of severe and persistent poverty. Bratt, Hartman, Meyerson (1986) point out in their book *Critical Perspectives on Housing* that severe and persistent poverty acts as a catalyst for homelessness, and in many cases a person in this condition is already homeless.

Furthermore, DiBlasio, Belcher, and Connors (1993) point out in their study that growing number of homeless are employed, but are unable to escape life on the streets because many jobs are low-paying service factor jobs resulting from changes in economic conditions such as an economic dislocation. According to them, an economic dislocation is the notion that individuals become dislocated

or displaced from mainstream society because of economic circumstances within the workforce, such as underemployment, temporary jobs, few benefits, plant closures, mergers and lay-offs. Thus, they suggest that the economic dislocation is one major factor causing homelessness. In their homeless study, among 178 homeless persons in 25 shelters in Maryland, 25 percent of the homeless were found to work full-time and 11 percent part-time. However, they were not able to support themselves or their families on the wages they earned. Blau (1992) broadens this perspective. He suggests that the risk factor causing homelessness can be traced to the business response to macro industrial policies of the postwar period during which reindustrialization, a shift to a service economy, and international competition required a transformation in the nature of the U.S. economy.

The conflict theorists also believe that the reduction or loss of social wages is the main risk factor in becoming homeless. A survey concerning the impact in the reduction or loss of welfare benefits on homeless people was conducted by the International Union of Gospel Missions (IUGM) in 1997. The results of this survey strongly give support to the conflict perspectives that the reduction or loss of social wages is one of the risk factors of homelessness. The nationwide survey was conducted at 135 Rescue missions

across the nation. The survey included 150,000 homeless men, women, and children. The results show that 20 percent of the homeless checking into America's Rescue missions have become homeless because of the loss of government benefits in the past year. This means that changes in both state and federal welfare programs, eligibility requirements for AFDC, SSI, food stamps, and Social Security Disability plays the major role affecting the living conditions of the poor. A study of the Conservation Company (1987) also supports this perspective. The study conducted in Pennsylvania found that 10 percent of those discontinued from GA (General Assistance) as a result of the Pennsylvania welfare reform act of 1982 became homeless.

Halter (1992) conducted a qualitative study to show the impact of a state welfare reform on individuals. The purpose of his study was to discuss the effect of one state's welfare policy changes on a segment of its General Assistance population, which became homeless. In his study, he interviewed 35 homeless people at two shelters in Philadelphia and found that during the initial stages of discontinuance of cash assistance, individuals would rely on family members and close friends. However, the longer this population remained homeless and without financial support, the more they depended on shelters for survival and the less

time they spent with relatives. This means that the family safety net is just a temporary remedy for the poor people who lost their benefits. Therefore, this study shows that the reduction or loss of welfare benefits may serve to reinforce a state of poverty and increase homelessness rather than bring people out of it.

Burtler (1997), conducting a research study, mailed a survey to 3,000 AFDC participants in Maine to learn of their experiences in the labor market and receiving AFDC. In this survey, she found that AFDC was keeping respondents from being homeless at the time of the survey. According to her study, the 1996 welfare reform bill forces most welfare recipients to do work, but that employment has not moved them out of poverty.

The homeless studies to estimate the relationships among structural/societal risk factors or between one of structural risk factors and homelessness have been conducted by some of conflict theorists. Burt (1992), Elliott and Krivo (1991), Bohanon (1991), Tucker (1990), and Belcher & DiBlasio, (1990) examine the relationships between the structural or societal risk factors and the rates of homelessness or homelessness. In their studies, they show which risk factors have statistically significant relationships with the increase of homelessness. The studies

suggest that the strongest risk factors among the structural or societal risk factors in becoming homeless are the housing variables.

Elliott and Krivo's (1991) article reports on a quantitative evaluation of the influence of several structural factors on rates of homelessness in sixty metropolitan areas in the United States. According to them, the structural factors are unavailability of low-cost housing, high poverty, poor economic conditions, concentrations of minorities and female-headed families, and the lack of community mental health care facilities. Thus, in their study, the dependent variable is the rate of homelessness, and the independent variable is unavailable low-cost housing, poverty, poor economic conditions, and the lack of community mental health care facilities. It is hypothesized that unavailability of low cost housing, high poverty, poor economic conditions, concentrations of minorities and female-headed families, and insufficient mental health care facilities for the indigent are determinants of a high level of homelessness. The results of a multivariate analysis show that seven of the nine independent variables have bivariate relationships consistent with the hypotheses. The homeless rate is negatively correlated with the amount of low-rent housing.

Thus, areas with more low cost housing have lower rates of homelessness. Also, areas in which more money is spent on mental health care facilities have notably lower levels of homelessness. Unskilled jobs and the percent of blacks, Hispanics, and female headed families all have positive relationships with homelessness, suggesting the importance of occupational structure and demographic composition as underlying conditions for higher levels of homelessness.

In contrast, the negative correlations of poverty and the unemployment rate with homelessness contradict the hypothesis that areas with more overall poverty and worse economic conditions have higher rates of homelessness. They found that the level of poverty and the unemployment rate in areas have no significant independent effect on rates of homelessness. According to these research results, the availability of low-cost housing is the strongest risk factor to becoming homeless. Thus, lack of low-cost housing units is the primary risk factor for the cause of homeless in this study.

To examine the effects of the structural conditions of areas on rates of homelessness, they used published data from the 1980 Census of Population and Housing and the U.S. Department of Housing and Urban development's (HUD, 1984)

study of homelessness. Metropolitan areas in the United States were the units used for the multivariate analysis in this study.

Bohanon (1991), in a cross sectional study, examines variations in the rate of homelessness across 60 metropolitan areas in the United States and confirms that homelessness is a housing and economic problem. The author assumes that higher rents would generate more homelessness and lower incomes among the poor would be correlated with higher levels of homelessness. The author also assumes that homelessness would be positively correlated with the employment rate and negatively related to the welfare benefits. Therefore, the author includes the median rent in each city, the city's unemployment rate, and average AFDC payment in the state as independent variables. The author also includes January temperature, annual precipitation, city household size, rent control, and the number of patients in state and local mental hospitals and state homes for the mentally retarded per thousand population in 1983 as independent variables.

The findings of this study show that rents and unemployment rate on the homeless rate are statistically significant. The extremely strong relationship between homelessness and rents suggests that homelessness is a

housing problem. The significance of the unemployment rate in explaining homelessness suggests that increased employment opportunities aid the poor in avoiding homelessness. In this study, both imply homelessness is also an economic problem. However, the AFDC and climatic variables consistently fail to exhibit statistical significance.

In order to examine economic dislocation as one of major risk factors causing homelessness, Belcher and DiBlasio (1990) conducted both bivariate and multivariate analysis. The data used for their study came from 178 homeless people in 25 Maryland shelters. They used logistic regression and found that a large portion of homeless people in their study was either employed at low-paying jobs or unemployed as a result of company economic decisions. Based on these results, they pointed out that economic dislocation theory is a plausible explanation of homelessness.

Burt (1992)'s study also shows that homelessness is a housing and economic problem. She examines the impact of factors hypothesized to affect homelessness in the 147 primary cities with populations over 100,000 in the United States. Multiple regression analysis was used to assess: the relationships among the variables representing the hypothesized casual factors, and the relationships between

the factors and increases in homelessness rates between 1981 and 1989. The homeless rates as the dependent variable were developed for 1981, 1983, 1986, and 1989, based on the number of shelter beds available in each city in those years. Results showed that homelessness based on shelter beds as an indicator almost tripled between 1981 and 1989 in every region of the country and in cities of all sizes and levels of prosperity. The independent variables (risk factors) in her study that tended to increase homeless rates were housing variables, income variables, social benefits, household resources, cost of living, and employment structure.

She found that housing variables, including the shortage of affordable housing and tighter rental housing markets (lower vacancy rates), were strongly associated with homelessness. In that, higher average rents are associated with greater homelessness. She also found that more homelessness is associated with greater unemployment, more retail employment, more single-person households, and the absence of a general-assistance program.

However, she found that, contrary to expectation, poverty rates were largely irrelevant in explaining the increase of homelessness rates. Although poverty is implicated in every discussion of the causes of

homelessness, a city's poverty rate rarely contributed to explaining differences between cities in homelessness rates. Another unexpected finding is that the payment level of public benefits had a positive association with homelessness. In that, she expected that payment levels increase as the city's cost of living increases, and higher levels of both predict more homelessness.

A number of need assessment studies support conflict theory as a frame of reference for understanding homelessness. The results of the studies show that housing and income or social benefits are the most important needs of homeless persons.

McChesney (1992) interviewed 80 mothers in five shelters for homeless families in Los Angeles County and found that the families in the sample were homeless because they were unable to keep up with their rent and so forced to leave housing, or, having left their housing for some reason, unable to come up with enough money to get back into housing, given the high rents. They needed housing, but had exhausted their own resources, and so could not afford to purchase or rent in the open market.

Schutt's research (1992) describes and explains the situation of homeless persons in housing, economic, and health-related services with intake interview data with 414

homeless persons collected in a large urban shelter for single adults. He found that the homeless persons were most interested in assistance with housing (86%), job opportunity (62%), and social benefits (59%). Only 17 and 16 percent were interested in alcohol and mental health services. This pattern underscores the importance of basic economic needs in efforts to respond to the problems of the homeless.

A need assessment of Ball and Havassy (1984) also supports the view that homelessness is a housing and economic problem. In their survey of 112 homeless people in the San Francisco area, respondents were most likely to be interested in affordable housing (86%), financial entitlements (74%), and employment (40%). Smaller numbers were interested in social contacts (32%), alcohol cessation (18%), and supportive counseling (14%). A qualitative study conducted by Banyard (1995) also supports that homelessness is a housing problem. The results of this study of the coping narratives of 64 homeless mothers living in temporary emergency shelters with their children in three small midwestern cities show that the most stressful problem is housing. Seventy three percent of homeless mothers point out that housing problems are the most stressful, and only 17 percent indicate medical/health problems as the most stressful.

According to Mulkern and Bradley (1986), about three quarters of homeless persons interviewed in Boston sought help with housing; about half sought help with obtaining a job, food, clothing, financial benefits, or dental care; 40 percent sought medical help; 30 percent sought help with alcohol or drug problems; and 20 percent expressed an interest in mental health care.

In brief, the homeless studies based on conflict theory show that the risk factors causing homelessness can primarily be traced to structural/societal factors such as poverty, lack of low-cost housing units, economic conditions such as unemployment, or the reductions of social wage. The conflict theorists argue that mental illness or substance abuse plays a more casual role in increasing the risk of homelessness, by reducing earning capacity and leading to downward mobility, cognitive impairment, and disruptive or bizarre behavior that strains the tolerance of family and friends. Therefore, mental illness or substance abuse for the conflict theorists is probably understood as factors that are exacerbated by the stresses and circumstances of being homeless (Burt, 1992).

Also, they suggest that individual factors or family disorganization or dysruption is appropriately explained by the structural relationship with society. Therefore,

individual factors or family disorganization only act to deepen severe poverty, which cause homelessness to increase.

As a result, conflict theorists believe that structural functionalists, who view personal risk factors as the cause of homelessness, ignore the changing social contexts in which poor people, including poor, non-institutionalized mentally ill and substance abusing adults, lived their lives, and the functionalists should turn a blind eye toward a well-developed body of scholarship suggesting a close historical relationship between homelessness and broader economic conditions (Koegel, Burnam, and Baumohl, 1996).

2) The Studies Based on Structural Functionalism

Structural functionalism argues that homelessness is best explained by the personal limitations of those who become homeless. According to this perspective, the risk factors causing homelessness are drawn from personal or family factors such as mental illness, substance abuse, or family disorganization caused by family violence or the lack of a family safety net. Therefore, a number of homeless studies based on structural functionalism show that a majority of the homeless suffer from psychiatric disorders

or alcohol/drug addiction problems. They also view the growing number of homeless families as coming from the difficulty of maintaining relationships between/among family members due to domestic violence. According to them, homeless families also lack a protective buffer of supportive family or friends such as a family safety net. These are the reasons why they do not focus on family poverty or the feminization of poverty in our society.

According to the homeless studies based on the structural functionalism, functionalists point out the high prevalence of mental illness or substance abuse among the homeless. The prevalence rates for the mentally ill population among the homeless range from 91 percent of the total sample (Bassuk et al., 1984) to 37 percent (Fischer et al., 1986). The range of the homeless who have a history of mental illness or hospitalization varies; from 97 percent of the total sample (Lipton et al., 1983) to 33 percent (Fischer et al., 1986). The prevalence rates for alcohol problems range from 4 percent to 86 percent, and rates for drug abuse from 1 percent to 70 percent (Fischer, 1989).

Bassuk, Rubin, and Lauriat (1984) interviewed 78 homeless men, women, and children staying at an emergency shelter in Boston and Cambridge, Massachusetts. The vast majorities were found to have severe psychological illnesses

that remained largely untreated. Approximately 91 percent were given primary psychiatric diagnoses: about 40 percent had psychoses, 29 percent were chronic alcoholics, and 21 percent had personality disorders. Approximately one-third had been hospitalized for psychiatric care. The authors found that mental illnesses are strongly related to becoming homeless. They also found that 74 percent of the overall sample had no family relationships, and 73 percent had no friends to provide support. Forty percent of the total shelter sample claimed that they had no relationship with anyone, not even with someone working for a social agency. Thus, they conclude that mental illness and the lack of a family safety net both play major roles in homelessness.

As part of a community-based survey of 529 homeless adults in Los Angeles County, Gelberg, Linn, and Leake (1988) analyzed factors associated with the use of mental health services. In this study, homeless persons who had had a previous psychiatric hospitalization had been homeless nearly twice as long as the rest of the sample. They found that many homeless adults have an overwhelming set of social, mental health, criminal, alcohol, and drug problems. The authors also found that the homeless persons who had had a previous psychiatric hospitalization were the most likely to have mental health problems, used alcohol and drugs the

most, and had the greatest involvement in criminal activities.

The most important result of this study is that 44 percent (232) of the sample of 529 homeless persons reported being hospitalized for a mental, emotional, nervous, alcohol, or drug problem at some time in their lives. This means that all of them experienced institutionalization.

Fischer, Shapiro, Breakey, Anthony, and Kramer (1986) examined selected sociodemographic and health characteristics of 51 homeless persons. The 51 homeless persons were compared to those of 1,338 men aged 18-64 years living in households in Eastern Baltimore. Homeless persons reported higher rates of hospitalization than housed men for both mental and physical problems. They found that 33 percent of the homeless had a previous psychiatric hospitalization, and 37 percent of homeless persons met DSM III criteria for psychiatric disorder. In addition, nearly 80 percent of the homeless were diagnosed as having had disorders at some time in their lives. According to the results of the studies, they suggest that deinstitutionalization and mental illness are the primary risk factors in becoming homeless.

Functionalists also suggest that substance abuse has a strong connection to homelessness. Vernez et al. (1988)

found that 48 percent of a sample drawn from three California counties had abused drugs other than alcohol at some time during their lives. Milburn (1989) found that prevalence estimates for current drug use among sheltered homeless people ranged from 20.8 to 58 percent; for current drug abuse, estimates ranged from 3 to 48 percent. Studies of alcohol abuse and alcoholism among homeless populations during the 1980s have been summarized by Fischer (1987) and Stark (1987). Stark (1987) reviewed the fifteen studies to see prevalence rates of alcohol abuse among the homeless. Stark found prevalence rates of alcohol abuse ranging from 10 percent to 45 percent. Fischer (1987) reported prevalence rates of alcohol abuse and alcoholism ranging from 15 to 86 percent. Wright and Weber (1987) reported prevalence rates for alcohol abuse, based on clinician judgment, of 47 percent for men and 16 percent for women among homeless persons using special health clinics for the homeless in sixteen large cities.

The interaction among drug abuse, alcohol abuse, and mental illness is also described by functionalists. Dual diagnoses range from 2 percent to 34 percent, with as many as one-third having concurrent alcohol and drugs problems, up to one-fourth having alcohol and mental disorders, about 3 percent having both mental and drug disorders, and perhaps

7 percent suffering from alcohol, drug, and mental problems in combination (Breakey et al., 1989; Farr et al., 1986; Ladner et al., 1986; McGerrigle and Lauriat, 1985; Rosnow, Shaw, & Stapleton-Concord, 1985, 1986; Schutt, 1988; Schutt & Garrett 1986; Toro & Wall, 1989; Wright & Weber, 1987). Among the homeless clinic users across the country, 57 percent of male and 41 percent female drug abusers were also alcoholic. Conversely, 18 percent of male alcoholics and 26 percent of female alcoholics also abused other drugs (Wright et al., 1987). Farr, Koegel, and Burnam (1986) found that 31 percent of the sample of homeless people on Los Angeles' skid row had current substance abuse disorders, including 27 percent with alcohol abuse or dependence and 10 percent with drug abuse or dependence.

The studies conducted mostly by functionalists confirm that substance abuse is at least as prevalent as severe mental illness among the homeless. Drug or alcohol problems are more than twice as prevalent among the homeless as males in the general public. The studies show that substance abuse probably plays some major role in increasing the risk of homelessness. Furthermore, functionalists suggest that substance abuse is one of the main factors causing homelessness.

In sum, functionalists focus more on the prevalence rates of mental illness and substance abuse among the homeless in explaining the cause of homelessness. The findings of studies of the functionalists generally show that more than one-third of the homeless are suffering from severe mental illness and have a history of mental illness or hospitalization and substance abuse problems. Baum and Burnes (1993) in their book *A Nation in Denial* stress the importance of alcohol, drugs, and mental illness in homelessness. They argue that researchers and analysts discuss alcohol, drugs, and mental illness, but take considerable pains to minimize their importance. Furthermore, they point out that some of researchers or analysts not only deny the importance of these conditions but also deny the causal relationship between them and homelessness. They conclude that the primary factor is not the lack of homes for the homeless. The homeless need access to treatment and medical help for the conditions that prevent them from being able to maintain themselves independently in jobs and housing.

Functionalists also look for the risk factor causing homelessness in the areas of individual or family violence. Herman, Susser, Struening, and Link (1997) identified risk factors in adverse childhood or adult experiences. They

conducted an empirical study and tested the hypothesis that adverse childhood experiences are risk factors for adult homelessness. They interviewed a nationally representative sample of 92 household members who had previously been homeless and a comparison group of 395 individuals with no prior homelessness. In this study, they found that adverse childhood experiences such as lack of care from parents and sexual or physical abuse are powerful risk factors for adult homeless. The results of this study supports the functional perspective because the study extends the boundary of personal risk factors including mental illness or substance abuse to individual living conditions such as adverse childhood experiences.

Bassuk et al. (1997) suggest that childhood risk factors including foster care placement and the mother's use of drugs, and adulthood risk factors including minority status, a recent move, a recent eviction, interpersonal conflict, frequent alcohol or heroin use, and a recent hospitalization for a mental health problem play essential roles in homelessness. They conducted a case control study to identify risk and protective factors for family homelessness. Two hundred twenty homeless mothers are compared to 216 low-income housed mothers in Worcester, Massachusetts. In a multivariate analysis, they found that

foster care placement and drug use by the respondent's primary female caretaker are the most salient childhood predictors of subsequent family homelessness in adulthood.

They also found that social or community supports or resources are protective against family homelessness; minority status increase the risk of becoming homeless; family support networks are closely related to homelessness; frequent use of alcohol or heroin is a risk factor; and mental health hospitalization within the past 2 years is a strong risk factor for homelessness. However, the results of this study show that violent victimization is not statistically significant, and therefore, not a risk factor.

Functionalists generally view family breakdown or disorganization as one of the main risk factors in homelessness. Bassuk, Rubin, and Lauriat (1986), describing the characteristics of homeless families, interviewed 80 homeless mothers and 151 children living in 14 shelters in Massachusetts. Ninety percent of the families were headed by women, and 91 percent were on AFDC. Two-thirds experienced a major family disruption and lacked or had minimal supportive relationships with relatives or friends. Seventy one percent of the mothers had personality disorders. They found that family disorganization or breakdown plays an important role in family homelessness. They also found that

deinstitutionalized persons or those suffering from mental illness had a strong tendency toward homelessness. Based on this study, they argue that not only is mental illness a primary factor in becoming homeless, but also family disorganization plays an important role in homelessness.

Browne (1993), Wood et al. (1990), D'Ercole and Struening (1990), Redmond and Brackmann (1990), Shinn, Knickman, and Weitzman (1991), and Bassuk and Rosenberg (1988) found that family violence is another factor strongly associated with homelessness. Browne (1993) points out that studies of homeless women reveal high lifetime rates of childhood physical and sexual abuse and of assault by male partners. In a small sample of homeless women, Redmond and Brackmann (1990) found that 50 percent of the respondents had been physically abused as children, 33 percent reported child sexual abuse, and 33 percent reported violence from an adult partner. During in-depth interviews with 141 women at a Manhattan shelter, D'Ercole and Struening (1990) found that 31 percent of the women reported childhood sexual molestation, 63 percent assault by an adult partner, 51 percent attack by a weapon, and 58 percent rape.

Other studies have compared homeless mothers with poorly housed women. Bassuk and Rosenberg (1988) compared 49 homeless female-headed families in Boston shelters with 81

of their housed counterparts drawn primarily from public or privately subsidized housing. Of the 41 homeless mothers, 42 percent reported childhood abuse (compared to 5 percent of the housed mothers) and 41 percent reported at least one adult relationship in which they had been physically assaulted by a male partner (compared to 20 percent of the housed mothers). Moreover, a history of family violence as a child or an adult was positively correlated with homelessness in multivariate analyses of the data. Wood et al. (1990) found that 34 percent of the homeless, versus 16 percent of housed mothers in L.A. reported spousal violence.

Shinn, Knickman, and Weitzman (1991) surveyed a random sample of 704 homeless families requesting emergency shelter in New York City and a representation of 524 public assistance families coming to income support centers for recertification in 1988. The study found that 11.4 percent of the homeless compared with 6.5 percent of the housed sample reported childhood physical abuse. Additionally, 9.9 percent of the homeless compared to 4.2 percent of the housed reported childhood sexual molestation. Finally, 27 percent of the homeless compared to 16.6 percent of the housed reported assaults or threats of violence by at least one intimate partner in adulthood.

Goodman (1991) examined the history of physical and sexual abuse among 50 homeless and 50 housed poor mothers and also found that when the prevalence of physical and sexual abuse is combined, 90 percent of the homeless sample and 88 percent of the housed sample had endured some form of physical or sexual abuse during their lifetimes.

It is therefore suggested that family violence including sexual or physical abuse may increase vulnerability resulting in later homelessness for some survivors. Therefore, the authors, based on structural functionalism, point out that for some homeless women the effects of early violence or molestation by intimates decreased their supportive networks and increased their risk of becoming homeless later in life. Also, women, in attempting to flee a violent mate, found themselves without adequate financial resources or stable housing leading to eventual homelessness (Browne, 1993).

Functionalists also believe that the lack of a family safety net, including family, relative, or friend support, is one of the risk factors in becoming homeless. Kingree, Stephens, Braithwaite, and Griffin (1999) show in their empirical study that a lack of friend support among the variables is most strongly associated with homelessness. This study examined risk factors for homelessness among 114

participants in a metropolitan residential treatment program (RTP) for low-income substance abusers. In this study, the dependent variable was recent homelessness and independent variables were depression, prior psychiatric Tx, family support, friend support, recent work, work skill, recent substance use, and polysubstance problem. Low levels of support from friends, greater depression, and recent substance use were bivariately associated with homelessness two months following completion of the RTP. However, friend support was the only risk factor associated with homelessness after controlling for other significant bivariate predictors.

Bassuk et al. (1996) used case control study with 220 homeless women and 216 housed women receiving AFDC in Worcester, Massachusetts. In this empirical study, they also points out that homeless women had smaller support networks than their housed counterparts.

Linn and Gelberg's (1989) need assessment study supports the structural functionalists' perspective in understanding homelessness. They measured five self-reported needs of homeless adults in two California beach communities and found markedly different preferences. Respondents placed the highest priority on good health; the priority given to a steady source of money and a permanent job was somewhat

lower, while others attached as high a priority to a permanent home or regular meals.

In brief, functionalists try to show the high prevalence rates of mental illness or history of hospitalization among the homeless population insisting that deinstitutionalization and mental illness are the primary factors in becoming homeless instead of structural factors that include lack of social policies for the homeless. In addition, they point out that alcohol or drug abuse, adverse childhood or adult experiences, a lack of a family safety net, and family violence are also risk factors that cause homelessness. They argue that the conflict theorists "normalized" homeless people in order to elicit public sympathy and advance a policy agenda that had far more to do with eliminating poverty among housed individuals than with providing needed help to the homeless. Resulting in the fact is that the conflict theorists do not identify which individuals or families are most vulnerable to becoming homeless.

3. Ideological Changes in the Theories of Homelessness

Ideological perspectives regarding homelessness have been developed from the theories. The conservative perspective on homelessness stems from structural functionalism, viewing homelessness as a consequence of personal problems or family disorganization. The liberal perspective on homelessness is rooted mostly in conflict theory, but structural functionalism also affects the liberal perspective. The liberal perspective views homelessness as a major social problem caused by societal factors such as the lack of a social welfare system. The radical perspective is based on the conflict theory: understanding homelessness as a structural problem in the capitalist society.

1) The Conservative Perspective

Conservatism is a set of beliefs that springs from a desire to conserve existing things, held to be either good in themselves, or better than the likely alternatives, or at least safe, familiar, and the objects of trust and affection (Scruton, 1982). This view implies a distrust of sudden or radical change preferring the maintenance of traditional

institutions and processes that should only be modified with extreme caution (Mullaly, 1997). The political consequences of these beliefs are a suspicion of state interference, a sympathy towards property rights, and an acceptance of inequalities with respect to class, education, status, and wealth (Roberts, 1971).

The central social values of conservatism are freedom (individual freedom) and liberty, individualism, and inequality. The dominant theme of individualism is that the individual must have as much liberty as possible to pursue his or her own interests and to bear the consequences of his or her actions. If everyone in society adheres to the principle of the pursuit of self-interest without harming others, then society will run smoothly. Conservative perspectives indicate that only when people fail to carry out their obligations or when government interferes with one's liberty do problems occur for the individual and for society. The conservatives fear that equality of incomes from work will destroy people's work incentive, including the social esteem that accompanies certain occupations (Mullaly, 1997). The major political beliefs of conservatism are: rule by a governing elite; subjugation of the political system to the economic system; law, order, and stability; and paternalism.

The conservative view of social problems seldom considers structural or environmental sources of social and economic problems. Social problems are rather framed as a matter of individual weakness, deviance, or heredity. Thus, social problems are viewed as personal problems, and the focus is on the troublesome person or family. The problem is supposed to be caused by defects of the mentally ill person, or the drug addict, or the poor person, or the criminal. The family also is seen as the source of personal problems because unfit parents will produce unfit children (Mullaly, 1997). In other words, parents who are lazy, dishonest, and inferior will produce children with similar characteristics. According to Gilder (1981), the decline of traditional family values and patterns may cause poverty or homelessness. In brief, the conservative view of social problems is consistent with the social pathology perspective. Conservatives suggest that social problems are the work of sick or pathological individuals who are defective, delinquent, dependent, and deficient.

Conservatives believe that the poor lack the skills or attitudes necessary to work their way out of poverty. They have insisted that supply conditions, especially the lack of adequate skills and motivation among indigents, is the major factor causing poverty or homelessness (Kelso, 1994).

Conservatives also believe that the problems of the poor stem from the fact that they have adopted a culture of poverty that embraced values differing substantially from those of mainstream society. The culture of poverty is a framework for conservatives that explains persistent poverty. Lewis (1966) suggests that many Puerto Ricans in New York City are poor because they do not have middle class norms and values. According to a cultural perspective of poverty, the poor have not been allowed to develop the proper values and behavior for achieving middle-class status in the United States. Furthermore, Banfield (1973) suggests that the innate "ethos" of some groups prevents them from acquiring the proper work habits, moral disposition, attitudes, and cultural norms necessary for social mobility regardless of government attempts to achieve this.

As a result, the conservative perspective on social problems, which are referred to as the personal deficiency approach, has informed the diagnostic, functional, and psycho-social traditions (Coates, 1991).

In terms of homelessness, conservatives believe that homelessness is caused not only by defects of the mentally ill person, the drug addict, the poor person, or the criminal but by family break-downs caused by such as sexual or physical abuse from partners or parents. Conservatives

are naturally reluctant to emphasize the societal or economic factors of homelessness, and they bridle at any hint of criticism that Republican domestic policies might have contributed to the growth of the homeless population. An emphasis on mental illness and substance abuse permeates their characterization of the homeless population (Blau, 1992). In brief, they view homelessness as a problem that flows from the personal and moral failure of those who are homeless (Baum and Burnes, 1993; Ellickson, 1990; Main, 1983). Therefore, conservatives seem to believe that government has little obligation to care for the homeless. This attitude is perhaps best exemplified by president Reagan's often quoted remark that "the homeless are homeless, you might say, by choice" (Bassuk, 1984).

In sum, conservatives try to detach homelessness from the problems of poverty and growing inequality. Furthermore, they oversimplify homelessness as just a consequence of individual failure or the family disorganization.

2) The Liberal Perspectives

Liberalism is generally classified as classical liberalism and new or reform liberalism. Here, new liberalism is the subject. Unlike classical liberalism, new

liberalism accepts the concept of equal freedom or opportunity and state intervention to the market. The new liberals seek to reduce inequality of wealth, status, or power by using the power of the state to provide opportunities such as public education or public welfare programs that would not be available to some people without government intervention. George and Wilding described new liberalism as reluctant collectivism (George and Wilding, 1976) and the middle way (George and Wilding, 1994).

Liberals share many of the same values with conservatives: beliefs in freedom, in individualism, and in competitive private enterprise. However, liberals hold fewer absolute values in that they accept intervention into the economy on the basis of pragmatism and humanism. Their pragmatism is based on a conviction that although capitalism may be the best economic system, it is not self-regulating. Their humanism is based on a recognition that capitalism is hurtful to many people (Mullaly, 1997). George and Wilding (1994) explain that liberalism starts from three basic assumptions. The first is that capitalism can probably be made more efficient in attaining economic ends than any alternative system yet in sight. Capitalism is seen as the best system in its capacity to generate economic growth, to give scope to individuals, and to realize their capacities.

The second assumption is that, whatever its virtue, capitalism creates problems. It creates poverty, unacceptable inequalities, unemployment, and homelessness. It blights lives and communities. These are problems, which are inherent in the very nature of the free market system. The problems are systemic, and they will not be solved simply by economic growth. The third belief is that government action can solve, or at least ease, many or most of these problems.

Liberals believe in freedom and individualism. However, they modify and qualify these values somewhat by pragmatic and humanistic concerns. Conservatives view freedom simply as freedom from the arbitrary power of governments, whereas liberals include in their value the freedom from such social evils as unemployment, disease, and squalor. To protect this latter freedom would obviously necessitate some form of state intervention, which in turn would be unacceptable to conservatives (Mullaly, 1997).

Individualism is a key value of liberals. It is suggested that all government action should have its goal the maximization of an individual's pursuit of self-interest. The purpose of government intervention is to maximize individual welfare. It attempts to remove obstacles to self-sufficiency. Liberals measure the total well-being

of society by simply summing up the well-being of all individuals in that society (Mullaly, 1997).

Liberals believe that social and economic mobility is possible because of equal opportunity. In other words, some people in society may be suffering, but if they work hard and take advantage of the opportunities available to them, they can get out of their present situation and move to a higher class. Liberals accept inequality of circumstances because of their profound belief in equal opportunity. No one has any more freedoms or liberties than anyone else. Everyone has access to education, the job market, health care, social services, housing, and so on. If a person fails in society, it is because he or she did not take advantage of available opportunities.

In sum, liberals think that inequalities should and could be reduced based on humanistic and/or pragmatic grounds. Humanistically, liberals are aware of the ugliness of poverty and would seek to eliminate it, which is a different concern from the search for equality. Pragmatically, a wider distribution of income will increase aggregate demand, thus lessening unemployment, and reduce social tension (George & Wilding, 1985).

Liberals do not place the blame for social problems squarely on the shoulders of the individual or his/her

family. Liberals accept the failure of the market to meet basic needs, the inability of the contemporary family to meet needs it supposedly met in the past, and the fact that economic growth will not, on its own, abolish poverty (George & Wilding, 1976). According to George and Wilding (1976), liberals have four major criticisms of capitalism. First, capitalism is not self-regulating. Second, capitalism is wasteful, inefficient, and misallocates resources. Third, capitalism will not by itself eliminate poverty and injustice. Finally, capitalism leads to the interest of the economically dominant groups being identified as the national interest. In spite of these significant criticisms of capitalism, liberals do not believe that it should be abolished. Because liberals do not seek to change the given economic system, most of their interventions into the economy will be symptom-focused and ameliorative rather than structural.

The imperfections of capitalism cause problems for some people. This perception stands in ranked contrast to the conservative belief that the individual causes problems for him or herself. In other words, whereas conservatives attribute social problems to weakness, deviance, or heredity, liberals attribute such problems to social disorganization inherent in an urbanized and industrialized

capitalist society (Mullaly, 1997). According to Mullaly, social disorganization may stem from the numerous independent social systems that comprise society which are not perfect and may not adequately provide the resources needed for healthy functioning.

Rubington and Weinberg (1989) suggest that this social disorganization produces stress and personal disorganization such as mental illness, alcoholism, family breakdown, crime, spousal and child abuse, even community disintegration. Because social problems are caused by some systems being out of tune with one another, the solution to the problem is to fine-tune these systems and restore equilibrium. This may involve personal and/or system change, but in all cases such changes are accommodative to the status quo (Carniol, 1984).

To prevent or reduce social problems, liberals believe that government programs could compensate for the chronic and acute ills of an industrial liberal society and ameliorate the resultant suffering. Thus, government is to be reactive when dealing with conditions defined as problematic, such as poverty, homeless, or ill health.

Although liberals focus more on society as the source of social problems, the personal deficiency view is not dropped completely. Society is viewed as a complex whole consisting of individuals interacting within numerous

interdependent social systems such as family, the workplace, and school. Liberals believe that these structures have legitimate functions that contribute to the healthy functioning of society because they are expected to integrate the individual into the larger society (Carniol, 1984). As a result, liberals believe that social problems occur mainly because of social disorganization including instrumental or technical flaws in the capitalist system that cause personal or family disorganization for some people.

With regard to homelessness, liberals understand that the risk factors causing homelessness are mainly drawn from poverty, lack of low-income housing or social welfare programs. They see that inequality and discrimination such as racial exclusion and inner city isolation are based on social disorganization. They also stress that personal or family factors such as mental illness, substance abuse, or family breakdown deepen their inferior living conditions more severely and increase the number of homeless people. In turn, mental disorders, substance abuse problems, and deficiencies in a family support network are viewed as either the direct consequence of homelessness itself or merely additional and unrelated burdens that some poor

people must carry into a competitive market place (Blasi, 1994).

In brief, liberals suggest that the lack of a social safety net including health, meals, income support, and housing is a primary factor in becoming homeless. Therefore, most liberals agree that the most important factor in the increase in the number of homeless during the 1980s was due to cutbacks in social programs proposed by the Reagan Administration.

3) The Radical Perspectives

Radicalism is a complex word. It includes collectivism, communism, socialism, social democracy, and feminism. Generally, radicals identify society with the whole community. Thus, the social will could imply the popular or general will. To radicals, social ownership is ownership by the people. Socialized property is owned by the whole. Social welfare programs would be available for all the people. Social participation in government is popular participation (Vincent, 1992).

Radicals have an optimistic developmental view of human beings. They believe that all humans are capable of self-development regardless of country, class, sex, or race,

and they are cooperative creatures. For radicals, cooperation and community are superior values to individualism and egoism. Individualism denotes isolation and competition. Radicals adhere to the two central social values: equality and solidarity or collectivism. Marxists equate liberty with equality of economic circumstances or human emancipation that can only be achieved under socialism. Radicals try to achieve economic equality such as income equality, political equality such as suffrage for all citizens, and social equality such as equal rights in health, education, or social welfare (Vincent, 1992). Solidarity is antithetical to individualism. Radicals agree that people should be treated fairly. However, radicals view capitalism as undermining social fairness in at least one fundamental respect. The owners of capital goods have a kind of power and control which is denied the rest of us (Gorden, 1988)

The radical proposes that current social and economic problems have their roots in the fundamental structures of the capitalist economic system (Gorden, 1988). Radicals believe that capitalism creates the tensions and conflicts, which became the crucial target for radical criticism. And capitalism is seen as the source of all injustice and inequality. With the rise of capitalism, Marx and his

followers saw on increasing degradation of industrial workers who had no control over their work process or product and who had to live in squalor, insecurity, and poverty. Workers' lives were reduced to a subsistence level, and the capitalists became enormously wealthy and their lives greatly enriched materially and politically (Djao, 1983).

For radicals, capitalism generally has been linked with poverty, unemployment, homelessness, and social distress since the mid-nineteenth century. Further, capitalism is seen both to generate and to exacerbate inequalities, creating deep social tension or conflict. Whereas public goods and the satisfaction of genuine human needs are neglected, private consumption and want satisfaction are encouraged under a capitalist society.

Consequently, capitalism undermines fellowship, solidarity, and cooperation. The patterns of distribution in capitalist societies are uncontrolled and arbitrary. Profit is always prioritized over the creative production of goods. Capitalism therefore destroys the enjoyment and aesthetic pleasure of production. It ignores the costs to people, unless they can be measured as tangible profits or losses. People themselves are viewed as commodities, which can be bought or sold (Vincent, 1992).

Marx's attitude toward this system was one of total rejection rather than of reform (Mishra, 1981). In a Marxist society, production would be governed by social criteria and the distribution of the fruits of labor, produced through co-operation, would be distributed according to the needs of people. Thus, a welfare society in the radical sense is one where the well-being of people is of primary consideration and where the mode of production is set up to meet human need rather than to make profit (Mishra, 1981). For Marx, the central feature of any society is its mode of production. The capitalist mode of production consists of the following structural (inherent) elements through which wealth, poverty, and inequality are generated and reproduced: private ownership of the means of production; production for profit; private property and inheritance; and the distribution of income and resources through the market mechanism (Mishra, 1981).

Radicals believe that the dominance of the market as a distributive mechanism of income and life chances denies human need and social solidarity altogether. Coercion and competition rather than cooperation and solidarity are the bases of a capitalist society. If welfare were to be institutionalized as a central value, private ownership of the means of production would have to transfer to public

ownership (Mullaly, 1997). The major economic beliefs of radicals are public ownership of the means of production, distribution of resources according to need, individual democracy, and a planned economy. Most radicals do not believe that the means of production can be controlled by regulation in a capitalist society. Private ownership creates two main classes: the capitalist class and the working class. They are based on an antagonistic relationship because their basic interests conflict with each other. The class conflict and exploitation, then, are the natural and inevitable results or inherent parts of capitalism and can only be abolished through the public ownership of the means of production (George & Wilding, 1994). The means of attaining public ownership advocated by the radical is nationalization.

The central political beliefs of the radical are government planning, a participatory democracy, a parliamentary system of government, and the view that capitalism can be transformed by class conflict. A belief in parliamentary democracy by most contemporary radicals is unmistakable, as evidenced by its acceptance in Western Europe's Communist parties (Mullaly, 1997).

Radicals believe that any significant social change can come about through the vehicle of class conflict. Some

radicals are united in their belief that class conflict will sooner or later lead to the downfall of capitalism. This change may come peacefully or violently. Unlike social democrats, who believe that the welfare state can be used as a vehicle for socialist change, radicals view the welfare state as an institution supporting capitalism. Some of them would focus their efforts on labor as the vehicle for socialist change (Mullaly, 1997)

Radicals believe that the term "social problem" mystifies structural issues of inequality, oppression, and alienation by turning them into individualistic issues of deviance, inadequacy, or pathology. Mullaly (1997) says that by focusing on the victims of inequality, oppression, and alienation and calling them criminals, drug addicts, or poor people, we are actually labeling them as troublemakers. The radical would trace these problems back, not to the individual, but to the social relationships determined by capitalism.

In sum, radicals agree that social problems are caused by the capitalist system. However, most radicals do not agree as to the way to resolve social problems. For some Marxists, social problems cannot be abolished by social policy in a capitalist society but only the abolition of capitalism (Mullaly, 1997). For social democrats, social

problems are resolved by a reorganization of the society that caused the problems in the first place. For them, welfare systems can form the basis and means for social or individual needs based on economic, political, and social equality. Therefore, social democrats argue that social welfare policy or programs should further justice and prevent problems rather than deal only with situations of injustice and the treatment of problems, also promote equality of opportunity, reduce all inequalities not just eliminate poverty, and promote greater control of social services by lay people rather than administrators and experts (George and Wilding, 1985). According to radicals, social services should be distributed according to need; they should be universal, comprehensive, adequate, and free. Prevention is a primary social welfare principle and there should be participation on the part of lay people in determining policy.

However, some radicals see that, although in capitalist society social services provide minimal help to some people, its main function is to support and strengthen the liberal-capitalist system. According to Galper (1975), most social service programs support and nurture capitalism. Social welfare programs support the labor market by making people's eligibility for assistance dependent on their past

experience and present relationship to the job market. Even social service programs such as day care depend on the needs of the dominant class for cheap labor, as day care spaces tend to increase during periods of low unemployment and are cut back during recessions. Eligibility for many welfare programs also depends on conforming to society's prevailing values. For example, public assistance regulations are often used to control the behavior of recipients in such areas as parenting, sexual conduct, and market purchases. Mullaly (1997) says the fact that social welfare programs are often underfunded and provide minimal assistance gives the message to those who depend on such programs that people who cannot make it in the private market really cannot count on a public support system for much help. In brief, the radical perspective sees the free market economy as meeting the interests of the capitalist class by ensuring the subservient position of the working class.

In terms of homelessness, radicals view it as an inevitable consequence of persistent poverty in a capitalist society. Radicals explain the risk factor causing homelessness in a structural and economic context. Most radicals believe that homelessness is rooted basically in the process of capital accumulation and the reduction of

real wages according to the development of capital accumulation.

Capitalists invest their capital to make more profit and workers sell their labor for their livelihood for cheap wages because of labor fluidity. The activation of capital accumulation with the ownership of the means of production thus brings about the devastation and deterioration of the living conditions of the working class and spreads poverty to the working class. As a result, the level of wages not only affects the level of profitability but also takes no account of the individual worker's family needs. It is therefore inevitable that many working-class people will have incomes insufficient to meet their basic family needs, including meals, clothing, and housing expenses. Thus, they may lose their housing because they cannot pay increasing rents with their incomes and finally become homeless in a capitalist society.

Therefore, according to the radical perspective, homelessness is understood as a structural problem in a capitalist society. Like poverty, homelessness is also the inescapable outcome of the ownership of the means of production.

Radicals also view the development of shelters for the homeless as a byproduct of the capital accumulation

functions. According to them, accumulation functions in the area of housing might include the development of affordable housing and well-maintained low-income housing which positively affects the health of workers which in turn increases their productivity. James O'Connor (1973) and Ian Gough (1979) indicate that these processes are the basic functions of legitimation and accumulation of the welfare state. Furthermore, some radicals see that subsidized housing programs like section 8, SROs, emergency shelters, or other federal legislations in the area of housing are used to maintain the healthy working and living conditions of the workers for capital, and also support the accumulation process through subsidies to private developers. As a result, shelters aid the accumulation process by addressing the basic survival needs of some of the homeless and thus preserving a segment of this potential group of laborers (Fabricant, 1987).

Some radicals, especially social democrats, would ascribe the rise of homelessness to the failure of capitalist housing production and the distribution structure, in addition to the process of capital accumulation. Basically, the capitalist housing market system serves the class interests of those in power. In the capitalist markets, housing is a financial investment or

production to make profit. Thus, expensive new housing is constructed for the affluent, and older housing is supposed to become available to the less affluent as it sharply drops in price when the increasing supply of new housing lessens its desirability (Smith, 1975; Grigsby, 1973). Therefore, poorer people take a lower quality of housing; this means that poor people get their housing as hand-me-downs from richer people.

As a result, the older housing units exist so long as their owners can make a profit on the units. The owners attempt to cram the poor in these units and charge the highest possible rents in order to increase their profits. If the owners no longer can make a profit on some housing, then they abandon it or renovate it for making more profits. When a condition of excess housing supply exists simultaneously with a shortage of low cost housing, conditions of housing market disequilibrium occur. Thus, it is the shortage of low-income housing due to the reliance on the free market in housing that has occasioned homelessness (Lang, 1989). In this view, homelessness is proof of the failure of many postindustrial societies to adequately protect their citizens from the cruelties of market capitalism.

4. Policy implications for the homeless

Critically, depending on ideological perspective, homeless policy will vary. Conservatives, for example, focus on the temporal treatment programs for the homeless. They view the emergency shelter as the most valuable program for the homeless persons regardless will of the homeless. Basically, they do not want to pay much on the homeless problem. In order to isolate the homeless from society, conservatives use the emergency shelter.

Emergency shelters originally planned for victims of the natural disasters such as earthquakes and hurricanes. Therefore, the purpose of the shelter is only temporary. Most emergency shelters allow the homeless to stay for a night and work on a first come, first served basis.

Radicals argue that with temporal and emergency shelters, conservatives try to lessen the attention given to more widespread transformations and increasing inequalities in the American economy (Phillips, 1990). Thus, they believe that the oversimplification of homelessness, that is, the detachment policy of homelessness from the problems of poverty and growing inequality is the main focus for the conservatives. Furthermore, radicals argue that emergency shelters themselves promote homelessness (Jencks, 1994) and

shelter systems create a shelter industry that feeds on itself rather than alleviating homeless problems (Blair, Jacobs, and Quiram, 1999).

According to the U.S. Conference of Mayors (1998), requests for shelter increased an average of 15 percent from 1997 to 1998 in thirty major cities. One of the major reasons explaining the growing number of emergency shelters is the reduction or shrink of public housing units including section 8 housing and single room occupancy (SRO) units. Because of a shortage of public housing units, applicants for housing waited an average of 24 months before receiving assistance. Table 1 shows that forty percent of cities have stopped accepting applicants for at least one assisted housing program due to the excessive length of the waiting lists. As a result, the waiting time for the public housing units forces homeless persons or families to enter emergency shelters. That is, for those without a place to call home, emergency shelters are the first place to turn for help.

Liberals believe that the government spends too little on the homeless problem. They believe that an increase in the number of homeless population is due to cutbacks in social welfare benefits for the poor by the Reagan Administration. They focus on legitimization of the homeless problem.

Table 1: Data on housing in twenty-five cities

City	Public housing wait (months)	Section 8 certificates wait (months)	Section 8 vouchers wait (months)	Stopped Accepting Applicants	Percent of Need Met
Boston	6	6	6	Yes	67
Burlington	12	0	12	No	23
Charleston	12	18	24	Yes	0
Charlotte	0	0	0	No	0
Chicago	0	0	0	Yes	32
Denver	36	24	24	No	25
Detroit	42	48	48	No	45
Los Angeles	36	0	84	No	5
Louisville	1	3	42	No	33
Miami	5	60	60	No	25
Minneapolis	24	24	24	Yes	25
Nashville	3	24	24	No	38
New Orleans	3	3	0	Yes	0
Norfolk	8	0	48	Yes	0
Philadelphia	0	18	0	No	24
Phoenix	12	48	48	No	18
Portland	12	0	12	Yes	0
Providence	12	18	18	No	65
Salt Lake City	24	28	0	No	5.2
San Antonio	4	0	30	Yes	10
San Diego	60	60	0	No	50
Seattle	8	24	24	No	5
St. Louis	4	10	10	No	0
St. Paul	36	18	18	Yes	50
Trenton	24	12	12	Yes	0

Source: *A status report on hunger and homelessness in American cities: 2000*, U.S. Conference of Mayors, Washington DC, 2000.

The Stewart B. McKinney Homeless Act enacted in 1987 represents the first comprehensive federal initiative to provide urgently needed assistance to protect and improve the lives and safety of the homeless. The act addresses the needs of homeless persons in the areas of emergency food and shelter, health and mental health care, substance abuse treatment, housing, educational programs, job training, and

other community services (McCarty, et al., 1991). However, under the McKinney Act, implementation of several programs contained in the National Affordable Housing Act enacted in 1990 is timid because increasing federal spending on the welfare and higher taxes are the primary concerns for the liberals in reality.

Radicals criticize the Stewart B. McKinney Homeless Act. First of all, they think the Act does not address the economic and social welfare policy roots of the homelessness crisis. Secondly, it does not replace severe budget cuts in social programs, nor does it not include mandated programs. Thirdly, the McKinney programs are mostly targeted toward emergency needs rather than long-term solutions. Lastly, the programs seriously underestimate the real resource costs of solving the crisis in an efficient and humane way (Wolch and Akita, 1989).

However, as the only one federal legislative response to homelessness, the Stewart B. McKinney Homeless Assistance Act (PL 100-77) has tried to focus government help and to develop some solutions for homelessness. The act established 15 new federal funding programs. Over the years, some of the original McKinney programs have been consolidated or eliminated, and some new programs have been added.

In addition to changes made through legislative amendments, some substantial changes to the McKinney Act have been made through cuts in funding and some programs have their funding eliminated completely. A total of fiscal year 1996 funding was declined about 25 percent (\$1,095 billion) from 1995 funding (\$1,446 billion). The Act still fosters primarily emergency relief instead of long-term solutions, which are adequate long-term residences for the homeless while they locate jobs, housing, foods, and social, health, and mental services. For example, in terms of housing services, the Act has focused on the emergency shelter than transitional or permanent housing units (Blair, Jacobs, and Quiram, 1999).

Fifty federal programs administered by eight federal agencies can provide services for homeless people. Of the 50 programs, 16 are targeted (reserved for the homeless) and 34 are nontargeted (available to low-income people). Table 2 shows 16 targeted programs and fiscal years funding.

Radicals believe that the government housing policy is failed because the housing market in the U.S. reflects the ground of the rolling class who makes profits through the market. Therefore, the policy initiative of radicals focuses on the affordable housing units for the homeless to reduce homelessness in the United States.

Table 2: Sixteen homeless programs and FY95-98 funding

Program name	Agency	1995	1998
Homeless children nutrition program	Agriculture	\$1.7*	\$1.9
Education for homeless children and youth	Education	28.8	28.8
Emergency food and shelter program	FEMA	130.0	100.0
Health care for the homeless	HHS	65.4	71.3
Projects for assistance in transition from homelessness (PATH)	HHS	29.5	23.0
Runaway and homeless youth-Basic center	HHS	40.5	43.6
Runaway and homeless youth-Street outreach	HHS	X	15.0
Runaway and homeless youth-Transitional living	HHS	13.6	14.9
Emergency shelter grants	HUD	155.0	165.0
Section 8 single-room occupancy moderate rehabilitation	HUD	X	23.5
Shelter plus care	HUD	162.0	116.9
Supportive housing program	HUD	602.0	574.2
Homeless veterans reintegration project	Labor	X	3.0
Domiciliary care for homeless veterans	Veterans Affairs	38.9	38.5
Homeless chronically mentally ill veterans	Veterans Affairs	32.3	36.4
Homeless providers grant and per diem program	Veterans Affairs	6.3	5.9

*:Dollars in millions

Source: U.S. General Accounting Office. 1999. *Homelessness-Coordination and evaluation of programs are essential*. U.S. General Accounting Office: Washington, DC.

They concern that the numbers of affordable low income housing units shrink dramatically. During the 1970s and 1980s, the supply of low rent units declined while the number of low-income renters rose dramatically (Daly, 1996). The number of affordable housing units is insufficient to meet needs. HUD (2000) reported that 5.4 million unassisted, very low-income renter households had "worst-case needs" for housing assistance in 1997. They pay over half their income for housing or live in severely inadequate housing and their incomes are below 50 percent of area median income.

Poor homeowners, half of them elderly, also confront housing problems. Foreclosures and evictions of homeowners in 1980s reached the highest level since the Depression (Leonard and Lazere, 1992; Dolbeare and Kaufman, 1995). The loss of housing resulting from gentrification, including the demolition or conversion of 5 million rooming housed and single room occupancy (SRO) units, often took place with the occurrence of local government. For example, New York City lost 109,000 SRO units from 1971 to 1987. Half of stock in Los Angeles and Seattle disappeared between 1970 and 1985. In 1970s and 1980s median rents increased at twice the rate

of median incomes. As a result, people were forced to double up.

During the 1980s, only one-quarter of the nation's low-income renters benefited from federal housing programs. Production of low rent or subsidized housing units virtually ceased after 1982. Government rental assistance declined relative to need. In 1974, 2.2 million renter households with income under \$ 5,000 received no rental assistance. By 1987, this group of eligible but non-subsidized households had grown to 3.2 million and 5.4 million by 1997. As the poor faced higher rents and lower incomes, they also confronted reduced federal benefits, tighter income eligibility limits, and more stringent offsets for earnings (Daly, 1996). By 1985, four fifths of poor renter households paid more than 35 percent of their income for rent and for more than half of these households rental payments accounted for over 60 percent of their income (Apgar, 1989). The 4.4 million poor renters spent at least half their income on housing in 1995 and 5.4 million in 1997 (HUD, 2000 and Daskal, 1998).

These trends have exacerbated inequalities and contributed to homelessness since the 1980s. Even if a person works full time, year round, it is not possible, at minimum wage levels, to secure affordable housing unless

there are two or more wage earners per household. Despite the growing labor force participation by women, median household income (in 1993 dollars) declined from \$ 32,182 in 1973 to \$ 31,241 in 1993. According to the U.S. Bureau of Labor Statistics, real average hourly earnings for American workers (in constant 1982 dollars) declined from a peak of \$ 8.40 in 1978 to \$ 7.41 in 1994 (Daly, 1996).

In brief, radicals, liberals, and conservatives have different views to protect or prevent homelessness. Homelessness is influenced by a complex array and demand factors affecting the nature, location, and affordability of rental housing. Focusing only on short-term or temporal solutions does not address the cause of homelessness, but instead merely ameliorates its symptoms. Therefore, increasing access to affordable housing units, ensuring economic security through an adequate minimum wage and improved job training and employment, providing necessary services, including physical and mental health care and education for homeless children, and ensuring the rights of people who become homeless are all interrelated to prevent homelessness (Foscarinis, 1996).

5. Controversial Issues on the Homeless Studies

1) Research Methodology Analysis

Generalization of homeless studies is often criticized because of the limitations of their research methodology. Since the 1970s, the homeless studies have been conducted by many researchers and investigators to find the reasons why people become homeless, how many homeless people are on the streets, and the characteristics of homeless people. The research methodologies of most studies were cross sectional and epidemiological. Few of them used ethnographic and longitudinal research methodology.

Epidemiological research methodology only focuses on individual differences among homeless people. Therefore, with this research methodology, we may understand who is likely to become homeless among people at different levels. But we could not know why they become homeless and also could not understand the relationship between the individual differences and the socioeconomic context of homelessness. On the other hand, ethnographic research methodology studies a culture from the homeless people's point of view, so that it provides a very detailed description of individually different paths to homelessness.

The homeless studies are almost cross sectional. Cross sectional research methodology studies homeless persons at a single point in time. This single-point-in-time approach however is limited in terms of knowing the lengths of homeless periods and the proportion of homeless people who have a long stay because some homeless people more quickly get out of the homelessness status. On the other hand, longitudinal research methodology focuses on homeless individuals from the time of their entry into homelessness until the time they move out of homelessness. Therefore, under the changing socioeconomic context over the decades, the longitudinal approach has potential in examining the influence of the historical context-- how the broad scale of social and economic factors at the macro level affect people's becoming homeless.

In brief, during the past decades, most of the homeless studies focused on the number, the cause, and the characteristics of the homeless population at a single point in time. Therefore, inevitably, the research methodologies they used were cross sectional and epidemiological. If we understand that homelessness is not a characteristic of people, we should focus more broadly on the condition in a socioeconomic and historical context that influences the consequences of homelessness. We also need to examine the

risk factors causing homelessness at different levels such as the individual, social, and economic in order to understand the dynamic relationships among the variables.

The homeless studies' generalization is also limited by researchers' focus on users of one shelter, their lack of standardized scales in estimating the prevalence rates of mental illness or substance abuse, and the sampling problems and the definitions of homelessness, mental illness, or substance abuse. Thus, uncertain generalization and operationalization directly impact on the variations of homeless studies. The homeless studies provide different estimates of the numbers of the homeless and of the prevalence rates of alcohol, drug, and mental disorders in the homeless population. Reported rates for mental health problems range from 2 percent to 90 percent, rates for alcohol problems from 4 percent to 86 percent, and rates for drug abuse from 1 percent to 70 percent (Fischer, 1989). Also, the number of the homeless population ranges from 250,000 to 3 million.

The differing research results between social scientists and psychiatrists in understanding the cause of homelessness are basically rooted in their theoretical or ideological perspectives. However, in order to figure out these differences, it is not enough to understand the

differences within theoretical or ideological backgrounds. More specifically, we need to look at the reasons in terms of research skills or measurements they used, sampling methods or sample size they chose, the research place they studied, and the homeless population that participated in the studies.

2) Differences in the Number of Homeless Population

Generally, conservatives try to minimize the number of homeless as they take a point in-time count. In this methodology, they estimate the number ranges from 250,000 to 300,000. They usually count the shelter users. In contrast, radicals are likely to take the number of homeless on an annual time base. Also, they try to count doubled-up homeless families, including the sheltered and street homeless. According to them, the homeless population ranges from 2.5 to 3 million nationally. Liberals count both the shelter users and street homeless. They do not accept the doubled-up homeless and those at risk of homelessness. They estimate the number of homeless population at from 550,00 to 600,000.

As a result, the differences in the number of homeless stem from different theoretical and ideological positions

because most researchers have their own perspectives in collecting the sample size and the place they chosen to research. Therefore, these research methodologies chosen inevitably result in the wide range of numbers of homeless.

However, regardless of theoretical and ideological backgrounds, most researchers and politicians agree that today's homeless is a major social problem, and the homeless population is growing dramatically. And since 1980, homeless families have been rapidly growing. Some studies of homeless families find that the major reasons of families becoming homeless come from economic conditions such as the affordability gap and the lack of low-income housing units. And some studies identify the major reasons at changing family conditions such as family breakdown drawn from physical or sexual abuse and an increasing number of single householders, especially female headed families.

(1) Sample Size

In order to generalize the results of studies, the sample size is important. Depending on the sample size, it is possible that the results will be different. There is no guideline to the sample size of a homeless study. Ideally, it will be best if all homeless persons were included to the

study. However, in reality, the researchers determine the sample size according to their convenience. In a study, Bassuk and researchers (1984) interviewed 78 homeless adults, and Fischer et al. (1986) studied only 51 homeless adults in their research. However, Crystal et al. (1986) conducted their study with 8,061 homeless adults, and Cohen and Burt (1990) interviewed 1,704 homeless adults. Different sample sizes may cause variations in the study results.

(2) The Place Sample Chosen

The homeless are either visible or invisible. The homeless who are using the private or public shelters and soup kitchens are countable. However, the homeless who are doubling up with relatives or friends or living on the streets are sometimes invisible and very difficult to count. It is possible that depending on the place chosen for a sample, it will yield different results. Snow et al. (1986) and Rossi et al. (1986) conducted their studies of the homeless who are sheltered and on the street. In their studies, the rate of a history of prior hospitalization and psychiatric disorder is less than the average rate of the others. Snow et al. found only 10 percent of the total sample (911 homeless adults) had a history of

hospitalization, and only 15 percent of the sample met DSM III psychiatric criteria for psychiatric disorder. However, most of studies focus on the homeless persons who are using the shelters in a large city because of convenience for researchers or restrictions in reality.

3) Differences of Prevalence of Mental Illness

In order to arrive at the most accurately determined estimates of prevalence, studies should be compared while controlling for problem definition and method of assessment, similarity of sampling techniques and sites, and demographic composition of the sample (Fischer and Breakey, 1991).

However, most homeless studies have been largely descriptive and have been plagued by methodological problems. Bassuk (1984) mentions that differences in results can be attributed to the different theoretical biases of the various investigators, to the use of different standardized scales as the basis for psychiatric evaluation, and most of all to the difficulty of obtaining a representative sample of a constantly shifting population. In addition, Fischer, Shapiro, Breakey, Anthony, and Kramer (1986) point out that definitions of homeless populations, sample selection, diagnostic criteria, and screening methods have produced

wide variations in estimates of prevalence. Caton (1990) also mentions that widely varying techniques have been used to determine the extent of psychiatric disorders among the homeless. As a result, among even psychiatrists, there is no acceptable or agreed upon techniques or skills to evaluate mental illness among the homeless. As a result, the varying of results for prevalence of mental illness is inevitable.

The earliest studies in this area employed a general approach: a clinical assessment of the presence of a psychiatric problem. Studies employing this technique have reported that from 22 percent (Hoffman et al., 1982) to 36 percent (Crystal et al., 1982) of their subjects displayed psychiatric symptoms, but necessarily diagnosable as mental ill. Crystal and Goldstein (1984) determined the prevalence of mental illness using a clinician's assessment of current disorder and/or a history of prior hospitalization. They found that 22 percent of the men and 47 percent of the women had some psychiatric symptoms, which did not necessarily indicate a diagnosable mental illness. For example, some individuals may have symptoms such as depression or paranoia without having the full-blown syndromes of major depressive illness or schizophrenia. Hospital records have been used to determine whether subjects can be classified as suffering from a psychiatric disorder. Lipton et al. (1983) looked at

hospital record diagnoses of the 90 emergency room subjects they studied and found that all subjects were given a psychiatric diagnosis.

Shaffer and Caton (1984) and Crystal et al. (1986) used subjects' self-reports of psychiatric symptoms. In Crystal et al.'s study of over 8,000 homeless adults, nearly one-quarter reported that they had psychiatric symptoms. However, the presence of symptoms did not necessarily mean that they were suffering from a diagnosable mental illness. Symptom rating scales have also been used in surveys of the homeless to determine the psychiatric status of study subjects. Using the Brief Symptom Inventory and Periodic Evaluation Record, Morse and Calsyn (1986) found 46.9 percent of their subjects scored above the cutoff on a global indicator of pathology. Roth and Bean (1986) used the Psychiatric Status Schedule and found that 34 percent of subjects had psychiatric symptoms. Rossi et al (1986) and Struening (1986) used the Center for Epidemiologic Study Depression Scale (CES-D scale) to assess depression. Rossi et al also used the Psychiatric Epidemiology Research Interview scale to determine whether any subjects suffered from psychosis, finding 15 percent did indeed suffer from its symptoms.

Studies that have applied DSM-III (the third edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association) criteria to classify subjects relying on agency clinical records or psychiatric interview data, have produced widely varying findings (Caton, 1990). Arce et al. (1983), and Bassuk (1984, 1986) used DSM-III criteria for psychiatric disorders and found over 70 percent of the sheltered homeless mothers had a psychiatric disorder. However, Snow et al. (1986) found that only 15 percent of their 911 shelter and street subjects had psychiatric symptoms with the same DSM-III criteria. To evaluate the rate of diagnosable mental illness among the homeless, Farr et al. (1986) used Diagnostic Interview on a sample of sheltered homeless and found that 37 percent met DSM-III criteria.

The widely varying figures concerning the rate of mental illness among the homeless are from 15 percent to 91 percent (Bassuk, 1984). According to the measurements used by researchers, the results vary. Generally speaking, based on the studies, about one in four is suffering from mental illness among the homeless. However, we cannot say that all of mentally ill homeless persons meet the disability criteria. The mental illness must interfere with the person's ability to work, handle personal affairs, or

perform normal activities of daily living that make self-sufficiency possible. However, different standardized scales as the basis for psychiatric evaluation are not acceptable to all psychiatrists. In other words, there is no evaluation tool to generalize the results.

4) Differences in the Prevalence of Substance Abuse

Most structural functionalists agree that substance abuse is one of causes in becoming homeless, and it has a severe impact on the risk of homelessness. However, conflict theorists believe that substance abuse is a casual factor that deepens extreme poverty rather than the single cause of becoming homeless. The current studies show that the effects of substance abuse may increase the risks of homelessness.

Drug abuse

Data on current drug use and abuse among the homeless are difficult to interpret for several reasons. First, many studies report "substance abuse" without differentiating between alcohol and other drugs. Second, even when drug abuse is identified separately, studies often fail to differentiate among occasional use, regular use, and abuse, or among types of drugs (e.g., tranquilizers, sleeping or

stay-awake pills, diet pills, marijuana, and street drugs). Third, data collection methods make for large differences: self-reports, institutional records, and physiological evidence yield widely different rates of use and abuse. Fourth, very different frequencies of uses have been reported, from "ever used" to "used at least once a week" to "used daily." Studies that include more types of drugs tend to report higher rates of drug abuse. Higher rates are also reported when researchers have broader definitions of abuse (Burt, 1992).

Alcohol abuse

The substantial variation among the studies (prevalence rates of alcohol abuse and alcoholism range from 4 to 86 percent) reflects firstly the lack of any uniform definition of alcohol abuse and alcoholism. And different methods or skills to evaluate the alcohol abuse were used. Some researchers used self-reporting for chemical dependency, and some of them used clinician assessment. Also, reported rates were based on many different indicators including daily use, excessive use, drinking problems, binge drinking, use of detoxification service, psychiatric diagnosis of lifetime alcohol abuse and lastly, samples drawn from very different locations and populations. Some

researchers chose the sample only at shelters or on the street at a large city.

**5) Lack of Studies on the Relationships between Variables
(Risk factors and Homelessness)**

Considerable controversy has surrounded attempts to understand homelessness and its cause. Difficulties in defining homelessness and measuring psychopathology, as well as differing political or ideological orientations, have confounded many of the issues regarding the homeless (Caton, 1990). Depending on the political and ideological orientations of the researchers or investigators, the risk factor studies of becoming homeless are divided to two groups; one is a social scientists group based on conflict theory and another is a psychiatrists group including psychologists theoretically based on structural functionalism.

The social scientists group, based on conflict theory, looks for the risk factors causing homelessness in the socioeconomic context. They believe that homelessness cannot be understood only in terms of individual factors. They believe that the causes of homelessness stem from structural or societal factors such as economic conditions, lack of

low-cost housing units, poverty, and the reduction or loss of social benefits. They strongly believe that if there were no alcoholics, no drug addicts, no mentally ill, no deinstitutionalization movement on personal or social pathologies at all, there would still be a formidable homelessness problem.

The social scientists group suggests that substance abuse, mental illness, the lack of a family safety net, or the family breakdown is not a cause of homelessness but a casual factor forcing the poor into severe or extreme poverty, becoming homeless or expanding the duration of homelessness. They particularly emphasize that substance abuse or mental illness plays some causal role in increasing the risk of homelessness.

The social scientists group says that focusing on the afflicted individuals including their degree of mental illness, substance abuse, the lack of a family safety net, and other personal factors explaining the cause of homelessness, is the classic argument of blaming the victim. According to them, blaming the victim approach ignores the causes leading to homelessness including, poverty, unemployment, lack of affordable housing, the loss or reduction of social safety net, and so on. They believe that psychiatrists group studies on those afflicted to determine

how they differ from the rest of us, to define the differences as the cause of homelessness, and to set up humanitarian programs to correct those differences in homeless people.

As a result, the social scientists group believes that efforts to identify the individual factors of homeless persons have prevented researchers or policy analysts from studying and countering the growth of poverty, the erosion of welfare benefits, the destruction of low-income housing units, and other contributors to homelessness that are not characteristics of individual victims. In addition, Shinn and Weitzman (1990) point out that such efforts risk ignoring other aspects of homelessness, overlooking other aspects of homeless persons, and giving the government an excuse to avoid other solutions.

On the other hand, the psychiatrists group based on structural functionalism believes that structural or societal factors can help explain why homeless individuals or families exist, but conflict perspectives do not identify which individuals or families are most vulnerable to becoming homeless. Generally, the psychiatrists group points out high rates of mental illness or substance abuse among the homeless people and argue that conflict theorists normalize homeless people in order to elicit public sympathy

and advance a policy agenda that has far more to do with eliminating poverty among the housed individuals than with providing needed help to the homeless (Koegel, Burnam, and Baumohl, 1996). The psychiatrists group finds the causes of homelessness in individual factors or family disorganization based on structural functionalism. According to them, drug or alcohol abuse, mental illness, the lack of a family safety net, family violence including sexual or physical abuse in childhood or adulthood from partners or parents, and deinstitutionalization are the primary causes of becoming homeless.

However, the cause of homelessness cannot be correctly answered by only one risk factor because it is a complex and multifaceted problem. Therefore, a comprehensive homeless study on all risk factors is needed to identify the risk factors at multiple levels. Such a comprehensive study would recognize the relationship of homeless people to their physical, economic, and social surroundings. The study, focusing on dynamic relationships among the risk factors on homelessness or the relationships between the risk factors and homelessness, should function to understand the homeless people in their individual, social, and economic contexts. All risk factors are variables necessary in understanding the relationships between the factors and homelessness. It

is important to identify how the risk factors operate at various stages of homelessness and identify interrelationships among variables. Variables in the homeless study may influence one another. The relationships among variables are likely to lead from macro to micro levels or from micro to macro levels. For example, the loss of social wages in the level of socioeconomic contexts leads welfare people to loss their homes if they do not have a family safety net at the individual level because they cannot keep paying rents. Alcohol abuse at the individual level may lead poor people to the loss of pocket money or properties resulting in unreliable social relationships with their families and then the loss of their family safety net. If such persons do not have proper treatment programs to cure or prevent their problems at the socioeconomic context, they are likely to become homeless.

On the other hand, the study of dynamic relationships between variables including all possible explainers becoming homelessness may function to concrete the fact that one or any combination factors among the possible risk factors are more important to explain the paths to homelessness than the homeless study focuses on only one of individual or structural/societal risk factors. For example, if mental illness turns out to be a major risk factor through the

study of dynamic relationships among variables including other individual and structural/societal risk factors, it will be a much more concrete and understandable explainer to the cause or growth of homelessness.

In brief, a study, which figures out the dynamic relationships between any single and every possible combinations of factors on homelessness, would be important because it would show how individuals are affected by the risk factors at macro or micro levels of homelessness. However, most of the risk factor studies on homelessness (Burt, 1992; Bohanon, 1991; Elliott and Krivo, 1991; Tucker, 1990; Quigely, 1990; Belcher and DiBlasio, 1990) are inclined to focus on the relationships with only structural/societal risk factors on the rate of homeless, or pay attention only to personal factors in explaining the cause of homelessness (Kingree et al. 1999; Herman et al., 1997; Bassuk et al. 1997; Caton et al. 1994; Browne, 1993; Susser et al. 1991; Shinn, Knickman, and Weitzman, 1991; Bassuk and Rosenberg, 1988; Bassuk et al., 1984).

Especially, the risk factor studies of the psychiatrists group are limited because of the next two reasons. Firstly, they focused only on the specific subgroups of the homeless population. For example, Bassuk et al (1997) chose their research sample among only the

homeless mothers in the large city. Susser et al. (1991) conducted their risk factor study among only the patients who admitted to a state mental hospital.

Secondly, most homeless studies of the psychiatrists group do not focus on the dynamic relationships among risk factors, or on the effects of risk factors on homelessness. They mostly emphasized only one among individual risk factors causing homelessness. For example, Caton et al. (1994), and Susser et al. (1991) emphasized that mental illness is the main cause of homelessness in their research. They did not pay attention to the relationships between other variables. Herman et al. (1997) also focused on a risk factor. In their case, adverse childhood experiences were a risk factor causing adult homelessness. Therefore, they focused only on the adverse childhood experiences as one of the risk factors in becoming homeless. They did not explain the relationship between variables in this study as well.

On the other hand, with correlation or regression analysis, the social scientists group tried to show the significance of relationships among risk factors or effects of the risk factors on homelessness. However, most of them used indicators for only showing the relationship between structural or societal risk factors such as poverty rate, unemployment rate, and rental vacancy rate on homelessness.

Burt (1992) and Krivo & Elliott (1991) used data for personal risk factors such as total state mental hospital expenditures explaining the cause of homelessness. However, data, which they used for the personal risk factor, are crude because the data for independent variables were not drawn from the units of dependent variables of their studies. For example, Burt (1992) and Elliott & Krivo (1991) found the data for personal risk factors at state or county level, but the units of their studies were specific cities in the U.S.

IV. Research Design

1. Introduction

What is the most crucial or primary risk factor of homelessness? Is there any order among the factors to explain why people become homeless? How much does each risk factor affect people becoming homeless? What is the relationship between risk factors and homelessness? To answer these questions, studies on homelessness should focus more on the dynamic relationship between the risk factors and homelessness and try to answer which variables are shown to be statistically significant explainers of homelessness? Although there are many studies about the number, cause, or the personal characteristics of homeless people, there are surprisingly few studies focusing on both structural/societal and individual variables that explain homelessness.

This study is a quantitative assessment of the influence of risk factors on the rates of homelessness. The risk factors of homelessness are drawn from studies based on various theoretical and ideological perspectives. The analysis of correlations among these factors and homelessness will precede multiple regression analysis. The

objectives of this correlation analysis are to obtain values that indicate the relationships between risk factors and to determine if a relationship exists between risk factors. In order to describe the further nature of the relationships and to assess the degree of accuracy of prediction achieved by the regression equation, regression analysis will be used to assess the relative importance of the risk factors in their contribution to variation in the rates of homelessness.

It is hypothesized that poverty, lack of affordable housing, economic conditions, the low level of entitlement benefits, family violence, alcohol and drug abuse, and mental illness are the risk factors increasing homelessness. These predictors stem from different theoretical perspectives.

Some studies of homelessness focus on the structural or societal risk factors to explain the cause or increase of homelessness. Some studies view only individual factors including the family safety net to understand the dynamics of homelessness. However, current policy or programs for homeless persons or families are focusing on particularly psychological or individual issues of alcohol and drug abuse and mental health of homeless people, and underestimating the root causes of homelessness such as permanent poverty,

economic conditions, a low level of welfare benefits, or the lack of affordable housing units drawn from societal/structural backgrounds. That is, the variety of direct services for emergency care including emergency shelters, health services, and case management services focuses mainly on curing individual deficits.

Homelessness is a heterogeneous and multifaceted phenomenon in our society. There may be no one risk factor to explain the cause of homelessness. Thus, shelter based emergency services curing individual deficits mainly based on structural functionalism and conservative perspectives may not be good long-term solutions.

This study focuses on the relationships among all risk factors including individual and structural/societal factors and the rate of homelessness. Based on the findings of univariate, bivariate and multivariate statistical analyses of this study, I will try to answer which variables, the risk factors, are shown to be statistically significant explainers of homelessness. This study is using data on homelessness from 52 metropolitan areas and 51 states.

2. The Risk Factors Explaining the Cause of Homelessness

As we understand homelessness as a major social problem, we consider the theories affecting explanations of the incidence of homelessness. There are two major theories that have been used to explain homelessness: structural functionalism and conflict theory. Structural functionalism argues that individual factors are the cause of homelessness. However, conflict theory says that the risk factors causing homelessness stems from societal or structural factors.

Four societal/structural factors are mostly cited as the major causes of homelessness in the homeless studies: (1) poverty, (2) economic conditions, (3) the lack of affordable housing, and (4) the low level or reduction of welfare benefits or the number of welfare recipients whose benefits were reduced or discontinued.

The most often cited risk factors from homeless studies based on the functional perspective are mental illness, alcohol or drug abuse, the lack of a family safety net, and family violence including sexual or physical abuse from partners or parents.

Table 3: The risk factors causing homelessness

Societal/structural factors	Individual factors
Poverty	Alcohol abuse
Lack of affordable housing units	Drug abuse
Economic conditions	Mental illness
The low level of the entitlement benefits or the number of welfare recipients	The lack of a family safety net
	Family violence (sexual or physical abuse)

3. Data

To examine the effects of the risk factors on rates of homelessness, published data from 15 different data sources were used. The data sources were the Census Bureau (Poverty in the U.S., 1996 and 1999, Statistical abstract of the U.S., 1999, State and metropolitan area data book, 1998, Cities and counties, 1994, and 1990 Census of population and housing, 1990), National Low Income Housing Coalition (Out of reach, 1999 and 1998), Department of Housing and Urban Development (The state of the cities 2000), the Urban Institute (America's homeless II, 2000 and America's homeless, 1989), Interagency Council on the Homeless (Homelessness: programs and the people they serve, 1999), Department of Health and Human Services (Mental Health

Service System Reports, 1990, KEN Mental Health Services Database, 1990), and National Association of State Alcohol and Drug Abuse Directors (State Alcohol and Drug Abuse Profile, 1996).

4. Operationalizations of Variables (Dependent and Independent Variables)

Basically, there are three models which will be examined in this study of homelessness. The three models will be examined in so far as they account for prediction of variance in the rates of homelessness respectively. In model I, the relationships between structural/societal risk factors and homelessness will be examined. And in model II, only research on relationships between individual risk factors and homelessness will be conducted. Finally, in model III, I will examine the effects of all risk factors including structural/societal and individual factors on homelessness rates.

Model I

The dependent variable: Homeless rate in 52 metropolitan areas

A rate of homelessness is the dependent variable in this study. To obtain a rate of homelessness, one needs

first to know how many homeless people there are in a given jurisdiction. There are no available data to examine the size of the homeless population. According to the researchers who study the number of homeless people, the range of the homeless population varies from 250,000 to 3 million. There is no guideline to decide the size of the homeless population. Ideally, it is the best that all homeless persons are counted in the study. However, in reality, researchers determine the size of the homeless population with regard to their economic or personal conditions including different theoretical and ideological points of view.

Since we do not have an actual rate of homelessness, a proxy measure, the national total of contact emergency shelter beds is used as a rate of homelessness. Even with this, we do not know the exact number of national emergency shelter beds at this particular time because there are no available data. In 1987, however, the Urban Institute estimated the total number of shelter beds in 182 cities, but the data are too old to reveal current facilities for homeless persons. Also, the bed count may be too high if the shelter operates at less than 100 percent capacity most of time, or too low if the shelter operates at overflow capacity most of time (Burt, 1992).

For these reasons, the data of the national survey of homeless assistance providers and clients was used in this study to get the number of total contact emergency shelter beds for the study. The number of contact emergency shelter beds shows how many homeless people contact the shelters to get the expected service at any given day. The national total contact emergency shelter beds was one of the measures used in the national survey of homeless assistance providers and clients (NSHAPC) conducted by Interagency Council on the Homeless, which is a working group of the White House Domestic Policy Council. The new survey was designed and funded by 12 federal agencies in a collaborative venture under the auspices of the Interagency Council on the Homeless. The U.S. Bureau of the Census collected the data, and the Urban Institute analyzed it. The survey is based on a statistical (randomly selected) sample of 76 metropolitan and non-metropolitan areas, including small cities and rural areas. Data for the survey were collected between October 1995 and November 1996.

In order to get the total number of contact emergency shelter beds, telephone interviews with representatives of 6,307 service locations offering 11,983 homeless assistance programs in the 76 sampling areas were conducted in February 1996. At any given day in February 1996, total emergency

shelter beds contacted by actual users totaled 103,254 people in 76 sampling areas. For my study, the data from 28 sampling MSAs (Metropolitan Statistical Areas) and 24 SMSAs (Smaller Metropolitan Statistical Areas) are taken because, in 24 rural sampling areas, the data on the independent variables were not available from census data or any other sources.

To obtain a rate of homelessness, the number of contact emergency shelter beds in each of 52 sampling areas (28 MSAs and 24 SMSAs) at any given day in February 1996 is divided by the total population of 1996 in these areas.

However, like any other measures of homeless people, the number of contact emergency shelter beds also has flaws. First, the number of contact emergency shelter beds is not an exact number of homeless people at any given day in February 1996 because this survey excluded the hidden homeless such as homeless persons on the streets, in abandoned areas, or doubled-up with relatives or friends. Furthermore, some homeless people do not want to use shelters, thus, a count of the contact emergency shelter beds underestimates the true number of homeless people.

Second, this measure based on the contact emergency shelter beds count will be affected by the jurisdiction's response to homeless problem. For example, some cities have

been reluctant to open shelters, preferring to ignore local homeless people or send them elsewhere.

However, homeless rates based on contact emergency shelter beds still reflect the relative degree of homelessness city to city.

Independent variables: Societal/structural risk factors
(with the rates of homelessness in 52 metropolitan areas)

There are four major structural/societal risk factors, which are mostly cited in the studies of homelessness, for the independent variables causing homelessness: poverty, economic conditions such as unemployment, lack of affordable housing, and the low level or reduction of entitlement benefits or the number of welfare recipients whose benefits were reduced or discontinued.

The following measures are used to operationalize independent variables. Poverty is one of the most primary factors causing homelessness for the conflict theorists. So I assume that the increasing number of poor people is closely related to the increasing number of homeless people. Poverty is measured by percent of persons below the government poverty level in 1993. The data come from the U.S. Census Bureau.

For lack of affordable housing or rental units, three indicators are used: the rental vacancy rate, the rate of renter occupied housing units renting at \$300 or below, and Fair Market Rents (FMR) for one bedroom. These housing factors are measured in each sampling area. I would expect that higher rents would generate more homelessness, and more renters occupied housing units renting at \$300 or below would decrease the number of homeless people who are under marginal living conditions. FMR (Fair Market Rents) for one bedroom in 52 sampling areas is also used for the housing indicator. The increasing FMR may be a burden for the poor people. Therefore, I would assume that higher FMR results in higher homeless people in the sampling areas.

The data about the rate of renter occupied housing units renting at \$300 or below and FMR for one bedroom in each area come from national survey results conducted by National Low Income Housing Coalition (1999). National Low Income Housing Coalition publishes a report, *Out of Reach: The gap between housing and income of poor people in the United States*. *Out of Reach* contains income and rental housing cost data for the fifty states and District of Columbia by state, metropolitan area, and county or, in the case of New England, town. Almost every year since 1989, *Out of Reach* has been updated, using HUD' latest estimates of

area median incomes and fair market rents as the basis of the analysis.

The data of the rental vacancy rate in each area come from the U.S. Census Bureau (2000). The Bureau conducted housing vacancy survey, *Housing Vacancies and Homeownership: Annual Statistics, 2000*. This survey estimated rental vacancy rates by state and metropolitan areas.

For the indicators of economic conditions, we may consider the unemployment rate, the unskilled jobs, or the number of person who do not have a high school diploma in the respective sampling areas. Workers who are employed in the service sector do not need high skills for jobs. Therefore, I assume that their wages are lower than those of skilled jobs. Also, less educated persons are more likely to work in the service sector than persons who get a college degree. However, most researchers or investigators agree that the employment rate is more likely to be a cause of homelessness than the other factors in the area of economic conditions.

Therefore, the unemployment rate, which stems from Census data, is used for the indicator of economic conditions. I would assume that the higher unemployment rate, the higher homeless rate in the sampling areas.

The number of recipients and level of benefits of welfare programs could be the indicators showing the impact of government entitlement benefits on the rate of homelessness. Thus, The SSI recipient rate, SSI benefits for individuals, AFDC grants for single parent families of 3 with no earnings, and the dollar gap between fair market rents of one bedroom and TANF grants at each sampling area are used as the indicators showing the impact of government entitlement benefits on the rate of homelessness. Because of unavailability of the data on the number of AFDC recipients in 52 sampling areas, the AFDC recipient rate is not used as an indicator to examine the relationship with homelessness in model I. As an alternative, I will use the AFDC recipient rate in model III as an indicator.

SSI and AFDC are both cash assistance programs to prevent people to become homeless. SSI is the basic federal program providing cash assistance to low-income individuals who are elderly, blind, or disabled. In 1995, the federal SSI benefit level for a single individual who no income was \$458 if the person lived alone. TANF (AFDC, before 1997) is the only federal program to provide cash benefits for the family. The TANF program provides welfare payments for needy children who have been deprived of parental support or care because their father or mother is absent from the home

continuously, is incapacitated, is deceased, or is unemployed. In 1993, the beneficiaries of AFDC were 14.1 million, and the beneficiaries of TANF were 12.2 million in fiscal year 1997 (U.S. Administration for children and families, 1999).

As a major income source for welfare families or individuals without extra earnings, public benefit programs may help welfare beneficiaries avoid homelessness. However, the low level of cash benefits such as TANF and SSI inevitably impacts on the living conditions of the recipients. It will be inferred that the low level or reduction of benefits reduces some people to an inability to pay for their living costs, including rent for their housing. For example, the real dollar value of AFDC had declined by almost half since the mid-1970s, and, in 1995, no single state paid benefits high enough to allow those AFDC families to reach even 75 percent of the poverty level. The average of TANF grant for a mother with two children was \$378 in 1999, but the average of FMR for one bedroom is \$376 and the average of FMR for two bedroom was \$417 in the same year. After consuming their all TANF benefits for the rents, the TANF beneficiaries cannot handle their living expenses including food, health, education, and so on (National Low Income Housing Coalition, 1999).

Therefore, the low beneficial levels of both programs mean a high level of homelessness. And as a protective factor to prevent the poor or families to become homeless, the increasing number of SSI and AFDC recipients with a livable income level decreases homelessness. Also the increasing dollar gap between FMR for one bedroom and TANF grant is related to higher homelessness rate.

As a result, I expect that higher benefit levels and increasing number of beneficiaries of the programs decrease the number of homeless people. And higher dollar gap between FMR for one bedroom and TANF grant has higher homeless rate. These data come from the U.S. Census Bureau (Statistical abstract of the U.S., 1997 and State and Metropolitan Area Data Book 1997-1998, 1998) and National Low Income Housing Coalition (1999).

Table 4 shows the measures, which are used to operationalize variables.

Table 4: Operationalizations of variables

(Societal/structural indicators)

Variables	Operationalization	Direction of Hypothesized Effects on Homeless Rates
Rate of homelessness: Rate of homelessness in 52 metropolitan areas	The number of contact shelter beds, 1996 ----- X 100 Total population in 1996	
Lack of affordable housing: Low rent housing	Rental vacancy rate in 1996, (%)	-
	Fair Market Rent for one bedroom in sampling areas in 1999, (\$)	+
	Renter occupied housing units renting at \$300 or below, 1990, (%)	-
Poverty: Percent below poverty	Percent of persons below poverty level in 1993	+
Economic conditions: Unemployment rate	Percent of persons unemployed in 1996	+
Impact of government benefits:	The number of SSI recipients in each sampling areas divided by total population, 1995	-
SSI recipient rate (%)	SSI monthly benefits for the individual in 1997	-
SSI benefits (\$)		
AFDC benefits (\$)	AFDC average monthly payment for the single parent family of 3 with no earnings in 1996	-
The dollar gap between FMR and TANF	The dollar gap between FMR of one bed room and TANF grant in 1999	+

Model II

The dependent variable: Homeless rate at the state level

(Data aggregated by state for personal risk factors)

Unfortunately, data for all risk factors, including personal and societal/structural factors, are not drawn from the 52 sampling areas (28 MSAs and 24 SMSAs) in model I. If I could have formal data for all factors at 52 sampling areas, I could have used a rate of homelessness, which is calculated for 52 sampling areas. However, only data for societal/structural risk factors are matched up or found at this level. In 52 areas, I could not find available data for the personal risk factors of homelessness from the Census data or any other sources.

Therefore, for the accuracy of this study, another rate of homelessness, the dependent variable, is needed which is aggregated by state, not by Metropolitan Statistical Areas, to understand the relationship between individual risk factors and a rate of homelessness. The U.S. Bureau of the Census conducted a population census by counting people where they live in March 1990. In this survey, the bureau counted contact emergency shelter beds in each state. A total of 168,309 persons contacted emergency

shelter beds for homeless in a single night in March 1990. This is certainly not an exact number of homeless people in 1990 because this survey excluded the hidden homeless such as homeless persons on the streets, in abandoned areas, or doubled-up with relatives or friends. However, because the purpose of this study does not focus on the number of homeless, we use this counting. Furthermore, the most important reason to use this counting is that state level data not only for individual risk factors but also for structural/societal risk factors are available in each state.

Therefore, in model II, the number of contact emergency shelter beds in each state is used as the dependent variable. To acquire the rates of homelessness of each state, the total contact number of emergency shelter beds in each state is divided by total population in each state in 1990.

Independent variables: Individual risk factors at the state level (with the rate of homeless in 51 states)

The individual factors explaining the cause of homelessness theoretically stem from structural functionalism. Five personal factors are mostly cited as the

major risk factors of homelessness for functionalists: (1) mental illness, (2) alcohol abuse, (3) drug abuse, (4) the lack of a family safety net, and (5) family violence including sexual or physical abuse from partners or parents.

It was difficult to find the data for independent variables at the same unit as the dependent variables. For example, although Elliott and Krivo (1991) found a dependent variable at the city level, they used data for personal factors (independent variables) at the state level. Therefore, as they indicated, data for the individual factors were crude in their study.

Unlike the flexibility and availability of data for societal/structural factors, data for individual factors causing homelessness are limited. This is a difficulty in conducting this study too. However, fortunately, even though there is an unavailability of data for individual risk factors in 52 sampling cities in model I, I could find the data for the individual factors at each state level. The data for major societal/structural risk factors such as poverty, unemployment, housing unavailability, and the reduction of social benefits are also available at this level. Therefore, with these data, I could finally conduct the research in order to understand the relationships among the variables at the state level.

Herman, Galanter, and Lifshutz (1991) conducted empirical research to examine the relationship between psychiatric disorders/substance abuse problems and homelessness. It was hypothesized that homelessness is a major problem among the persons diagnosed with both substance abuse problems and psychiatric disorders. To examine this issue, the researchers used a questionnaire, which was administered to 100 consecutively admitted hospital patients who were suffering from both substance abuse problems and psychiatric disorders. In this study, they found that almost half of the patients (N=46) were homeless at the time of admission. As a result, their findings indicate that homelessness is a serious problem among patients with both substance abuse problems and psychiatric disorders.

According to the results of this study, there was a strong relationship between the number of hospital admissions with substance abuse problems or mental illness and homelessness. Furthermore, total state expenditures on mental hospitals or substance abuse programs might be possibly related to homelessness.

Therefore, as an independent variable to show the relationship between mental illness and homelessness, I use two available pieces of data. One is the rate of the

estimated yearly number of persons with serious mental illness, age 18 and older, by state in 1990. I expect that higher rates of serious mental illness persons are associated with higher homeless rates in each state. This data comes from U.S. Department of Health and Human Service. The U.S. Department of Health and Human Service provides Knowledge Exchange Network Mental Health Services Database (<http://iservices.cdmgroup.com/cmhsdata/databases>). Knowledge Exchange Network Mental Health Services Database (KEN) includes national statistics in the mental health field.

Another is the total expenditures by state and county mental hospitals in 1986. I assume that more total expenditures on mental hospitals is related to a decrease in homelessness. These data stem from U.S. Department of Health and Human Service. The U.S. Department of Health and Human Service (1986) reported *State and County Mental Health Hospitals United States and Each State, 1986*. This report presents detailed data on state and county mental hospitals including the total expenditures by state and county mental hospitals. According to this report, the total expenditures of 51 states were \$6,325,844,000 in 285 state mental hospitals in the U.S. in 1986.

As an independent variable to show the relationship of the substance abuse (alcohol and drug abuse) indicators and homelessness, the rate of substance abuse clients in each state will be a good examiner. However, because of unavailability of the data, I will use substance abuse treatment admission rate in each state stemming from National Association of State Alcohol and Drug Abuse Directors (NSADAD) and Substance Abuse of Mental Health Services Administration (SAMHSA). NASDAD (1999) presented a report, *State Resources and Services Related to Alcohol and Other Drug Problems: An analysis of State Alcohol and Drug Abuse Profiles for Fiscal Years 1996 and 1997*. This report is usually generated on an annual basis and contains information about and analysis of financial and client data for substance abuse treatment and prevention services submitted by each state. Each state, the District of Columbia, and Puerto Rico have a designated Alcohol and Other Drug (AOD) Agency responsible for the allocation and effective utilization of federal and state monies specifically targeted for alcohol and other drug treatment and prevention services.

I will also use the data come from Substance Abuse of Mental Health Services Administration (SAMHSA). SAMHSA (1998) reports *Treatment Episode Data Set (TEDS)*, which is

state data about substance abuse treatment between 1993 and 1998. TEDS aggregates data collected through the disparate data collection systems of the Single State Agencies for substance abuse treatment. The TEDS presents numbers of admissions to substance abuse treatment facilities and admission rates by state.

And I will also use per capita public spending on alcoholism clients in each state. This data comes from National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism. National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism (1992) measured changes in specialty alcoholism treatment spending 1979 and 1989 nationally and by state in their survey, *1990 National Drug and Alcoholism Treatment Unit Survey*. I assume that with more per capita spending on alcoholism clients there is a decrease in the homeless rate, and the increasing number of substance abuse treatment admissions is related to higher homeless rates in 51 states.

To examine the relationship between the family violence and homelessness, the number of abused women among homeless persons in each state will be a good indicator. However, because of the data unavailability, the number of shelters (shelter rates) for abused women is used. Women once remained in the home and suffered physical, sexual, or

verbal abuse but now may leave the abusive situation and enter shelters to be counted among the homeless.

Accordingly, the increasing number of sexually or physically abused women especially without any social or family supports may mean the increasing number of homeless persons and shelters for them because the shelter is only a place for abused women without any social or family supports.

Although the number of shelters for abused women, the indicator for the family violence, will be affected by local governments' response to the problem, the indicator reflects the relative degree of family violence state to state. So I use this indicator as an alternative to show the relationship between the family violence and homelessness in state levels.

As a result, the shelter rate for abused women in 1990 is an independent variable to show the relationship with homeless rate. I assume that higher shelter rate for abused women in each state means higher homeless rate. This data come from the U.S. Census Bureau.

Examining the lack of a family safety net of the individual is extremely difficult, since there is no such data to show this individual condition in each state level.

Table 5: Operationalizations of variables (Individual indicators)

Variables	Operationalization	Direction of Hypothesized Effects on Homeless Rates
Rate of homelessness: Rate of homelessness in 51 states	The number of contact shelter beds, 1990 ----- X 100 Total population each state in 1990	
Mental illness: The rate of estimated number of mental ill persons	Percent of estimated 12-month number of persons with serious mental illness, age 18 over, by state, 1990 divided by each state total population	+
State total expenditures to mental hospitals	Total expenditures by state and county mental hospitals (\$), 1986	-
Substance abuse: Alcohol and drug treatment admission rate	The rate of alcohol and drug treatment admission by state in 1991 (%)	+
Per capita public spending on alcoholism clients	Per capita public spending on alcoholism clients at specialty treatment units by state, (\$), 1991	-
Family violence: Shelter rate for abused women	The number of shelters for abused women in each state divided by total shelters for abused women, 1990 (%)	+

Therefore, even though the lack of a family safety net can be an indicator showing the cause of homelessness, I exclude this independent variable from this study.

Model III

The dependent variable: Homeless rate at the state level

The same dependent variable in model II is used. Thus, the rate of homelessness (dependent variable) comes from contact emergency shelter beds in each state, 1990. To acquire the rates of homelessness of each state, total contact number of emergency shelter beds in each state is divided by total population in each state in 1990.

Independent variables: Structural/societal and individual risk factors at the state level (with the rate of homeless in 51 states)

As indicators for independent variables in model I, the indicators for structural/societal factors in model III are drawn from four major structural/societal risk factors, which are mostly cited in the homeless studies: poverty, economic conditions such as unemployment, lack of affordable housing, and the low level or reduction of entitlement benefits.

Poverty is one of the most primary factors causing homelessness for the conflict theorists. So I assume that the increasing number of poor people is closely related to the increasing number of homeless people. Poverty is measured by percent of persons below the government poverty level in each state, 1990. I also use the number of female householder families without workers living below poverty level in each state, 1990 as an indicator to measure poverty. Since 1980, single-headed homeless families, especially headed by women, have become the fastest growing subgroup of homelessness. About 43 percent of families headed by women are living below poverty level in 1990 (The National Commission on Children, 1991). I, thus, expect that the increasing number of female householder families below poverty level is related to the high level of homelessness. The data come from the U.S. Census Bureau.

For lack of affordable housing or rental units, one indicator, renter occupied housing units renting at \$300 or below in 51 states, 1990, is used. I would expect that more renter occupied housing units renting at \$300 or below would decrease the number of homeless people who are under marginal living conditions. The data come from the U.S. Census Bureau (Housing Characteristics in American Fact Finder, <http://factfinder.census.gov.../>).

Unemployment rate, which stems from Census data, is used for the indicator of economic conditions. I would assume that the higher unemployment rate, the higher homeless rate in each state.

The number of recipients of SSI and AFDC are the indicators showing the impact of government entitlement benefits on the rate of homelessness in this model III. AFDC (now changed to TANF) and SSI are the only federal programs to provide cash benefits for the family or the individual. AFDC program provides welfare payments for needy children who have been deprived of parental support or care because their father or mother is absent from the home continuously, is incapacitated, is deceased, or is unemployed.

The cash benefits such as SSI and AFDC inevitably impacts on the living conditions of poor people. It will be assumed that the increasing number of recipients of SSI and AFDC means a low level of homelessness because welfare benefits basically function as a protective factor for people to prevent becoming poorer or homeless in the social safety net system. These data come from the U.S. Census Bureau (State and Metropolitan Area Data Book 1997-1998, 1998).

For individual risk factors, the same indicators used in model II are used. Table 6 shows the measures, which are used to operationalize variables.

Table 6: Operationalizations of independent variables in states (structural/societal and individual indicators in 51 states)

Variables	Operationalization	Direction of Hypothesized Effects on Homeless Rates
Rate of homelessness: Rate of homelessness in 51 states	The number of contact shelter beds, 1990 ----- X 100 Total population each state in 1990	
Mental illness: The rate of estimated number of mental ill persons of each state total population and	Percent of estimated 12-month number of persons with serious mental illness, age 18 over, by state, 1990 of each state total population	+
State total expenditures in mental hospitals	Total expenditures by state and county mental hospitals (\$), 1986	-
Substance abuse: Alcohol and drug treatment admission rate	The rate of alcohol and drug treatment admissions by state in 1991 (%)	+
Per capita public spending on alcoholism clients	Per capita public spending on alcoholism clients by state, (\$), 1991	-

Table 6. (Cont.)

Family violence: Shelter rate for abused women	Shelters for abused women in each state divided by total shelters for abused women, 1990 (%)	+
Poverty: Percent below poverty level	Percent of persons below poverty level in each state, 1990	+
Female householder families below poverty level	The number of female householder families without workers living below poverty level in each state, 1990	+
Economic conditions: Unemployment rate	Percent of persons unemployed in each state, 1990	+
Lack of affordable housing: Renter occupied housing units	Percent of renter occupied housing units renting at \$300 or below divided by total housing units in each state, 1990	-
The impact of government benefits: SSI recipient rate	The number of SSI recipients divided by total population in each state, 1990 (%)	-
AFDC recipient rate	The number of AFDC recipients divided by total population in each state, 1990 (%)	-

5. The unit of Analysis

In order to obtain a rate of homelessness, two units of analysis are used in each model. In the first model, 52 sampling areas are used because the Interagency Council on the Homeless (1999) collected the homeless data from these units. The 52 sampling areas include: the 28 largest

metropolitan statistical areas (MSAs) and 24 small and medium-sized metropolitan statistical areas selected at random to be representative of geographical regions in the United States.

In the second and third models, data is aggregated by the 51 states because the U.S. Bureau of Census conducted a survey for the homeless in 1990, and a rate of homelessness in each state is available in this data.

6. The Research Method

To conduct this study, it is hypothesized that societal/structural risk factors, including poverty, lack of affordable housing, economic conditions, the low level or reduction of welfare benefits; and personal risk factors, including mental illness, substance abuse, or family violence impact on homelessness. In order to investigate the relationships between pairs of variables, correlation analysis and single regression will be used. Second, multiple regression is used to estimate the effects of poverty, lack of affordable housing, economic conditions, the low level or reduction of entitlement benefits, mental illness, substance abuse, and family violence on the rates of homelessness. To examine any order among variables,

stepwise regression analysis is also used. Stepwise multiple regression analysis is used to determine which independent variables make meaningful contributions to the overall prediction (Mertler and Vannatta, 2001).

In brief, the objectives of this regression study are to determine if a relationship exists between variables; to describe the nature of the relationship; to assess the degree of accuracy of prediction achieved by the regression equation; and to assess the relative importance of the various predictor variables in their contribution to variation in the criterion variable.

Therefore, first, zero-order correlations are basically sought because the simplest way to examine the relationship between the risk factors and homeless rates is to look at their zero-order correlations, which show strength of association without accounting for the influence of any other predictor variables. A scatter diagram of a correlation of + or - 1.00 would consist of a perfect line of dots, which would correspond to the regression line. Perfect correlation rarely exists when looking for correlations between human characteristics. A range from + or - 0.9 to 1.0 is very high and shows a very strong relationship between variables, and a range from + or - 0.0 to 0.2 is very weak and shows a negligible relationship

between variables (Rowntree, 1981). Then, the study will proceed from correlation data to the implied causal models inherent in the regression analysis. So the analyses of the study will be conducted at the different levels, including univariate, bivariate, and multivariate statistics. This study does not mean to establish cause and effect relations, since regression analysis based on cross-sectional survey data has its limitation (Black, 1993).

7. The Findings: Model-I

1) Univariate Statistical Analysis

Table 7 presents descriptive statistics for variables in 52 metropolitan areas. Table 7 only includes the data on societal/structural risk factors and homeless rates. A total of nine indicators are used to estimate the relationships between variables in four major societal/structural risk factors and homelessness rates: unemployment rate, poverty rate, rental vacancy rate, the rate of renter occupied housing units renting at \$300 or below, SSI recipient rate, SSI benefit level for the individual, AFDC monthly payment per family of 3 with no earnings, FMR (Fair Market Rents) for one bedroom, and the dollar gap between FMR for one bedroom and TANF grant.

In Table 7, the mean of the homeless rate in 52 metropolitan sampling areas was found to be 0.1 percent (0.09923). Bar graph 1 shows the percent of homeless rate in 52 sampling areas on the vertical axis and homeless rate in each area on the horizontal axis.

Table 7: Data for nine structural/societal risk indicators and homeless rate in 52 metropolitan areas

52 sampling areas	Homeless rate in 1996 (%)	Unemployment rate in 1996 (%)	Poverty rate in 1993 (%)	SSI recipient rate in 1995 (%)	SSI benefits for the individual in 1997 (\$)
Atlanta	.065	3.8	13.4	1.70	484
Baltimore	.147	4.4	9.9	2.04	484
Boston	.179	4.2	10.6	4.26	610
Chicago	.069	5.0	13.7	2.38	484
Cleveland-Lorain-Elyria	.044	5.1	14.6	2.21	484
Dallas	.049	4.0	14.9	1.36	484
Denver	.230	3.9	10.6	1.40	546
Detroit	.114	4.5	15.7	2.36	498
Houston	.113	5.5	17.8	1.64	484
Kansas City	.098	4.1	12.4	1.36	484
Los Angeles-Long Beach	.078	7.3	19.9	3.70	640
Miami	.036	6.4	20.0	5.20	484
Minneapolis-St. Paul	.098	3.1	9.5	1.27	565
Nassau-Suffolk	.017	6.5	14.7	1.42	570
New York	.109	6.5	14.7	4.44	570
Newark	.065	6.5	14.7	2.08	515
Oakland	.092	4.6	10.2	3.15	640
Orange County	.022	7.3	19.9	1.84	640
Philadelphia	.140	5.7	13.2	2.35	511
Phoenix-Mesa	.130	3.7	16.5	1.38	484
Pittsburgh	.050	5.0	13.1	2.30	511
Riverside-San Bernardino	.058	7.3	19.9	2.71	640
St. Louis	.103	4.5	13.1	2.04	484
San Diego	.059	5.3	16.3	2.73	640
San Francisco	.107	4.6	10.2	3.93	640
Seattle-Bellevue-Everett	.104	5.4	10.3	1.50	512
Tampa-St. Petersburg-Clearwater	.178	3.9	14.8	2.00	384

Table 7. (Cont.)

Washington	.124	4.4	9.9	1.29	484
Bangor	.089	5.3	15.2	4.27	494
Bergen- Passaic	.037	6.5	14.7	1.58	515
Birmingham	.072	3.2	16.8	2.88	484
Boise City	.114	3.9	11.5	1.42	532
Bremerton	.031	5.4	10.3	1.29	512
Dover	.087	5.1	13.0	1.89	484
Enid	.133	3.4	16.2	2.28	537
Indianapolis	.097	3.2	11.8	1.52	484
Jackson, MI	.072	5.1	14.2	2.32	498
Kenosha	.062	5.0	13.7	1.97	568
Las Cruces	.886	10.2	30.0	2.62	484
Lincoln	.057	2.6	9.0	1.25	492
Melbourne- Titusville- Palm Bay	.027	5.4	11.6	1.48	484
Norfolk- Virginia Beach- Newport News	.134	4.8	14.1	1.93	484
Oklahoma	.181	3.4	16.1	1.69	537
Redding, CA	.091	9.9	15.9	4.70	640
Sacramento	.092	6.0	14.6	3.52	640
Salt Lake City-Ogden	.119	3.2	9.9	1.08	484
Savannah	.098	4.8	18.6	2.86	484
Shreveport- Bossier City	.066	7.2	22.9	3.92	484
Springfield	.079	4.5	13.2	3.57	610
Utica-Rome	.024	5.3	14.1	3.11	570
York	.028	4.3	8.2	1.33	511
Youngtown- Warren	.048	6.4	15.6	2.55	484
Mean	.09923	5.1269	14.3404	2.3667	530
Median	.09000	5.0000	14.1500	2.0600	505
Mode	.10	6.50	14.70	1.29	484
Standard Deviation	.1201	1.5476	3.9135	10409	58
Range	.88	7.60	21.80	4.12	156
Sum	5.16	266.60	745.70	123.07	27552

Table 7. (Cont.)

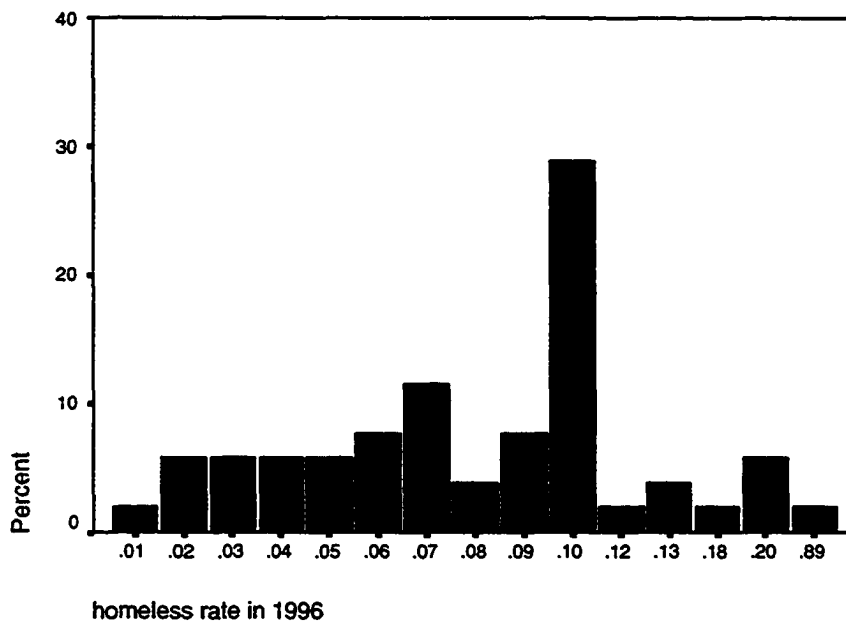
52 sampling areas	FMR (fair market rent) for one bedroom in 1999, (\$)	The dollar gap between FMR for one bedroom and TANF grant for family of 3, 1999, (\$)	The rate of renter occupied housing units renting at \$300 or below, 1990, (%)	AFDC average monthly payment per family, \$, 1996	Rental vacancy rate in 1996 (%)
Atlanta	590	310	13.94	246	10.5
Baltimore	515	116	11.84	321	7.1
Boston	723	158	11.63	528	5.9
Chicago	619	242	9.19	310	7.9
Cleveland-Lorain-Elyria	480	118	17.6	308	8.4
Dallas	560	372	6.09	162	8.9
Denver	499	143	12.49	304	5.2
Detroit	525	66	12.87	365	8.8
Houston	464	279	10.26	162	8.0
Kansas City	444	152	9.12	256	7.9
Los Angeles-Long Beach	592	-34	4.10	549	8.7
Miami	563	260	15.18	267	8.3
Minneapolis-St. Paul	521	-262	8.93	440	3.9
Nassau-Suffolk	906	329	1.02	565	5.1
New York	785	208	11.25	565	5.5
Newark	681	257	17.18	345	11.4
Oakland	686	60	6.67	549	6.8
Orange County	704	78	0.89	549	5.9
Philadelphia	584	181	6.45	360	10.0
Phoenix-Mesa	505	158	3.43	300	8.0
Pittsburgh	411	8	13.7	360	8.7
Riverside-San Bernardino	489	-137	3.49	549	8.6
St. Louis	386	94	16.68	256	5.9
San Diego	583	-43	2.62	549	6.0
San Francisco	923	297	6.17	549	3.1

Table 7. (Cont.)

Seattle-Bellevue-Everett	582	36	6.72	493	7.1
Tampa-St. Petersburg-Clearwater	472	169	7.39	267	7.4
Washington	699	300	10.2	391	8.8
Bangor	424	-37	11.33	401	7.2
Bergen-Passaic	749	325	6.44	345	1.9
Birmingham	413	249	17.37	148	8.6
Boise City	445	169	7.08	278	5.8
Bremerton	479	-67	15.23	493	5.6
Dover	538	200	8.42	279	7.7
Enid	300	8	9.57	262	11.0
Indianapolis	453	165	7.38	242	6.8
Jackson, MI	397	-62	15.62	365	10.2
Kenosha	470	-203	7.96	404	5.5
Las Cruces	367	-122	11.20	376	7.1
Lincoln	398	34	10.03	315	6.6
Melbourne-Titusville-Palm Bay	452	149	2.93	267	9.0
Norfolk-Virginia Beach-Newport News	487	196	4.95	239	6.5
Oklahoma	361	69	9.19	262	10.7
Redding, CA	415	-211	4.93	549	7.2
Sacramento	490	-136	5.42	549	8.1
Salt Lake City-Ogden	501	50	16.36	363	4.6
Savannah	450	170	11.95	246	11.6
Shreveport-Bossier City	387	197	10.76	154	7.2
Springfield	514	-51	11.21	528	5.8
Utica-Rome	400	-177	13.81	565	6.9
York	439	36	14.93	308	8.7
Youngtown-Warren	350	-12	15.10	360	8.1
Mean	523	93	9.74	369	7.4269
Median	490	117	9.80	353	7.3000
Mode	300	8	9.19	549	5.90
Standard Deviation	135	156	4.48	128	2.0219
Range	623	634	16.71	427	9.70
Sum	27170	4851	506.57	19163	386.20

According to Graph 1, about 30 percent of the rates of homeless among the sampling areas is 0.1 percent. In short, the homeless rate shows one homeless person for every 1,000 people in 52 sampling cities at any given day in 1996. Table 7 also shows the average unemployment rate, 5.1 percent, and poverty rate, 14.3 percent in the 52 cities. I hypothesized that higher unemployment rate and poverty rate would generate higher homeless rates. In Table 7, Las Cruces (NM) shows the highest unemployment rate (10.2 %) and poverty rate (30.0 %) on the highest homeless rate (0.886 %). This suggests a relationship that will be examined in all 52 sampling areas.

Graph 1: Homeless rates in 52 metropolitan areas, 1996



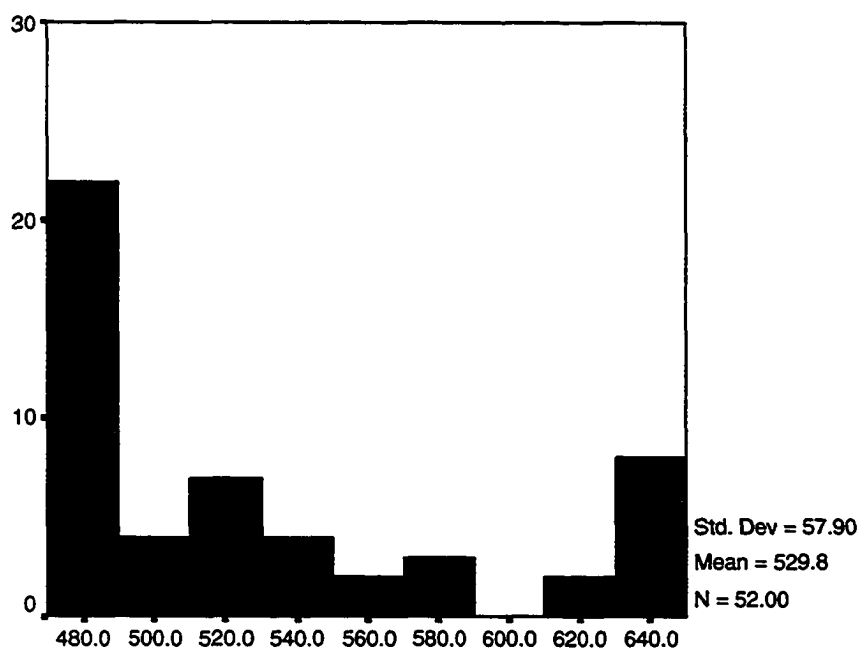
Rental vacancy rates are assumed to reflect the tightness of the housing market. Usually, a rate under 5 percent is taken to mean a local market in which rental housing is scarce and demand for housing may force prices higher (Burt, 1992). According to Table 7, the average rental vacancy rate is over five percent. It is 7.4 percent. Of three cities with under 5 percent of rental vacancy rate, only one city's homeless rate (San Francisco, 0.107 %) is a little over the mean (0.099 %). With this data on Table 7, perhaps the rental vacant rates in 52 metropolitan areas may not be a good indicator showing the relationship with a high level of homelessness and I will need to examine this data more deeply with bivariate and multivariate statistics.

I hypothesized that the average fair market rent for the one bedroom and the average monthly benefits of SSI and AFDC are related to homelessness. Based on these assumptions, I expected that higher rents generate more homelessness. And more welfare benefits make it possible for recipients to pay their living costs, including rents. Table 7 shows that the average monthly benefits of SSI and AFDC are \$530 and \$369 respectively, compared to \$522, the average of FMR for one bedroom in 52 sampling areas. Graph 2, 3, and 4 show the number of 52 sampling areas on the

vertical axis and SSI benefits for individual, AFDC grant for the family, and FMR for one bedroom on the horizontal axis respectively.

According to Graph 2, in more than 25 sampling areas, the SSI recipients' monthly benefits are below \$500. Table 7 and Graph 3 also show that the average monthly benefit level of AFDC recipients is about \$369. However, as we can see in Graph 4, FMR for one bedroom in about 20 sampling areas are over \$500 per month.

Graph 2: SSI benefits for individual, 1997

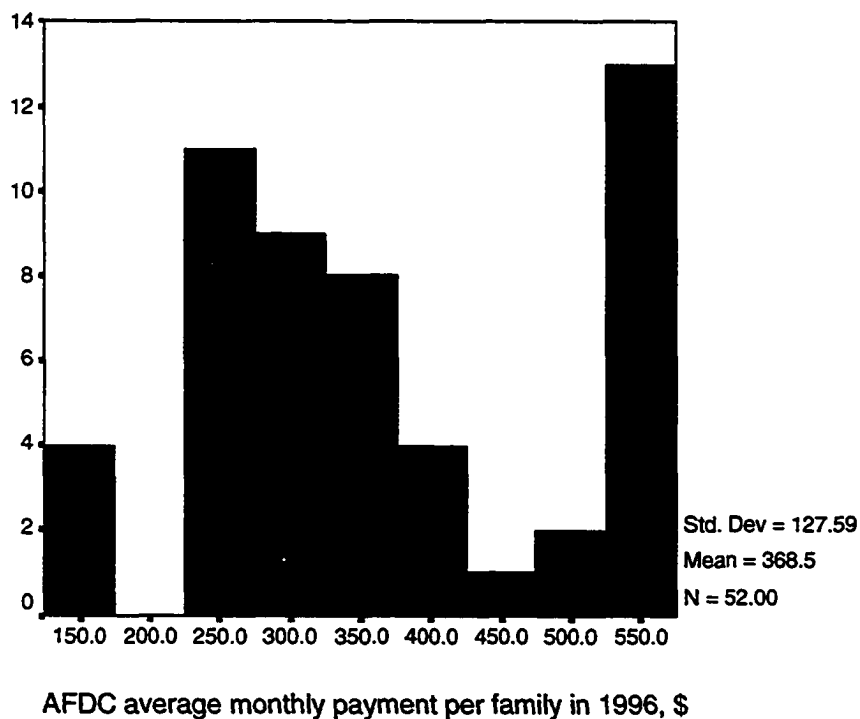


SSI benefit \$ for individual in 1997

This suggests, that AFDC beneficiaries may have a more difficult time living with their benefits because the

AFDC grant (\$369) is only 70 percent of SSI grant (\$530), and AFDC grant is for the family of 3 with 2 children compared to SSI grant only for the individual. Thus, AFDC recipients may need extra work, income, or financial and physical supports from their relatives or friends to pay their increasing living costs including rents.

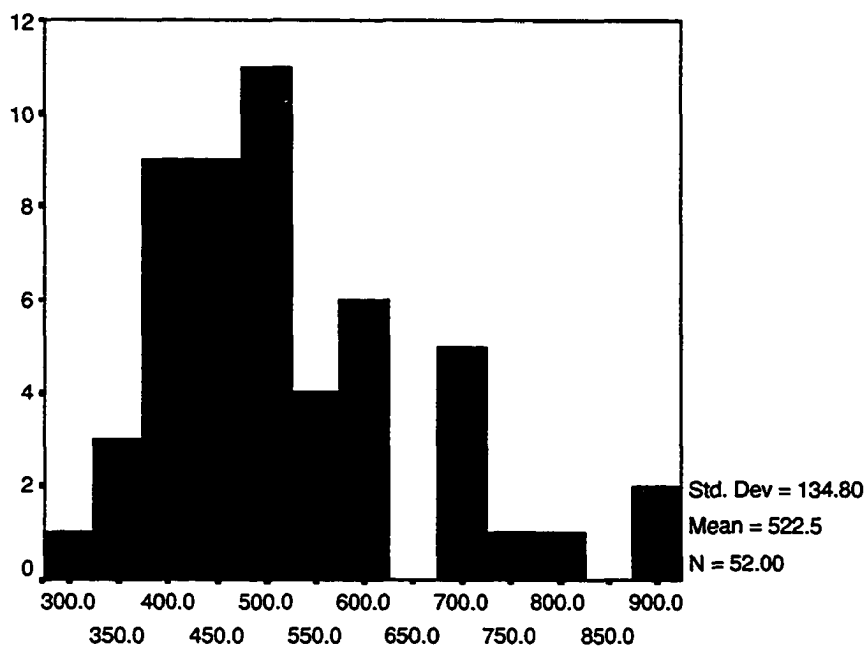
Graph 3: AFDC grant for the family, 1996



This is strongly supported by the dollar gap between FMR for one bedroom and TANF grant. The average dollar gap is \$93 (see Table 7). Graph 5 shows the number of sampling areas on the vertical axis and the dollar gap between FMR

for one-bedroom and TANF benefits on the horizontal axis. According to Graph 5, the TANF recipients in 29 sampling areas need more than \$100 to pay just their rents to fill the gap between fair market rent for one bedroom and TANF benefits for a single parent family with 2 children. Based on this, the higher dollar gap between FMR and TANF benefits may be related to higher level of homelessness.

Graph 4: Fair Market Rents for one bedroom, 1999

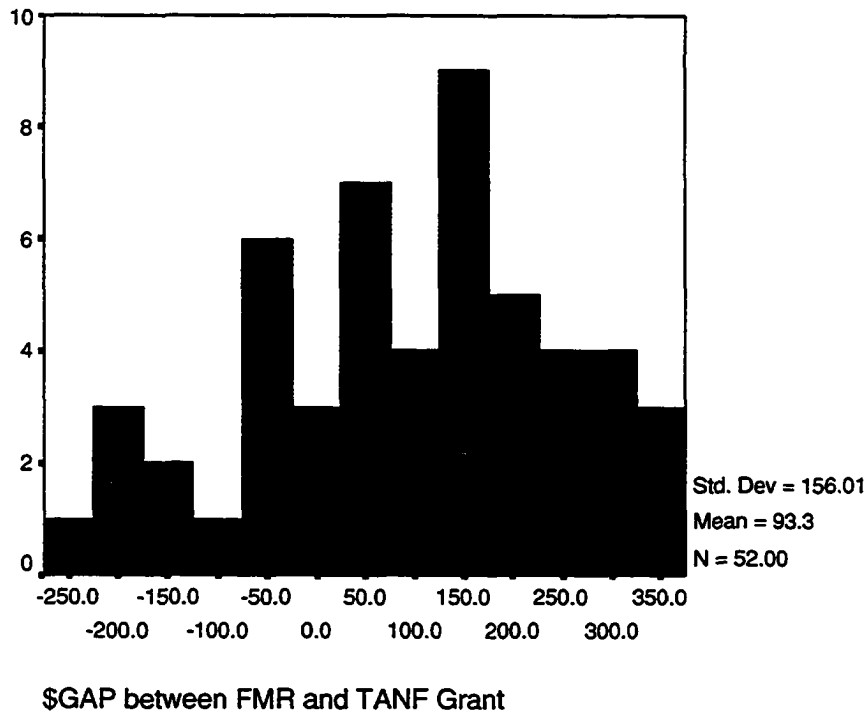


FMR (Fair market rent \$)for one bed room in 1999

This means that the single parent families with two children on AFDC may have a difficulty in paying their rent with their benefits. So, the rental vacancy rates in 52

metropolitan areas may not be a risk factor in becoming homeless as much as the impact of the low level of welfare benefits.

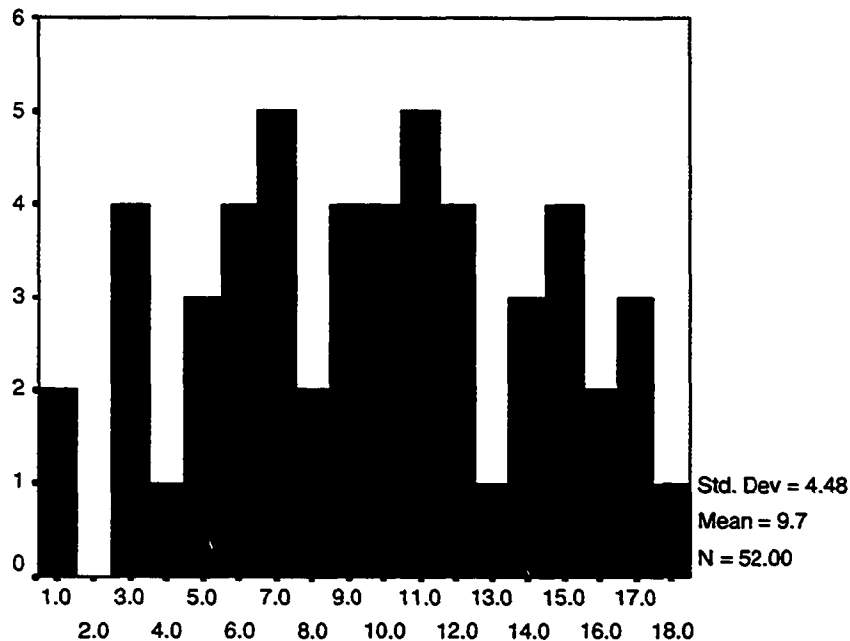
Graph 5: Dollar gap between FMR and TANF grant



However, this expectation is not supported by the data. For example, Shreveport-Bossier City in Louisiana shows a lower homeless rate (.066), but has the lowest AFDC benefits (\$154). And Las Cruces has the highest homeless rate, but shows little higher AFDC benefits (\$376) than the average AFDC benefits (\$369). That is, based on the data, I may assume that the low level of welfare benefits will not

be correlated with a high level of homelessness in 52 metropolitan areas. The data also show that the number of SSI recipients may not be associated with homelessness. Salt Lake City-Ogden has the lowest SSI recipient rate (1.08), but homelessness rate is .119. I had assumed that higher SSI recipient rate means lower homeless rate.

Graph 6: The rate of renter occupied housing units renting at \$300 or below, 1990



% of renter occupied units below \$ 300 divided by total housing units

An indicator of renter occupied housing units renting at \$300 or below at sampling areas measures the lack of low cost housing for the poor living under the poverty level. Graph 6 and 7 show the number of sampling areas on the vertical axis and percent of renter occupied housing units

renting at \$300 or below and the poverty rate on the horizontal axis respectively. According to Graph 6, the average of low renting units at \$300 or below in sampling areas is below 10 percent of total housing units. A total of 28 sampling areas have below 10 percent of renter occupied housing units renting at \$300 or below.

Graph 7 shows that more than the average 14 percent of the poor under the poverty level (Mean of poverty rate is 14.3 in the sampling areas) are residing at each sampling area. The lack of low cost housing units may affect the living arrangements of the poor under the poverty level. Because the sampling areas have affordable housing units for the poor, they are not likely to become homeless. This means that the lack of low renting housing units is closely related to homelessness of the poor. Based on this, I assumed that the lack of low renting housing units may affect homelessness. However, this hypothesis is also not explained by the data. According to the data, Orange County shows the lowest rate of renter occupied housing units renting at \$300 or below (.89%), but has the second lowest homeless rate (.022).

In brief, univariate statistics suggest that the unemployment rate and the poverty rate are associated with homelessness among the variables representing structural

and societal risk factors and also indicate that other variables including housing factors and welfare benefit factors may not be good examiners explaining the relationships between the variables in 52 metropolitan areas.

Graph 7: Poverty rate in 1993



2) Bivariate Statistical Analysis

- Correlation analysis

The simplest way to examine the relationship between societal/structural risk factors that cause homelessness and homeless rates is to look at zero order correlations, which show strength and direction of association between variables. Table 8 gives these correlations for each block of variables in the analysis. Some variables hypothesized to bear strong relationships appear to do so and some of them do not, at least at the level of zero order correlations. Further, some variables show associations that go in the opposite direction from theoretical predictions.

Nine indicators are used to estimate correlations between variables in four major societal/structural risk factors and homelessness rates: unemployment rate, poverty rate, rental vacancy rate, SSI recipient rate, SSI benefit level for the individual, AFDC average monthly payment per family, FMR for one bedroom, the rate of renter occupied housing units renting at \$300 or below, and the dollar gap between TANF grant and FMR for one bedroom.

In the univariate analysis, I expected that higher unemployment rates and poverty rates would generate higher

homeless rates. Because Las Cruces (NM) showed the highest unemployment rate (10.2 %) and poverty rate (30.0 %) on the highest homeless rate (0.886 %). Therefore, analyzing bivariate statistics, I can expect to see significant relationships between both indicators and the homeless rate in the 52 sampling areas.

The univariate analysis suggested that rental vacancy rates in the sampling areas are not the major factors to impact on the homeless rate because the mean of rental vacancy rates was over five percent. (A rate under five percent is considered to rental housing scarcity and demand for housing.)

The univariate analysis also indicated that the average monthly fair market rent for one bedroom (\$523), the average monthly benefits of SSI for the individual (\$530), SSI recipient rate, and the AFDC average monthly payment per family (\$369) were not related to a high level of homelessness. I hypothesized that higher benefit levels would reduce homelessness and higher rent would generate more homelessness. The univariate analysis showed that the beneficiaries of each of two cash benefits could not live without any other sources if they pay their all cash benefits for their rents. In addition, I assumed that the welfare recipients (AFDC or SSI) need extra work, income,

or physical support from their relatives or friends to pay their living costs including rents.

This was strongly supported by the dollar gap between FMR for one bedroom and TANF grant. The average dollar gap between them was \$93. The TANF recipients in 29 sampling areas need more than \$100 to pay just their rents to fill the gap between fair market rent for one bedroom and TANF benefits for the single parent family with 2 children. This meant that the single parent families with two children on TANF have a difficulty in paying their rent with their benefits. Therefore, I assumed that the rental vacancy rates in 52 cities may not be a major factor in becoming homeless as much as the impact of the low level or reduction of welfare benefits on homelessness. However, the results of univariate analysis failed to support the expectations. The results showed that the variables including the average monthly fair market rent for one bedroom, the average monthly benefits of SSI for the individual, AFDC average monthly payment per family, and the dollar gap between FMR for one bedroom and TANF benefits for the family of 3 with 2 children do not have meaningful relationships with homelessness.

Finally, I assumed that the lack of low renting housing units affects homelessness because the average of

low renting units in sampling areas is below 10 percent of total housing units. However, the univariate analysis also showed the fact that the lack of low renting housing units was not related to homelessness of the poor.

Now, through analyzing bivariate statistics, I may begin to address if the findings drawn from the univariate analysis have statistically significant relationships between both indicators of independent variables and the homeless rate in the 52 sampling areas. In Table 8, nine indicators among the societal/structural risk factors explaining the cause of homelessness are presented to estimate correlations between variables.

According to Table 8, five of nine indicators for independent variables in terms of the direction of the bivariate relationships were consistent with the hypotheses. Homeless rates are negatively correlated with the rental vacancy rate, AFDC average monthly payment per family, and SSI benefit level. That is, the higher rental vacancy rate, and the higher AFDC average monthly payment per family, the lower homeless rate. Also, the higher SSI benefit level has the lower homeless rate.

Table 8: Zero order correlations between each structural/societal indicators and homeless rate in 52 metropolitan areas

Nine structural/societal indicators	Homeless rate in 1996
Poverty rate in 1993	.491**
Unemployment rate in 1996	.315*
SSI recipient rate in 1995	.045
The rate of renter occupied housing units renting at \$300 or below	.038
FMR for one bedroom in 1999, (\$)	-.175
\$gap between FMR and TANF	-.156
SSI benefit for individual in 1997, (\$)	-.094
AFDC average monthly payment per family in 1996, (\$)	-.041
Rental vacancy rate in 1996	-.017

*. Correlation is significant at the 0.05 level (1-tailed)

** . Correlation is significant at the 0.01 level (1-tailed)

On the other hand, homeless rates were positively correlated with the unemployment rate and the poverty rate in each sampling areas. The higher poverty rate, and unemployment rate mean the higher homeless rate.

However, the negative correlations of FMR for one bedroom, the dollar gap between FMR for one bedroom and TANF benefits for families of 3, and the positive

correlation of renter occupied housing units renting at \$300 or below with the homeless rate and SSI recipient rate show the opposite direction from the theoretical hypotheses. That is, the negative correlations of FMR for one bedroom in the sampling areas with homelessness contradict the hypothesis that areas with higher FMR for one bedroom have higher rates of homelessness. The increasing fair market rent for one-bedroom impacts on the living conditions of the poor because they have to pay rent with most of their household incomes. Therefore, I expected that the more FMR for one bedroom, the higher homeless rate.

The dollar gap between FMR for one bedroom and TANF grant for a single family of 3 with no earnings has a negative relationship with homeless rates. This result also contradicts the expectation. When fair market rents are higher than TANF grant for the single parent families of three, the families with only TANF income may not be able to pay for their housing. That is, I assumed that the dollar gap between them is higher, thus, homeless rate is higher in the sampling areas.

The positive correlations of renter occupied housing units renting at \$300 or below and SSI recipient rate with homelessness also contradict the hypotheses that the higher

renter occupied housing units for the poor and more recipients on SSI have the lower rate of homelessness.

Table 8 shows that two indicators had significant effects on the homeless rate. It also identifies an order among the variables. Among the nine indicators based on societal/structural factors, Table 8 presents the most crucial risk factor by a rank ordering on the homeless rate. According to the Table 8, correlation coefficients of poverty rate and unemployment rate on the homeless rate are .491 and .315 respectively. This suggests that homelessness is an economic problem. The significance of the unemployment rate in explaining homelessness suggests that increased employment opportunities aid the poor in avoiding homelessness. And the significance of the poverty rate supports the idea that poverty is a major social problem that impacts on the cause of homelessness.

However, rental vacancy rates, SSI benefits for the individual, and AFDC average monthly payment per family have no correlations with homelessness because correlation coefficients (Pearson's r) of these predictor variables are far below $-.20$. In Table 8, the effect of the rental vacancy rate ($r = -.017$), SSI benefit level ($r = -.094$) and AFDC average monthly payment per family ($r = -.041$) are now negative as I assumed but correlation coefficients were

very weak and not significant. SSI recipient rate has a positive relationship with the homeless rate and Pearson's r is .045. That is, SSI recipient rate is not also statistically significant.

The rate of renter occupied housing units renting at \$300 or below, and FMR for one bedroom contradict the expected hypotheses and also not significant because correlation coefficients are .038, and $-.175$ respectively. The effect of the dollar gap between TANF grant for a single family of 3 with no earnings and FMR for one bedroom also contradicts the expectation. I expected a positive relationship with the rate of homelessness. The result is negative and also not statistically significant because it is also very small ($r = -.156$).

The lack of significance of the rental vacancy rate and the rate of renter occupied housing units for the poor contradicts with arguments about the structural causes of homelessness and it is not consistent with the findings of other multivariate studies, which found the shortage of affordable rent units to have strong negative effects on homelessness (Elliot & Krivo, 1991, Bohanon, 1991, and Tucker, 1990). This is probably because of different measures used in each homeless study, a change of the housing conditions during the past decades, or year gaps of

the data used. For example, Elliot & Krivo(1991), Bohanon (1991), and Tucker (1990) used 1979 data to see the housing effect on the homeless rate in their studies.

In brief, the correlation coefficients show poverty and unemployment among the societal/structural risk factors significantly correlated to the homeless rate.

- Bivariate regression analysis

The results of bivariate regression analysis also show that the poverty rate and the unemployment rate have a significant impact on the homeless rate. According to Table 9, the R square or amount of variance explained in the poverty rate on homelessness is .241 and Beta = .491, $t(50) = 3.98$, $p < .001$. This means that about 24 percent of the variation in homelessness can be explained by the poverty rate alone when not controlling for other variables. Also, the R square of unemployment rate on homelessness is .099 and Beta = .315, $t(50) = 2.34$, $p < .05$. This means that about 10 percent of the variation in homelessness can be associated with the unemployment rate when other variables are not controlled for.

On the other hand, the results of bivariate regression show that the remaining seven indicators (rental vacancy rate, SSI recipient rate, SSI benefits for the individual, AFDC average monthly payment per family, FMR for one bedroom, the dollar gap between TANF grant and FMR for one bedroom, and the rate of renter occupied housing units renting at \$300 or below) are not statistically significant. The R square (.000) and P level ($p = .906$) of the rental vacancy rate on homelessness show that the rental vacancy rate on homelessness is meaningless. The rate of renter occupied housing units renting at \$300 or below is also insignificant (R square = .001 and $P = .788$).

Thus, I can say that the rental vacancy rate and renter occupied housing units for the poor on homelessness are not important factors explaining homelessness.

SSI benefits for the individual (R square = .009 and $p = .509$) and SSI recipient rate (R square = .002 and $p = .749$) are also statistically insignificant. The result shows that the low level of welfare benefits on homelessness and recipient rate are also meaningless and there are no correlations with SSI benefits and the number of recipients on homelessness.

FMR for one bedroom and the dollar gap between FMR for one bedroom and TANF grant explain less than 6 percent

Table 9: Bivariate regression coefficients between nine indicators showing structural/societal factors and homeless rate in 52 metropolitan areas

	Beta	R	R square	Adjusted R	t	p level
Homeless rate						
Poverty rate	.491	.491	.241	.225	3.980	.000
Unemployment rate	.315	.315	.099	.081	2.344	.023
The rate of renter occupied housing units renting at \$300 or below (%)	.271	.038	.001	-.019	.271	.788
SSI recipient rate	.045	.045	.002	-.018	-.321	.749
FMR for one-bedroom	-.175	.175	.031	.011	-1.260	.214
\$ gap between FMR for one-bedroom and TANF grant	-.156	.156	.024	.005	-1.116	.270
SSI benefits for the individual	-.094	.094	.009	-.011	-.665	.509
AFDC average monthly payment per family	-.041	.041	.002	-.018	-.294	.770
Rental vacancy rate	-.017	.017	.000	-.020	-.119	.906

of the variation in homelessness (R square is .024 and .031 and p level is .214 and .270 respectively). The results are statistically insignificant. Thus, there are no correlations between these two predictor variables and homelessness.

3) Multivariate Statistical Analysis- Multiple regression analysis

Correlation analysis produces correlation coefficients that give us a good idea of the degree of correlation between the predictor variables and the criterion variable. Bivariate regression analysis presents regression coefficients to estimate the linear relationship between one predictor variable and a criterion variable.

Multiple regression can tell us approximately what percentage of the variation within values of the criterion variable can be explained by the predictor variables. The use of a regression equation helps us estimate the actual value of a criterion variable, knowing the corresponding values for various predictor variables (Weinbach and Grinnell, 1995). A multiple regression analysis must also take into consideration the fact that the predictor variables are not only correlated with the criterion

variable, but also correlated to a greater or lesser degree with each other, referred to as multicollinearity.

The use of stepwise multiple regression analysis analyzes the particular order among the structural/societal risk factors, predictor variables, and that it is possible to estimate the relative impact of each and all the structural/ societal risk factors on a criterion variable, the homeless rate.

In the bivariate analysis, I investigated the relationship between pairs of variables. The bivariate statistics showed that the poverty and unemployment rate among the societal/structural risk factors are significantly related to the homeless rate. Correlation coefficients (r) of the poverty rate and unemployment rate on the homeless rate were .491 and .315 respectively.

Regression coefficients in simple regression were also statistically significant for both variables. This suggested that homelessness is a structural problem in our society. The significance of the unemployment rate in explaining homelessness suggests that increased employment opportunities aid the poor in avoiding homelessness. And the significance of the poverty rate supports that poverty is a major social problem impacting on the cause of homelessness.

Through the multiple regression analysis, I will estimate the effects of the unemployment rate, poverty rate, rental vacancy rate, the number of SSI recipients, SSI benefit level for the individual, AFDC average monthly payment per family, FMR (Fair Market Rent) for one bedroom, the dollar gap between FMR for one bedroom and TANF grant, the rate of renter occupied housing units renting at \$300 or below on the rate of homelessness. Further, it tells how one variable changes when controlling for another.

In addition, in order to get strong correlations between variables, I examine standard errors. Using the standard deviation of observed values around the regression line called standard error of estimate, it is possible to acquire a more accurate prediction of the dependent variable in the study. Because the closer the standard error is to zero, the more confident we can be that the regression equation will give us good predictions (Weinbach and Grinnell, 1995).

For the study's accuracy, a predictor variable, AFDC average monthly payment for a family of 3 with no earnings, is excluded because of a multicollinearity problem. The correlations among the predictor variables show that the SSI benefit level is strongly related to AFDC average monthly payment per family, and unemployment rate is also

highly related to poverty rate. According to Table 10, the correlation coefficient between SSI benefits and AFDC average monthly payment per family is .823, and the coefficient between unemployment rate and poverty rate is .654.

Table 10: Zero order correlation matrix between each structural/societal indicators in 52 metropolitan areas

	Unempl oyment rate in 1996	Pove rty rate in 1993	Rental vacanc y rate in 1996	SSI recip ients in 1996	SSI benefit \$ for individ ual in 1997	AFDE average monthly payment per family in 1996	FMR \$ for one bedroo m in 1999	\$gap betw een TANF and FMR
Povert y rate in 1993	.654*							
Rental vacanc y rate in 1996	-.024	.249 *						
SSI recipi ent rate in 1995	.459	.370	.004					
SSI benefi t \$ for indivi dual in 1997	.303*	.022	-.304*	.430*				

Table 10. (Cont.)

AFDE averag e monthl y paymen t per family in 1996	.377**	-	-	.359*	.823**		
		.097	.375**	*			
FMR \$for one bedroo m in 1999	.113	-	-	.117*	.386**	.479**	
		.196	.391**	*			
\$gap betwee n FMR and TANF grant	-.223	-	.076	-.161	-.416**	-.480**	.477**
		.075					
The rate of renter occupi ed housin g units rentin g at \$300 or below	-.216	-	.220	.056	-.478**	-.326**	-
		.110				.340**	.000

*. Correlation is significant at the 0.05 level (1-tailed)

** . Correlation is significant at the 0.01 level (1-tailed)

Multicollinearity is a problem that arises when there exists moderate to high intercorrelations among predictor variables. Multicollinearity is diagnosed by two statistical methods: tolerance and variance inflation

factor (VIF). Typically, possible values range from 0 to 1, and a value of 0.1 serves as the cutoff point for tolerance. If the tolerance value is less than 0.1, multicollinearity is a distinct problem. Values of VIF those are greater than 10 are generally caused for concern (Mertler and Vannatta, 2001).

A value of tolerance and VIF for AFDC average monthly payment for a family of 3 is .085 and 11.831 respectively (see Table 11). However, a value of tolerance and VIF for unemployment rate, poverty rate, or SSI benefits for the individual is an acceptable level to conduct a multiple regression. Therefore, in order to avoid a multicollinearity problem, an indicator, AFDC average monthly payment for a family of 3 with no earnings, is eliminated.

Finally, I could conduct multiple regression with 8 indicators in model I: poverty rate, unemployment rate, the rate of renter occupied housing units renting at \$300 or below, SSI recipient rate, the dollar gap between FMR for one bedroom and TANF grant, SSI benefits for the individual, rental vacancy rate, and FMR for one bedroom.

The regression in Table 12 yields an F statistic of 2.788, which is statistically significant at the 5 percent level ($p = .014$).

Table 11: Collinearity Statistics of nine structural/societal indicators in 52 sampling areas

Nine Indicators	Tolerance	VIF
Poverty rate in 1993	.358	2.792
Rental vacancy rate in 1996	.699	1.431
SSI recipient rate in 1995	.514	1.946
SSI benefit \$ for individual in 1997	.210	4.753
AFDC average monthly payment per family in 1996	.084	11.862
FMR \$for one bedroom in 1999	.101	9.860
\$gap between TANF and FMR	.105	9.540
The rate of renter occupied housing units renting at \$300 or below	.556	1.946
Unemployment rate	.343	2.918

The regression also shows that R square is .342.

Since the inclusion of even an irrelevant regressor will increase R square little, it is usually desirable to correct for an irrelevant regressor by reducing R square appropriately. Therefore, adjusted R square, which is R square adjusted for the degrees of freedom absorbed by the number of variables in the equation, is needed. That is, adjusted R square is a more accurate reflection of the true amount of variance explained by the equation because R and R square typically overestimate their corresponding population values especially with small samples. Thus, adjusted R square is calculated to account for such bias

(Mertler and Vannatta, 2001). The model 1 in Table 12 shows that adjusted R square is .219.

Table 12: Multiple Regression for 8 indicators and homeless rate in 52 metropolitan areas

Model	R	R Square	Adjusted R	Standard Error of the Estimate	F	Sig. F change	Total df
1	.584a	.342	.219	.1062	2.788	.014	51

a. Predictors: (Constant), \$GAP between FMR and TANF Grant , poverty rate of all ages in 1993, SSI recipient rate in 1995, rental vacancy rate in 1996, SSI benefit \$ for individual in 1997, the rate of renter occupied housing units renting at \$300 or below in 1990, unemployment rate in 1996, FMR (Fair market rent \$) for one-bedroom in 1999

That is, this model indicates that the overall model of eight independent variables significantly predicts homelessness, R square = .342, adjusted R square = .219, F (8, 43) = 2.78, $p < .05$. The R square (.342) means that this model accounts for 34.2 percent of the variance in homelessness. Thus, 34.2 percent of homeless population are explained by societal/structural risk factors including eight predictor variables, especially unemployment rate, poverty rate, rental vacancy rate, SSI recipient rate, SSI benefit level for the individual, FMR (Fair Market Rent) for one bedroom, the dollar gap between FMR for one bedroom and TANF grant, and the rate of renter occupied housing units renting at \$300 or below. The R square also explains that this model cannot account for 66.7 percent of the

variance in homelessness and other risk factors including not only personal factors such as mental illness, substance abuse, or family breakdown, but also other societal/structural factors not mentioned in this model are obviously needed to explain the increase of homelessness. This will be a challenge to future research goals.

The results of regression model are strikingly consistent with the discussion about poverty rate's impact on the rate of homelessness in the bivariate analysis. The bivariate statistics showed that poverty and unemployment

Table 13: Multiple Regression Coefficients between 8 structural/societal indicators and homeless rates in 52 metropolitan areas

	Standardized coefficients (Beta)	Unstandardized coefficients (B)	Standard error	t	Sig.*
The homeless rate (Constant)		.129	.270	.477	.636
Poverty rate in 1993	.637	1.955E-02	.006	3.234	.002
FMR for one bedroom in 1999	.167	1.488E-04	.000	.665	.510
The rate of renter occupied housing units renting at \$300 or below	.093	2.501E-03	.004	.563	.577

Table 13. (Cont.)

\$ gap between FMR and TANF grant	-.303	-2.332E-04	.000	- 1.240	.222
SSI benefits for individual in 1997	-.234	-4.865E-04	.001	-932	.357
Rental vacancy rate in 1996	-.179	-1.063E-02	.009	- 1.224	.228
SSI recipient rate in 1995	-.147	-1695E-08	.020	-858	.396
Unemployment rate in 1996	-.034	-2.609E-03	.016	- .167	.868

Dependent variable: homeless rate in 1996

* $P < .05$ or $P < .01$ (1 tailed)

among the societal/structural risk factors are significantly related to the rate of homelessness.

Table 13 displays that poverty rate is related to a significantly higher homeless rate because the standardized coefficient (Beta) for poverty rate is .637. The strongest effect value of the standardized coefficients is +1 or -1. The unstandardized coefficients (B) for the variables further demonstrate their substantive importance. The unstandardized coefficients indicate how much the value of the dependent variable changes when the independent variable increases by one unit (Mertler and Vannatta,

2001). Thus, a modest one percent increase in poverty rate would increase the homeless rate by 0.019 percent. That is, one percent increases in the poverty rate would represent an increase of 1.9 homeless persons for every 10,000 people in 52 metropolitan areas.

The standard error of the poverty rate (.006) closes to 0 point and p-level of the poverty rate is .002. Thus, only the poverty rate is statistically significant or contributing to this model (poverty rate: Beta = .637, $t(43) = 3.23$, $p < .05$, 1-tailed).

However, this multiple regression shows that the unemployment rate's impact on the homeless rate is not statistically significant and also does not have a major effect on the high level of homelessness. This result contradicts bivariate statistical analysis, which showed that the unemployment rate affects homelessness ($R = .315$, Beta = .315, F statistics = 5.493, and $p = .023$). In Table 13, p-level of the unemployment rate is .868 and Beta (standardized coefficient) of unemployment rate is $-.034$ (1.0 or -1.0 has the strongest effectiveness on the dependent variable). The negative estimate of unstandardized coefficients of the unemployment rate on the homeless rate contradicts the hypothesis that a high

unemployment rate has a high homeless rate in the sampling areas.

Even though there are acceptable values of tolerance and VIF between the poverty rate and the unemployment rate, because of the high level of correlation coefficient ($r=.654$, see Table 10) between them, I also conducted two separate multiple regressions, first, without the poverty rate and then without the unemployment rate to see the impact of each indicator on homelessness. The results of these multiple regressions also show that the unemployment rate is not a statistically good factor.

Table 14: Multiple Regression for 7 indicators and homeless rates in 52 metropolitan areas

Model	R	R Square	Adjusted R	Standard Error of the Estimate	F	Sig. F	Total change df
Regression 1: 7 indicators without poverty rate	.426a	.181	.050	.1170	1.892	.233	51
Regression 2: 7 indicators without unemployment rate	.584b	.341	.236	.1050	1.892	.007	51

a Predictors: (Constant), the rate of renter occupied units below \$ 300 in 1990, \$GAP between FMR and TANF Grant , SSI recipient rate in 1995, rental vacancy rate in 1996, unemployment rate in 1996, SSI benefit \$ for individual in 1997, FMR (Fair market rent \$)for one bed room in 1999

b Predictors: (Constant), SSI benefit \$ for individual in 1997, poverty rate of all ages in 1993, rental vacancy rate in 1996, \$GAP between FMR and TANF Grant , renter occupied units below \$

300 in 1990, SSI recipients (%) in 52 sampling areas, FMR (Fair market rent \$)for one bed room in 1999

According to Table 14, the first regression is not statistically significant because p level is .233 (p level is significant at $p < .001$, $p < .05$ or $p < .01$).

On the other hand, the regression 2 shows almost same results with model I (see Table 12). The regression 2 accounts for 34.1 percent of variance in homelessness. Thus, 34.1 percent of homeless population is explained by seven indicators except the unemployment rate. As a result, unlike the result of bivariate regression between the unemployment rate and the homeless rate, when other indicators control the unemployment rate in multiple regression, then unemployment rate is not a statistically significant indicator.

These results may occur because the general unemployment rate is not related to the proportion of the population which is both non-employed and at the greatest risk of becoming or staying homeless. Some social scientists suspect that the government underestimates the extent of unemployment by 50 to 300 percent (Kogut & Aron, 1980; Yankelovich, et al. 1983). In fact, the unemployment rate includes only those who are without a job and currently looking for work. Therefore, it excludes all

people who have given up looking for work when nothing satisfactory can be found. As a result, the unemployment rate may be over-representing people who are unemployed for relatively short periods of time, and who, consequently, are less likely to become homeless. Furthermore, a low unemployment rate allows the conservatives to blame homeless people for their plight and to ignore structural/societal risk factors that cause homelessness. This suggests that future research should begin examining the effect of the relative numbers of those who have given up searching for jobs as a structural economic condition influencing the homeless rate.

Table 15, stepwise multiple regression analysis of eight predictors with the homeless rate, shows a kind of rank ordering of eight risk factors on the homeless rate. The stepwise procedure defines an order based on the relative uniqueness of the variables in the sample at hand. The most highly correlated with the homeless rate in Table 13 is the poverty rate. The R square of the poverty rate on homelessness is .241, thus 24.1 percent of the variance in homelessness is explained by the poverty rate.

The increase of the R square change for each new variable extends the variance in homelessness. 2.5 percent of variance (R square change=.025) in homelessness is

associated with the rental vacancy rate. SSI recipient rate and renter occupied housing units at \$300 or below account for 2.1 and 2.5 percent of the variance in homelessness respectively.

Table 15: Stepwise multiple regression analysis of eight predictors with homeless rate in 52 metropolitan areas

Model I	R	R square	R square change	Adjusted R square	Standardized coefficients (Beta)
Step 1: Poverty rate	.491 a	.241	.241	.225	.637
Step 2: SSI recipient rate and poverty rate	.512 b	.262	.021	.232	-.179
Step 3: Rental vacancy rate, SSI recipient rate, and poverty rate	.536 c	.287	.025	.243	-.234
Step 4: The rate of renter occupied housing units renting \$300 or below, SSI recipient rate, rental vacancy rate, and poverty rate	.559 d	.312	.025	.253	-.303

Table 15. (Cont.)

Step 5: The dollar gap between TANF and FMR for one-bedroom, the rate of renter occupied housing units renting \$300 or below, SSI recipient rate, rental vacancy rate, and poverty rate	.573 e	.328	.016	.255	.167
Step 6: SSI benefits for the individual, the dollar gap between TANF and FMR for one-bedroom, the rate of renter occupied housing units renting \$300 or below, SSI recipient rate, rental vacancy rate, and poverty rate	.578 f	.335	.007	.246	-.034

Table 15. (Cont.)

Step 7: FMR for one-bedroom, SSI recipient rate, the rate of renter occupied housing units renting at \$300 or below, the dollar gap between TANF and FMR for one-bedroom, SSI benefits for the individual, rental vacancy rate and poverty rate	.584 g	.341	.007	.236	-.147
Step 8: Unemployment rate, the rate of renter occupied housing units renting at \$300 or below, SSI recipient rate, FMR for one-bedroom, The dollar gap between TANF and FMR for one-bedroom, SSI benefits for the individual, rental vacancy rate and poverty rate	.584 h	.342	.000	.219	.093

- a Predictors: (Constant), poverty rate of all ages in 1993
- b Predictors: (Constant), poverty rate of all ages in 1993, SSI recipient rate (%) in 52 sampling areas
- c Predictors: (Constant), poverty rate of all ages in 1993, SSI recipient rate (%) in 52 sampling areas, rental vacancy rate in 1996
- d Predictors: (Constant), poverty rate of all ages in 1993, SSI recipient rate (%) in 52 sampling areas, rental vacancy rate in 1996, the rate of renter occupied units below \$ 300 in 1990
- e Predictors: (Constant), poverty rate of all ages in 1993, SSI recipient rate (%) in 52 sampling areas, rental vacancy rate in 1996, the rate of renter occupied units below \$ 300 in 1990, \$GAP between FMR and TANF Grant
- f Predictors: (Constant), poverty rate of all ages in 1993, SSI recipient rate (%) in 52 sampling areas, rental vacancy rate in 1996, the rate of renter occupied units below \$ 300 in 1990, \$GAP between FMR and TANF Grant , SSI benefit \$ for individual in 1997
- g Predictors: (Constant), poverty rate of all ages in 1993, SSI recipient rate (%) in 52 sampling areas, rental vacancy rate in 1996, the rate of renter occupied units below \$ 300 in 1990, \$GAP between FMR and TANF Grant , SSI benefit \$ for individual in 1997, FMR (Fair market rent \$)for one bed room in 1999
- h Predictors: (Constant), poverty rate of all ages in 1993, SSI recipient rate (%) in 52 sampling areas, rental vacancy rate in 1996, the rate of renter occupied units below \$ 300 in 1990, \$GAP between FMR and TANF Grant , SSI benefit \$ for individual in 1997, FMR (Fair market rent \$)for one bed room in 1999, unemployment rate in 1996

The dollar gap between FMR for one bedroom and TANF for a single parent family of 3 with no earnings accounts for 1.6 percent of the variance in homelessness. And then, FMR for one-bedroom (R square change = .007), unemployment rate (R square change = .000), and SSI benefits for the individual (R square change = .007) affect homelessness with a total of only 1.4 percent of the variance.

As a result, a multivariate analysis shows that, among nine independent variables, the poverty rate is strongly related to the homeless rate. That is, poverty is a major social problem that strongly impacts on the growth of homelessness among the structural/societal risk factors explaining the cause of homelessness in model I and no

other factors were found to be statistically significant predictors.

8. The findings: Model II

1) Univariate Statistical Analysis

In model II, the dynamic relationship between individual risk factors and homelessness and the effects of the variables on homelessness is examined. Table 16 displays the data for individual risk factors and the homeless rates in 51 states. A total of five indicators is used to estimate the relationship between variables in four major individual risk factors explaining the cause of homelessness based on structural functionalism: mental illness, alcohol and drug abuse, and family violence.

Five indicators showing four individual factors are: the rate of estimated 12-month number of persons age 18 and older with serious mental illness in each state, total expenditures in each state and county mental hospitals, per capita public spending on alcoholism clients in each state, substance abuse treatment admission rate, and shelter rate for abused women in each state. Table 16 shows mean,

median, mode, standard deviation, range, and sum of each indicator and homeless rate.

Table 16: Data for five individual risk indicators and homeless rate in 51 states

51 states	Homeless rate in 1990 (%)	The rate of estimated 12 month number of persons with serious mental illness in state, 1990 (%)	Per capita public spending on alcoholism clients, 1989 (\$)	Substance abuse treatment admission rate, 1991 (%)
Alabama	.03	3.99	2.20	.68
Alaska	.07	3.71	37.73	.28
Arizona	.07	3.96	6.81	.82
Arkansas	.02	3.97	4.65	.89
California	.10	3.99	4.46	1.14
Colorado	.07	3.99	7.22	.93
Connecticut	.12	4.17	13.21	.88
Delaware	.05	4.08	4.21	.26
District of Columbia	.73	4.36	16.16	.30
Florida	.10	8.40	4.29	1.59
Georgia	.03	23.15	5.57	.85
Hawaii	.07	4.04	5.14	1.14
Idaho	.04	3.75	4.55	.55
Illinois	.06	4.01	5.52	1.38
Indiana	.03	3.99	5.31	.56
Iowa	.03	4.00	16.97	.40
Kansas	.03	3.96	6.94	.53
Kentucky	.03	4.00	6.18	.58
Louisiana	.03	3.83	4.77	1.45
Maine	.03	4.04	10.78	.85
Maryland	.05	4.09	8.40	.61
Massachusetts	.10	4.19	9.19	.55
Michigan	.04	3.97	5.27	1.41
Minnesota	.05	3.96	10.19	1.59
Mississippi	.01	3.83	4.69	1.08
Missouri	.04	4.01	5.62	.67
Montana	.05	3.90	8.15	.50
Nebraska	.05	3.93	6.89	.71
Nevada	.08	4.07	3.82	.79
New Hampshire	.03	4.04	5.71	1.45
New Jersey	.09	4.13	7.19	.78
New Mexico	.04	3.81	13.56	1.42
New York	.02	4.12	18.86	.44

North Carolina	.04	4.09	5.68	.63
North Dakota	.04	3.92	7.23	.69
Ohio	.04	4.01	4.55	.78
Oklahoma	.06	3.96	7.96	.39
Oregon	.11	4.02	5.24	.81
Pennsylvania	.07	4.13	7.07	.46
Rhode Island	.04	4.19	13.08	.39
South Carolina	.02	3.98	7.27	5.10
South Dakota	.05	3.86	7.17	1.48
Tennessee	.03	4.05	3.73	2.05
Texas	.04	3.86	4.76	.94
Utah	.05	3.43	7.43	.96
Vermont	.04	4.03	5.54	1.87
Virginia	.04	4.09	10.42	.75
Washington	.09	4.00	9.29	.49
West Virginia	.02	4.06	3.08	.66
Wisconsin	.03	3.98	9.49	2.50
Wyoming	.03	3.79	12.56	.40
Mean	.062	4.44	8.07	.97
Median	.042	4.00	6.89	.78
Mode	.03	3.96	4.55	.39
Standard Deviation	.098	2.74	5.56	.76
Range	.72	19.72	35.53	4.84
Sum	3.21	226.89	411.76	49.41

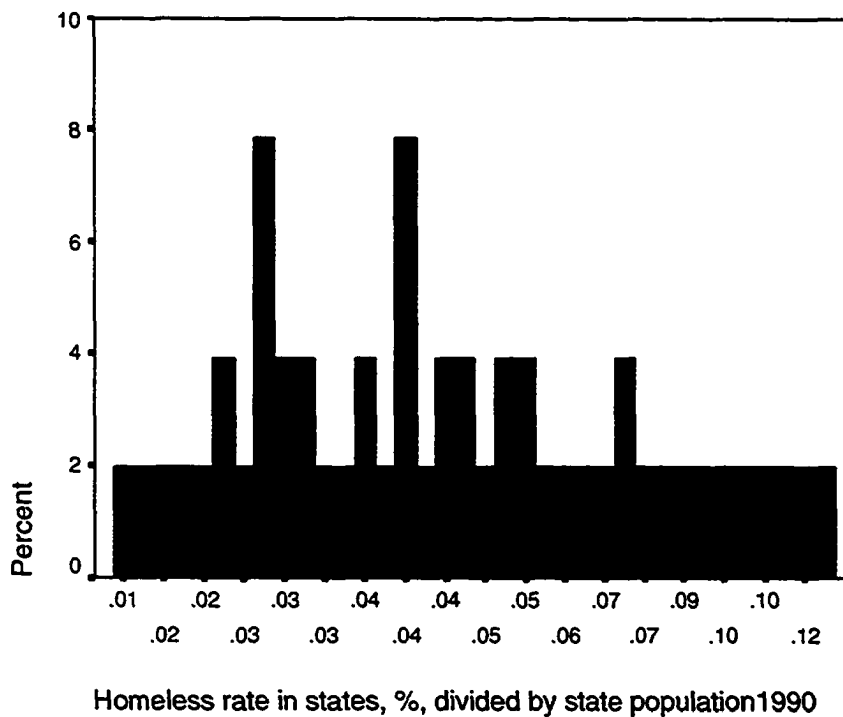
Table 16: Data for five individual risk indicators and homeless rate in 51 states (Cont.)

	Shelter rate for abused women, 1990 (%)	Total expenditures in state and county mental hospitals, 1986 (\$)
Alabama	1.10	75,221,000
Alaska	1.30	14,793,000
Arizona	2.40	28,434,000
Arkansas	.80	59,319,000
California	10.70	345,718,000
Colorado	1.40	62,961,000
Connecticut	1.30	144,973,000
Delaware	.30	25,632,000
District of Columbia	.40	135,000,000
Florida	5.10	159,342,000
Georgia	1.60	227,380,000
Hawaii	.60	12,932,000
Idaho	.70	8,859,000

Illinois	4.60	181,398,000
Indiana	2.40	102,095,000
Iowa	1.40	43,090,000
Kansas	.50	59,127,000
Kentucky	1.60	45,917,000
Louisiana	2.10	86,099,000
Maine	.40	29,000,000
Maryland	1.70	165,994,000
Massachusetts	2.30	102,861,000
Michigan	4.30	301,529,000
Minnesota	2.00	72,898,000
Mississippi	1.10	46,885,000
Missouri	1.00	154,579,000
Montana	.40	15,543,000
Nebraska	.30	28,278,000
Nevada	.40	15,434,000
New Hampshire	.20	24,157,000
New Jersey	2.20	258,875,000
New Mexico	.90	22,133,000
New York	6.40	151,934,6000
North Carolina	2.70	147,244,000
North Dakota	.30	22,348,000
Ohio	4.20	27,643,000
Oklahoma	1.00	67,619,000
Oregon	2.10	44,248,000
Pennsylvania	5.10	437,547,000
Rhode Island	.30	21,893,000
South Carolina	.70	66,740,000
South Dakota	.30	13,153,000
Tennessee	2.00	82,951,000
Texas	8.90	211,751,000
Utah	.40	15,124,000
Vermont	.20	10,106,000
Virginia	1.60	137,359,000
Washington	2.50	76,301,000
West Virginia	1.10	26,052,000
Wisconsin	2.20	129,131,000
Wyoming	.40	12,831,000
Mean	.97	120,114,568
Median	.78	62,961,000
Mode	.39	8,859,000
Standard Deviation	.76	220,576,301
Range	4.84	1,510,487,000
Sum	49.41	6,125,843,000

According to Table 16, the mean of the homeless rate in each state is .062 percent. This means that there are about 6.2 homeless persons for every 10,000 people in each state at any given day in 1990. Graph 8 also shows that, in more than 50 percent of 51 states, the homeless rate is less than .06.

Graph 8: Homeless rates in 51 states, 1990



Compared to the homeless rate (.099) in 1996 in table 7 (about 10 homeless persons per 10,000 people at any given

day in 1996), this data shows that the number of homeless population is dramatically growing.

Table 16 also shows that there are an average of 444 persons who have serious mental illness for every 10,000 people and an average of 97 persons per 10,000 people who received substance abuse treatment in each state. I assumed that more persons with mental illness and persons suffering from a substance abuse problem mean a higher homeless rate based on functionalists' perspectives.

However, these expectations have not been supported by the descriptive data shown in Table 16. For example, Georgia has much a lower homeless rate (.02%) than the average, but has the highest rate of estimated 12-month number of persons with serious mental illness, 23.15 percent. And South Carolina has the same homeless rate with Georgia (.02%), but has the highest substance abuse treatment admissions (5.10%). These individual findings contradict the original hypotheses. I will examine these hypotheses more deeply with bivariate and multivariate statistics.

I assumed that more spending on mental illness hospitals or substance abuse clients decrease homelessness. The data shows a significance in the relationship between two indicators; per capita public spending on alcoholism

clients and total expenditures in state and county mental hospitals, and the homeless rate.

Table 16 indicates that New York has the second lowest homeless rate (.02%) and has the highest total expenditure in state and county mental hospitals (\$ 1,519,346,000) and the second highest per capita public spending on alcoholism clients (\$18.86 per clients).

I also hypothesized that a higher shelter rate for abused women may affect a high level of homelessness. However, Table 16 does not support this hypothesis. For example, the District of Columbia has the highest homeless rate and a lower shelter rate for abused women (.40). However, California has the highest shelter rate for abused women, but has only a little higher homeless rate (.1%) than the average (.062%). Also, New Hampshire has the low homeless rate (.03%) and the lowest number of shelters for abused women (.20%). Thus, I cannot say that more shelters for abused women affect a high level of homelessness until more comprehensive statistical analyses examine this hypothesis too.

In brief, univariate analysis shows that there could be a significant relationship between two variables; the spending on mental illness hospitals and substance abuse clients, and homelessness. That is, total expenditures in

state and county mental hospitals and per capita spending on alcoholism clients may decrease homelessness based on univariate statistical analysis of model II. However, I need advanced statistical methodologies to examine the hypotheses which a higher shelter rate for abused women affects homelessness and more mental illness persons and persons suffering from substance abuse problem are related to a higher homeless rate. In univariate statistical analyses, I could not find any close relationships between these variables and the homeless rates.

2) Bivariate Statistical Analysis

- Correlation analysis

In univariate statistical analysis, I found a suggestion that more spending on mental hospitals or substance abuse clients decreases homelessness. Also I needed to examine the hypotheses that a higher shelter rate for abused women increases homelessness and more mental illness persons and persons suffering from substance abuse problem create a higher homeless rate. To examine these hypotheses more deeply, five indicators are used to estimate correlations and simple regression coefficients

between variables in four individual risk factors and homeless rates.

Table 17 shows zero order correlations between five indicators and homeless rates. According to Table 17, only one indicator has a bivariate relationship consistent with the expected direction of the hypotheses. That is, the homeless rate is negatively correlated with total expenditures in state and county mental hospitals. I expected that more spending on mental illness would decrease homelessness. However, a correlation between two variables was almost zero and not statistically significant ($r = -.005$).

The negative correlations of the rate of estimated 12-month number of persons with serious mental illness ($r = -.010$), shelter rate for abused women ($r = -.037$), and substance abuse treatment admission rate ($r = -.161$) on the homeless rate show the opposite direction from the theoretical hypotheses and very weak correlations with the homeless rate. Therefore, they are not statistically significant and meaningless.

A positive correlation of per capita spending on alcoholism clients ($r = .219$ and $p = .061$) is not statistically significant and also contradicts the hypothesis. I expected a more spending on alcoholism

clients decrease homelessness, a negative correlation between this predictor variable and homelessness. I will examine these results in simple and multiple regression analysis.

Table 17: Zero order correlations between five indicators for individual risk factors and homeless rate in 51 states

Five indicators	Homeless rate in 1990, %
Per capita public spending on alcoholism clients, \$, 1989	.219
Substance abuse treatment admission rate, 1991	-.161
Shelter rate for abused women, 1990, %	-.037
The rate of estimated 12-month number of person with serious mental illness, %, 1990	-.010
Total expenditures in state and county mental hospitals, 1986, \$	-.005

- **Bivariate regression analysis**

Table 18 displays the results of simple regression between each predictor variable and the homeless rate. The results show that the relationships between each predictor variable and a criterion variable are statistically

insignificant and meaningless. For example, in Table 18, an indicator of per capita public spending on alcoholism clients on the homeless rate, which has the highest variance in explaining homelessness (4.8 percent of explained variance) among these individual factors, is statistically meaningless (Beta= .219, $t(49) = 1.57$, $p = .123$).

Table 18: Bivariate regression coefficients of 5 individual risk factors on homeless rate in 51 states

	R	R square	Adjusted R	Beta	T	p level
Homeless rate, 1990						
Per capita public spending on alcoholism clients, \$, 1989	.219	.048	.028	.219	1.570	.123
Substance abuse treatment admission rate, 1991	.161	.026	.006	-.161	-1.143	.259
Shelter rate for abused women, 1990, %	.037	.001	-.019	-.037	-.261	.795

Table 18. (Cont.)

The rate of estimated 12-month number of persons with serious mental illness, %, 1990	.010	.000	-.020	-.010	-.072	.943
Total expenditure in state and county mental hospitals, 1986, \$.005	.000	-.020	-.005	-.032	.975

As a result, Table 18 indicates that the relationships between each of the individual risk factors and the homeless rates almost do not exist, thus cannot explain the effects of each individual risk factor on the cause or increase of homelessness with bivariate statistics in model II.

3) Multivariate Statistical Analysis - Multiple regression analysis

Univariate statistical analysis suggested a significant result, in which two variables indicating total expenditure on mental illness hospitals and per capita public spending on alcoholism clients negatively affect

homelessness. This result was theoretically acceptable because I hypothesized that more spending on mental illness hospitals and substance abuse clients decrease homelessness. However, bivariate statistical analyses failed to explain this result. Thus, I concluded that each indicator explaining the cause of homelessness was not a good examiner and there were no relationships between variables in model II.

Table 19: Multiple regression for 5 individual risk factors and the homeless rates in 51 states

Model- II	R	R square	Adjusted R	Standard error of the estimate	F change	Sig. F change
	.256	.065	-.038	.1004	.630	.678

In order to examine the effects of five indicators on homeless rates, multiple regression is used. The multiple regression result of model II (see Table 19) shows that the whole indicators representing individual risk factors are not associated with a high level of homelessness. Adjusted R (-.038) and R square (.065) are negative and very small, so statistically meaningless. In addition, p level is .678; thus this model is not statistically significant. Stepwise

regression analysis (Table 20) is also not meaningful in this p level.

As a result, I can possibly conclude that the data showing individual risk factors in causing homelessness in model II do not have statistically significant relationships with a high level of homelessness.

There are possible answers to explain this result. Firstly, indicators explaining individual risk factors on the cause of homelessness are not good examiners in showing any relationships between variables.

Table 20: Stepwise multiple regression analysis of five predictors with homeless rates in 51 states

Model II	R	R square	R square change	Adjusted R square	Standardized coefficients (Beta)
Step 1: Per capita public spending on alcoholism clients, \$, 1989	.219	.048	.048	.028	.209
Step 2: Per capita public spending on alcoholism clients, \$, 1989 and Substance abuse treatment admission rate, 1991	.249	.062	.014	.023	-.125

Table 20. (Cont.)

Step 3: Per capita public spending on alcoholism clients, \$, 1989, Substance abuse treatment admission rate, 1991, and total expenditures in state and county mental hospitals, 1986, \$.255	.065	.003	.005	-.067
Step 4: Per capita public spending on alcoholism clients, \$, 1989, Substance abuse treatment admission rate, 1991, total expenditures in state and county mental hospitals, 1986, and shelter rate for abused women, 1990, %	.255	.065	.000	-.016	.020

Table 20. (Cont.)

Step 5:	.256	.065	.000	-.038	.013
Per capita public spending on alcoholism clients, \$, 1989, Substance abuse treatment admission rate, 1991, total expenditures in state and county mental hospitals, 1986, and shelter rate for abused women, 1990, %, and estimated 12-month number of persons with serious mental illness, %, 1990					

a Predictors: (Constant), per capita public spending on alcoholism clients, state, 1989

b Predictors: (Constant), per capita public spending on alcoholism clients, state, 1989, substance abuse treatment admission rate, state, %, 1991

c Predictors: (Constant), per capita public spending on alcoholism clients, state, 1989, substance abuse treatment admission rate, state, %, 1991, total expenditures, state and county mental hospitals, \$, 1986

d Predictors: (Constant), per capita public spending on alcoholism clients, state, 1989, substance abuse treatment admission rate, state, %, 1991, total expenditures, state and county mental hospitals, \$, 1986, shelter rate for abused women, 1990 %

e Predictors: (Constant), per capita public spending on alcoholism clients, state, 1989, substance abuse treatment admission rate, state, %, 1991, total expenditures, state and county mental hospitals, \$, 1986, shelter rate for abused women, 1990 %, estimated number of serious mental illness, state, %, divided by state population, 1990

It is possible that there are more accurate examiners to show a closer relationship between variables than the

five indicators used in model II. Secondly, as the results of this model show, the individual risk factors may be not directly associated with a high level of homelessness. This second assumption is also a possibility. Thirdly, it is also possible that the individual risk factors will be related to homelessness only if societal/structural risk factors causing homelessness are analyzed together with the same model. In this circumstance, the individual risk factors may explain some relationships with the homeless rate. In order to examine this third possibility, I need another model, model III. I will include individual and structural/societal risk factors at the same model to examine the relationship to the rate of homelessness in 51 states.

As a result, in model II, five indicators come from four individual risk factors causing homelessness failed to show significant correlations with a high level of homelessness. Also, multiple regression analysis showed that homelessness is not properly explained by five indicators; thus the result of this model II is statistically insignificant. Based on the result of the study in model II, I believe that individual efforts of the homeless subjects and services that focus only on improving

individual deficits will be largely insufficient to resolve their homeless problems.

9. The findings: Model III

1) Univariate Statistical Analysis

In model III, I used the same data of model II for a criterion variable, dependent variable, and five indicators for individual risk factors. In order to examine the risk factors including individual and societal/structural factors on the rate of homeless, I will apply six indicators showing structural/societal risk factors on homelessness to model II: the rate of renter occupied housing units renting at \$300 or below, poverty rate, the number of female householder families without workers below poverty level, unemployment rate, SSI recipient rate, and AFDC recipient rate in each state, 1990. Finally, in model III, I will analyze eleven risk factors including 5 individual indicators used in model II and six structural/societal indicators on homelessness in 51 states.

Table 21 displays the data for each state and their frequency distributions; mean, median, mode, standard deviation, range, and sum of the data.

Table 21: Data for societal/structural risk factors and homeless rate in 51 states

51 states	Homeless rate, state, 1990	Poverty rate, state, 1990 (%)	Unemployment rate, state, 1990, (%)	SSI recipient rate, 1990, (%)
Alabama	.03	19.20	6.90	3.30
Alaska	.07	11.40	7.00	.90
Arizona	.07	13.70	5.50	1.20
Arkansas	.02	19.60	7.00	3.20
California	.10	13.90	5.80	2.80
Colorado	.07	13.70	5.00	1.10
Connecticut	.12	6.00	5.20	.90
Delaware	.05	6.90	5.20	1.20
District of Columbia	.73	21.10	6.60	2.60
Florida	.10	14.40	6.00	1.70
Georgia	.03	15.80	5.50	2.40
Hawaii	.07	11.00	2.90	1.30
Idaho	.04	14.90	5.90	1.00
Illinois	.06	13.70	6.20	1.50
Indiana	.03	13.00	5.30	1.10
Iowa	.03	10.40	4.30	1.20
Kansas	.03	10.30	4.50	1.00
Kentucky	.03	17.30	5.90	3.10
Louisiana	.03	23.60	6.30	3.10
Maine	.03	13.10	5.20	1.90
Maryland	.05	9.90	4.70	1.20
Massachusetts	.10	10.70	6.00	2.00
Michigan	.04	14.30	7.60	1.50
Minnesota	.05	12.00	4.90	.90
Mississippi	.01	25.70	7.60	4.40
Missouri	.04	13.40	5.80	1.60
Montana	.05	16.30	6.00	1.30
Nebraska	.05	10.30	2.20	1.00
Nevada	.08	9.80	4.90	1.00
New Hampshire	.03	6.30	5.70	.60
New Jersey	.09	9.20	5.10	1.30
New Mexico	.04	20.90	6.50	2.00
New York	.02	14.30	5.30	2.20

North Carolina	.04	13.00	4.20	2.20
North Dakota	.04	13.70	4.00	1.30
Ohio	.04	11.50	5.70	1.40
Oklahoma	.06	15.60	5.70	1.90
Oregon	.11	9.20	5.60	1.10
Pennsylvania	.07	11.00	5.40	1.60
Rhode Island	.04	7.50	6.80	1.70
South Carolina	.02	16.20	4.80	2.60
South Dakota	.05	13.30	3.90	1.40
Tennessee	.03	16.90	5.30	2.80
Texas	.04	15.90	6.30	1.70
Utah	.05	8.20	4.30	.70
Vermont	.04	10.90	5.00	1.80
Virginia	.04	11.10	4.30	1.50
Washington	.09	8.90	4.90	1.20
West Virginia	.02	18.10	8.40	2.60
Wisconsin	.03	9.30	4.40	1.70
Wyoming	.03	11.00	5.50	.70
Mean	0.06	13.28	5.47	1.71
Median	0.04	13.10	5.50	1.5
Mode	.03	13.70	4.30	1.2
Standard Deviation	9.84	4.27	1.13	.81
Range	.72	19.70	6.20	3.80
Sum	3.21	677.40	279.00	87.40

Table 21: Data for societal/structural risk factors and homeless rate in 51 states (Cont.)

51 states	AFDC recipient rate, state, 1990, (%)	The rate of renter occupied housing units renting at \$300 or below, state, 1990, (%)	The number of female householder families below poverty level
Alabama	3.30	10.11	79,510
Alaska	4.40	2.50	4,238
Arizona	4.00	4.31	43,657
Arkansas	3.10	9.63	39,345
California	6.80	2.99	304,579
Colorado	3.30	6.75	36,245
Connecticut	4.10	3.99	29,634
Delaware	3.30	3.60	6,250
District of Columbia	8.90	9.24	12,164
Florida	3.20	3.84	151,639
Georgia	4.90	7.48	110,893

Hawaii	4.00	4.25	6,937
Idaho	1.70	9.31	9,242
Illinois	5.70	6.38	150,913
Indiana	3.00	7.41	62,068
Iowa	3.50	9.32	27,404
Kansas	3.10	8.34	24,327
Kentucky	5.50	10.42	60,887
Louisiana	6.60	9.54	114,006
Maine	5.00	5.05	12,745
Maryland	4.10	4.08	47,808
Massachusetts	4.70	6.33	64,764
Michigan	7.40	5.89	155,142
Minnesota	4.00	5.91	39,519
Mississippi	6.80	10.27	71,668
Missouri	4.30	8.31	63,941
Montana	3.60	11.21	10,270
Nebraska	2.80	9.75	14,508
Nevada	2.10	3.84	10,683
New Hampshire	1.90	2.93	5,860
New Jersey	4.20	3.45	67,594
New Mexico	4.40	7.43	25,502
New York	5.70	7.26	271,681
North Carolina	3.80	7.28	93,929
North Dakota	2.50	11.75	6,527
Ohio	6.10	8.13	157,143
Oklahoma	4.10	9.19	46,243
Oregon	3.50	6.93	29,786
Pennsylvania	4.60	6.70	137,239
Rhode Island	5.20	7.23	11,061
South Carolina	3.40	7.36	61,878
South Dakota	2.70	12.18	7,739
Tennessee	4.70	9.29	78,055
Texas	4.00	7.48	241,700
Utah	2.70	7.31	14,210
Vermont	4.40	4.01	5,029
Virginia	2.60	5.02	66,480
Washington	4.90	6.03	51,193
West Virginia	6.10	9.26	28,203
Wisconsin	4.80	6.59	53,139
Wyoming	3.50	9.48	5,024
Mean	4.25	7.10	63,337
Median	4.10	7.28	43,657
Mode	4.00	2.50	4,238
Standard Deviation	1.50	2.50	68,745
Range	7.20	9.68	300,341
Sum	217.00	362.29	3,230,201

Because I have already pointed out the consequences of individual risk factors on homeless rates in model II, I will focus on the relationship between structural/societal risk factors and homeless rates here.

Table 21 shows that the average percent of renter occupied housing units renting at \$300 or below to total housing units in each state is 7.10. This means that over 92 percent of total housing units are renting for over \$300 per month in each state. I hypothesized that more housing units for the poor resulted in a smaller homeless rate. However, this expectation is not well supported by the data. The District of Columbia, showing the highest homeless rate (.73%), has a higher percent of renter occupied housing units (9.24%) for the poor.

The poverty rate contradicts the hypothesis. I assumed that a higher poverty rate means a higher homeless rate. However, Mississippi and Louisiana, with the lowest homeless rate (.01%) in Mississippi and low homeless rate (.03%) in Louisiana, have the highest poverty rate (25.70%) and the second highest poverty rate (23.60%) respectively. The number of female householder families below poverty level also contradicts my assumption that a more number of female householder families below poverty level in each state may increase homelessness. New York, the second

highest number of female householder families below poverty level (271,681), has a lower homeless rate (.02). And the District of Columbia, the highest homeless rate, has a lower number of female householder families below poverty level (12,164).

I also hypothesized that a higher unemployment rate resulted in a higher homeless rate. However, Table 21 shows that the unemployment rate may not be related to homelessness because West Virginia, with the second lowest homeless rate (.02%), has the highest unemployment rate (8.40%). Nebraska has the lowest unemployment rate (2.20%) but just a little lower homeless rate (.05%) than the average (.06%).

I also expected that more welfare beneficiaries mean a lower homeless rate because cash assistance from welfare programs represent a major income source that may help welfare families or individuals avoid homelessness. However, the real value of welfare benefits decrease every year. In 1985, AFDC benefits declined to 63% of their 1968 value (Rossi, 1989). Some AFDC beneficiaries cannot even pay their rent with their entire benefits. Based on 1994 fair market rents (FMR), the FMR for two bedrooms is higher than the entire maximum AFDC grant for a family with 2 children in every state except Alaska (Dolbeare, 1996).

Therefore, the recipients cannot pay their increasing rent with their benefits, or, after paying rent, they cannot save money for their living expenses such as clothing, food, medicine, education, and so on. As a result, they may leave their housing and move to their friends or relatives' house and, if they consume all their personal resources, then they may become homeless.

Table 21 shows that the District of Columbia, with the highest homeless rate (.73), had the highest number of AFDC recipients (8.90) in 1990. Therefore, I assume that the number of AFDC recipients may be related to homelessness. However, Mississippi has the lowest homeless rate (.01) and the highest SSI recipients (4.40). This result shows that I need more comprehensive researches to examine the relationships between the number of SSI beneficiaries and the homeless rates. With bivariate and multivariate statistics, I will examine this result more deeply.

Univariate statistical analysis shows that poverty rate, the number of female householder families below poverty level, unemployment rate, and the rate of renter occupied housing units for the poor may be not related to a high level of homelessness. On the other hand, the number of AFDC recipients is associated with a high level of

homelessness, but the number of SSI recipients is not related to homelessness in univariate analysis. Thus, more advanced statistical analyses to examine the relationships between these societal/structural indicators, especially the number of welfare beneficiaries, and homeless rates are needed.

2) Bivariate Statistical Analysis

- Correlation analysis

Table 22 presents correlation coefficients between each independent variable and homeless rates. Some variables hypothesized to bear strong relationships appear to do so, and some of them do not. Correlation coefficients below + or - .20 show no significant correlation between variables. A total of eleven indicators are used to estimate correlations in four major societal/structural risk factors and four individual risk factors: poverty rate, the number of female householder families without workers below poverty level, unemployment rate, the rate of renter occupied housing units renting \$300 or below, SSI recipient rate, AFDC recipient rate, the rate of estimated 12-month number of persons with serious mental illness, substance abuse treatment admission rate, total

expenditures by state and county mental hospitals, per capita public spending on alcoholism clients, and shelter rate for abused women.

In the univariate analysis, the District of Columbia (the highest homeless rate, 0.73) had the highest AFDC recipients (8.90) in 1990. However, Mississippi has the lowest homeless rate and the highest SSI recipients. Thus, I needed more comprehensive statistical methodologies to examine the relationships between the number of welfare beneficiaries and homeless rates.

According to table 22, four of eleven indicators for independent variables have bivariate relationships consistent with the hypotheses. The homeless rate is negatively correlated with total expenditures in state and county mental hospitals and renter occupied housing units renting at \$300 or below.

I assumed that more expenditures on state and county mental hospitals resulted in less homeless people. Also, I hypothesized that more renter occupied housing units for the poor decrease the homeless rate. However, correlation coefficients of two indicators with homeless rates are not statistically significant (total expenditures in state and county mental hospitals, $r = -.005$, and renter occupied housing units renting \$300 or below, $r = -.017$).

Therefore, they do not have correlations with the homeless rate.

Table 22: Zero order correlations between 11 indicators and homeless rate in 51 states

Societal/structural and individual indicators	Homeless rate
AFDC recipient rate	.420*
Per capita spending on alcoholism clients	.219
Poverty rate	.140
Unemployment rate	.101
SSI recipient rate	.054
Substance abuse treatment admission rate	-.161
The number of female householder families below poverty level	-.090
Shelter rate for abused women	-.037
The rate of renter occupied units renting at \$300 or below	-.017
The rate of estimated number of mental illness	-.010
Total expenditures state and county mental hospital	-.005

*. Correlation is significant at the 0.01 level (1-tailed).

The homeless rate is positively correlated with the poverty rate ($r = .140$), the unemployment rate ($r = .101$), AFDC recipient rate ($r = .420$), and SSI recipient rate ($r = .054$). Among these indicators, only AFDC recipient rate is

correlated with the homeless rate and statistically significant even though I assumed that more AFDC people decrease homelessness.

The negative correlation coefficients of the shelter rate for abused women ($r = -.037$) and the number of female householder families below poverty level ($r = -.090$) are almost zero and contradict the hypotheses, thus statistically insignificant. I assumed that a higher shelter rate for abused women is related to a higher homeless rate and a more female householder family below poverty level means a high level of homelessness. Per capita public spending on alcoholism clients ($r = .219$ and $p = .061$), the rate of estimated number of mental illness ($r = -.005$), and substance abuse treatment admission rate ($r = -.161$) also contradict our expectations, and statistically there are very weak correlations with homeless rates.

- Bivariate regression analysis

According to Table 23, R square of AFDC recipients rate on the homeless rate is .177 and $p = .002$. Thus, 17.7 percent of the variation in homelessness is explained by AFDC recipient rate in each state, when not controlled by

other variables. However, the rest of the indicators are not statistically significant in simple regression analysis. For example, R square of per capita spending on alcoholism clients on homeless rate is .048 and p level is .123.

As a result, bivariate regression analysis shows the same result with the correlation analysis: that more AFDC recipients have more homeless people in each state.

Table 23: Bivariate regression coefficients of individual and structural/societal risk factors on the homeless rate in 51 states

	R	R square	Adjusted R	Beta	t	p level
AFDC recipient rate	.420	.177	.160	.420	3.243	.002
Per capita spending on alcoholism clients	.219	.048	.028	.219	1.570	.123
Substance abuse treatment admission rate	.161	.026	.006	-.161	-1.143	.259
Poverty rate	.140	.020	.000	.140	.989	.328
Unemployment rate	.101	.010	-.010	.101	.711	.480

Table 23. (Cont.)

The number of female householder families below poverty level	.090	.008	-.012	-.090	-.633	.530
SSI Recipient rate	.054	.003	-.017	.054	.382	.704
Shelter rate for abused women	.037	.001	-.019	-.037	-.261	.795
The rate of renter occupied units renting at \$300 or below	.017	.000	-.020	-.017	-.122	.903
The rate of estimated 12-month number of person in mental illness	.010	.000	-.020	-.010	-.072	.943
Total expenditures state and county mental hospital	.005	.000	-.020	-.005	-.032	.975

In brief, the results of bivariate regression (simple regression) show that only AFDC recipient rate is correlated with homeless rates and statistically significant.

However, the results of bivariate regression analysis also indicate that the rest of the ten variables on the homeless rate are not statistically significant and thus meaningless in this model.

3) Multivariate Statistical Analysis- Multiple regression analysis

In bivariate statistical analysis, I found the fact that the number of AFDC recipients (AFDC recipient rate) was closely related to a high level of homelessness in each state. The bivariate statistics showed that the AFDC recipient rate among the individual and societal/structural risk factors is significantly associated with the homeless rate. The correlation coefficient of AFDC recipients on the homeless rate was .420. The regression coefficient was also statistically significant for the variable. This suggests that the increasing number of AFDC recipients with low welfare benefits seriously affects homelessness. The significance of the rate of AFDC recipients in explaining homelessness suggests that decreased or lost AFDC benefits force welfare people into homelessness and that the social safety net aids the poor in avoiding or preventing homelessness.

In order to verify the results of bivariate analysis, I use multiple regression analysis. In multivariate analysis, I will estimate the effects of individual and structural/societal risk factors on homelessness and the changes of each variable with respect to another.

I will conduct multiple regression with ten predictor variables explaining the cause of homelessness and a criterion variable because of multicollinearity problem. Tolerance statistics and VIF of the shelter rate for abused women are .054 and 18.633 respectively. Also correlation coefficient between the shelter rate for abused women and the number of female householder families below poverty level is .939. As a result, for multiple regression analysis of model III, I eliminate one indicator, shelter rate for abused women, and then finally conduct the regression with only ten indicators. In order to avoid multicollinearity problem, 10 predictor variables are also examined. Table 24 shows tolerance statistics and VIF. According to Table 24, multicollinearity is not a problem among ten predictor variables.

Among the ten variables, four variables indicate individual risk factors; the rate of estimated 12-month numbers of persons with serious mental illness, total expenditure in state and county mental hospitals, per

capita spending on alcoholism clients, and substance abuse treatment admission rate. The others six variables indicate structural/societal risk factors, poverty rate, the number of female householder families below poverty level, unemployment rate, the rate of renter occupied housing units renting at \$300 or below, and the rate of SSI and AFDC recipients.

Table 24: Collinearity Statistics in 10 structural/societal and individual predictor variables in 51 states

<u>10 predictor variables</u>	<u>Tolerance</u>	<u>VIF</u>
AFDC recipient rate	.517	1.935
Per capita spending on alcoholism clients	.667	1.498
Substance abuse treatment admission rate	.803	1.246
Poverty rate	.247	4.048
The number of female householder families below poverty level	.361	2.770
Unemployment rate	.551	1.814
SSI recipient rate	.283	3.531
The rate of renter occupied units renting at \$300 or below	.539	1.856
The rate of estimated 12-month number of person in mental illness	.956	1.046
Total expenditures state and county mental hospital	.423	2.363

The regression in Table 25 yields an F statistic of 2.188, which is statistically significant at $p = .039$. The regression also shows that R square is .354 and adjusted R square is .192.

Table 25: Multiple regression for ten individual and structural/societal indicators and the homeless rate in 51 states

Model III	R	R square	Adjusted R	Standard error of the estimate	F	Sig. F change	Total df
	.595	.354	.192	8.852E-02	2.188	.039	50

a Predictors: (Constant), SSI recipient rate, state, 1990, %, substance abuse treatment admissions, state, %, 1991, the rate of estimated number of serious mental illness, state, %, divided by state population, 1990, the rate of renter occupied units below \$300, 1990, total expenditures, state and county mental hospitals, \$, 1986, per capita public spending on alcoholism clients, state, 1989, unemployment rate, %, 1990, the number of female householder families below poverty level, 1990, persons below poverty level, %, 1990, AFDC recipients, %, 1990

That is, model III indicates that the overall model of ten independent variables significantly predicts homelessness, R square = .354, adjusted R square = .192, $F(10, 40) = 2.18$, $p = .039$. The R square (.354) means that this model accounts for 35.4 percent of variance in homelessness. Thus, 35.4 percent of the homeless population are explained by individual and societal/structural risk factors including ten predictor variables. The R square also explains that this model cannot account for 64.6 percent of the variance in homelessness. Other risk

factors, which are not mentioned in this model, are obviously needed to explain the cause of homelessness.

Table 26: Multiple regression coefficients of homelessness rate on 10 indicators in 51 states

	Standardized coefficients (Beta)	Unstandardize d coefficients (B)	Standard error	t	Sig. *
Homeless rate (constant)		1.244E-02	.087	.143	.887
AFDC recipient rate	.654	4.411E-02	.012	3.698	.001
Poverty rate	.401	9.242E-03	.006	1.567	.125
Total expenditure state and county mental hospital	.049	2.176E-11	.000	.249	.804
Per capita spending on alcoholism clients	.020	3.534E-04	.003	.129	.898
The rate of estimated 12-month number of person in mental illness	.005	1.780E-04	.005	.038	.970
The number of female householder families below poverty level	-.349	-5.000E-07	.000	- 1.650	.107

Table 26. (Cont.)

SSI recipient rate	-.302	-3.693E-02	.029	- 1.266	.213
Unemployment rate	-.221	-1.913E-02	.015	- 1.290	.204
The rate of renter occupied units renting at \$300 or below	-.174	-6.861E-03	.007	- 1.007	.320
Substance abuse treatment admission rate	-.142	-1.835E-02	.018	- 1.000	.323

Dependent variable: Homeless rate in 51 states, 1990

* $P < .05$ or $P < .01$ (1 tailed)

Table 26 displays that the AFDC recipient rate is strongly associated with higher homeless rate because the standardized coefficient (Beta) for AFDC recipients rate is .654. The unstandardized coefficients for the variables further demonstrate their substantive importance concerning the homeless rate. A modest one percent increase in the AFDC recipients rate would increase the homeless rate by 0.044 percent. That is, a one percent increase in AFDC recipients rate creates an increase of 4.4 homeless persons for every 10,000 people in each state. Standard error of the AFDC recipient rate (.012) closes to 0 point and p-

level of the rate of AFDC recipients is .001. According to Table 26, only the AFDC recipient rate is statistically significant or contributed to model III, AFDC recipient rate Beta = .654, $t(40) = 3.698$, $p = .001$, 1-tailed.

Table 27, stepwise multiple regression analysis of ten predictors with the homeless rates in 51 states, shows a rank ordering of ten risk factors' impact on the homeless rate. The stepwise procedure defines an order based on the relative uniqueness of the variables in the sample at hand. The most highly correlated with the homeless rate in Table 25 is the AFDC recipient rate. The R square of the AFDC recipient rate on homelessness is .177, thus 17.7 percent of the variance in homelessness are explained by the number of AFDC recipients in each state. The increase of the R square change for each new variable extends the variance in homelessness. 8.9 percent of variance in homelessness are associated with the number of female householder families below poverty level (R square change = .089). The SSI recipient rate in each state accounts for 2.6 percent of the variance in homelessness (R square change = .026).

Substance abuse treatment admission rate (R square change = .012), unemployment rate (R square change = .015), per capita public spending on alcoholism clients (R square change = .000), poverty rate (R square change = .015),

Table 27: Stepwise multiple regression analysis of 10 indicators on homeless rate in 51 states

Model III	R	R square	Adjusted R square	R square change	Beta
Step 1: AFDC recipient rate	.420 a	.177	.160	.177	.654
Step 2: AFDC recipient rate and the number of female householder families below poverty level	.516 b	.266	.235	.089	-.185
Step 3: AFDC recipient rate, the number of female householder families below poverty level, and SSI recipient rate	.540 c	.292	.247	.026	-.302
Step 4: AFDC recipient rate, the number of female householder families below poverty level, SSI recipient rate, and Poverty rate	.554 d	.307	.247	.015	.401

Table 27. (Cont.)

Step 5: AFDC recipient rate, the number of female householder families below poverty level, SSI recipient rate, Poverty rate, and Unemployment rate	.568 e	.322	.247	.015	-.221
Step 6: AFDC recipients rate, the number of female householder families below poverty level, SSI recipient rate, Poverty rate, Unemployment rate, and Substance abuse treatment admission rate	.578 f	.334	.243	.012	-.142
Step 7: AFDC recipient rate, the number of female householder families below poverty level, SSI recipient rate, Poverty rate, Unemployment rate, Substance abuse treatment admission rate, and the rate renter occupied housing units renting at \$300 or below	.593 g	.352	.246	.018	-.174

Table 27. (Cont.)

Step 8: AFDC recipient rate, the number of female householder families below poverty level, SSI recipient rate, Poverty rate, Unemployment rate, Substance abuse treatment admission rate, the rate of renter occupied housing units renting at \$300 or below, and Total expenditures in state and county mental hospitals	.594 h	.523	.230	.002	.049
Step 9: AFDC recipient rate, the number of female householder families below poverty level, SSI recipient rate, Poverty rate, Unemployment rate, Substance abuse treatment admission rate, the rate of renter occupied housing units renting at \$300 or below, Total expenditures in state and county mental hospitals and per capita public spending on alcoholism clients	.595 I	.354	.212	.000	.020

Table 27. (Cont.)

Step 10:	.595 j	.354	.192	.000	.005
AFDC recipient rate, the number of female householder families below poverty level, SSI recipient rate, Poverty rate, Unemployment rate, Substance abuse treatment admission rate, the rate of renter occupied housing units renting at \$300 or below, Total expenditures in state and county mental hospitals and per capita public spending on alcoholism clients, and the rate of estimated 12-month number of person in serious mental illness					

a Predictors: (Constant), AFDC recipients, %, 1990

b Predictors: (Constant), AFDC recipients, %, 1990, the number of female householder families below poverty level, 1990

c Predictors: (Constant), AFDC recipients, %, 1990, the number of female householder families below poverty level, 1990, SSI recipients in 1990, %

d Predictors: (Constant), AFDC recipients, %, 1990, the number of female householder families below poverty level, 1990, SSI recipients in 1990, %, persons below poverty level, %, 1990

e Predictors: (Constant), AFDC recipients, %, 1990, the number of female householder families below poverty level, 1990, SSI recipients in 1990, %, persons below poverty level, %, 1990, unemployment rate, %, 1990

f Predictors: (Constant), AFDC recipients, %, 1990, the number of female householder families below poverty level, 1990, SSI recipients in 1990, %, persons below poverty level, %, 1990, unemployment rate, %, 1990, substance abuse treatment admissions, state, %, 1991

g Predictors: (Constant), AFDC recipients, %, 1990, the number of female householder families below poverty level, 1990, SSI recipients in 1990, %, persons below poverty level, %, 1990, unemployment rate, %, 1990, substance abuse treatment admissions, state, %, 1991, renter occupied units below \$300, 1990

h Predictors: (Constant), AFDC recipients, %, 1990, the number of female householder families below poverty level, 1990, SSI recipients in 1990, %, persons below poverty level, %, 1990, unemployment rate, %, 1990, substance abuse treatment admissions, state, %, 1991, renter occupied units below \$300, 1990, total expenditures, state and county mental hospitals, \$, 1986

i Predictors: (Constant), AFDC recipients, %, 1990, the number of female householder families below poverty level, 1990, SSI recipients in 1990, %, persons below poverty level, %, 1990, unemployment rate, %, 1990, substance abuse treatment admissions, state, %, 1991, renter occupied units below \$300, 1990, total expenditures, state and county mental hospitals, \$, 1986, per capita public spending on alcoholism clients, state, 1989,

j Predictors: (Constant), AFDC recipients, %, 1990, the number of female householder families below poverty level, 1990, SSI recipients in 1990, %, persons below poverty level, %, 1990, unemployment rate, %, 1990, substance abuse treatment admissions, state, %, 1991, renter occupied units below \$300, 1990, total expenditures, state and county mental hospitals, \$, 1986, per capita public spending on alcoholism clients, state, 1989, estimated number of serious mental illness, state, %, divided by state population, 1990

the rate of estimated number of serious mental illness divided by state population, (R square change = .000), the rate of renter occupied units below \$300 (R square change = .018), and total expenditures in state and county mental hospitals (R square change = .002) affect homelessness with a total of 6.2 percent of the variance.

As a result, a multivariate analysis shows that, among ten independent variables, the AFDC recipient rate is strongly associated with the homeless rate. That is, the increasing number of AFDC recipients is a major risk factor for homelessness because of the low level of their benefits. Thus, the increasing number of AFDC recipients related to low level of benefits is a major social problem strongly affecting the cause or increase of homelessness among ten individual and structural/societal risk factors of becoming homelessness in this model III.

V. Discussion and Policy Implications

This study resulted in the analysis of three multiple regression models showing that structural/societal risk factors, most notably poverty rates, are strongly associated with the homeless rate in model I. Individual risk factors explaining the cause of homelessness do not have a high level of correlation with homelessness and do not affect homelessness in model II. Among ten indicators including individual and societal/structural risk factors, the number of AFDC recipients (AFDC recipient rate) is highly correlated and associated with a high level of homelessness in model III.

The significance of this regression study is to examine the dynamic relationships between the risk factors and homelessness. The most important finding of this study shows that individual risk factors explaining the cause or increase of homelessness can be explained only in the model III in which structural/societal risk factors are included. That is, in model II, five indicators representing individual risk factors including mental illness, alcohol and drug abuse, and family violence are not statistically significant and are not good examiners for explaining a high level of homelessness. The analysis failed to prove

any significance of individual risk factors causing homelessness. Model II failed to show any statistical significant relationships and explained less than four percent of the variance in homelessness (R square = .065, Adjusted R square = .038, $F(5, 45) = .630$, and $p = .678$). Thus, individual risk factors including mental illness, substance abuse, and family violence did not explain a high level of homelessness in model II.

The results of model III also indicate that individual vulnerabilities or deficits such as mental illness, and drugs or alcohol addictions rank lowest among the rankings of the risk factors when individual and societal/structural factors for becoming homelessness are included in the analysis. Among the ten variables in model III, individual risk factors were the rate of estimated 12-month numbers of persons with serious mental illness, total expenditure in state and county mental hospitals, per capita spending on alcoholism clients, and substance abuse treatment admission rate. And six variables indicating structural/societal risk factors were poverty rate, the number of female householder families below poverty level, unemployment rate, the rate of renter occupied housing units renting at \$300 or below, and the rate of SSI and AFDC recipients.

Four indicators representing individual risk factors account for a total of only 1.4 percent (see Table 27) of the variation in homelessness. When ten indicators including six structural/societal and four individual risk factors are examined in the model III, they explain 35.4 percent of the variation in homelessness.

This result suggests that the individual risk factors are not the major risk factors. Individual factors are the secondary or casual risk factors in becoming homelessness. The data seem to support the conclusions of conflict theorists. The conflict theorists argue that individual risk factors such as substance abuse, mental illness, or family disorganization are not the main reasons but rather secondary factors explaining homelessness. They agree that individual risk factors are the casual or secondary factors that reduce earning capacity and lead to downward mobility, cognitive impairment, and disruptive or bizarre behavior that strains the tolerance of their families and friends. Therefore, for conflict theorists, individual risk factors as the secondary factors affect the inferior living conditions of the poor people or extend the duration of a person or family's homelessness in areas where there are high rates of poverty.

The findings of this study strongly show that individual and structural/societal risk factors are interrelated with each other. In order to understand consequences of homelessness which is a multifaceted problem in our society, individual risk factors explaining homelessness will need to be examined or analyzed at multiple levels: individual, social, and economic. Because individual risk factors are only meaningful when examined together with social and economic surroundings. Therefore, understanding or explaining the cause or increase of homelessness, it is important to recognize the relationship of homeless people in their individual, social, and economic context because homeless problems are generated by the transactions between people and their social and economic environments.

This approach is closely related to ecological perspective in social work practice. In terms of social work practice, social workers working with homeless people substantially need to recognize: formal and informal networks surrounding homeless people, their own capacities, and societal systems, including available resources to solve their problems. Furthermore, social workers identify the unavailable resources for the homeless, demand them to the local and federal government, and underlie

societal/structural environments surrounding homeless people.

That is, the main aim of social workers in the field of homelessness is to strengthen the adaptive capacities of homeless people, to build new connections between homeless people and resource systems, and to influence their environments so that transactions are more adaptive. For this purpose, social workers should focus not only on the particular characteristics of homeless people, but also on the root causes of homelessness such as permanent poverty, economic conditions, a low level of welfare benefits, or the lack of affordable housing units drawn from societal/structural bases. Only emphasis on the ability of individuals underestimates the consequences of homelessness in our complex society. Based on this approach, social workers can improve interaction between homeless people and resource systems and help policy makers develop and change homeless policy with giving practical help to homeless people.

A family safety net including relatives, friends, parents can function as a risk or preventive factor in becoming homelessness or not. In this study, I could not examine the dynamic relationship of a lack of a family safety net and homelessness because there is no nationwide

data at this particular time. So this is left as a future study goal. Also other possible risk factors, which are not mentioned in this study, based on the theoretical backgrounds, including individual and structural/societal factors, are obviously needed to explain more concrete reasons for becoming homelessness. This is also a future goal for the next homeless study that can be conducted in certain localities.

Functionalists believe that the presence or absence of a family safety net is not only a major risk factor but also a protective factor in becoming homelessness. On the other hand, conflict theorists argue that a family safety net is a just temporary remedy. Prior studies (McChesney, 1992; Belle, 1990 and 1982; Stack, 1974) indicated that the lack of the family support networks is associated with a high level of homelessness. Bassuk et al. (1997) yielded consistent results. They conducted a case control study with 220 homeless mothers and 216 low-income housed mothers in Massachusetts. They used a multivariate logistic regression analysis in the study and indicated that homeless women had fewer network members, and their relationships were more conflicted. However, an empirical study (Shinn, Knickman, Weitzman, 1991) indicated that homeless mothers have more family support networks than

housed mothers. Shinn, Knickman, and Weitzman (1991) conducted a case control study with 677 mothers in families requesting shelter and 495 mothers in housed families in New York City.

Of course, society needs to give a social safety net. This study suggests that social safety net surely functions as a protective factor to prevent people from becoming homeless or a risk factor to force people to becoming homeless because poverty and the number of AFDC recipients with the low level of benefits have significant correlations with a high level of homelessness in model I and III.

According to the general buffering theory of social safety net, if people receive social support during the process of becoming homeless their levels of strain would be reduced (Cohen and Wills, 1985). Lazarus and Folkman (1984) also indicate that this buffering effect would only occur if the social support received increased people's resources for coping with stressful event. That is, the buffering effect of social safety net only reduces people's levels of strain if the resources provided are closely linked to the specific need elicited by a stressful event. Therefore, the social safety net must match the needs of people in order to reduce their problems. This provides a

possible answer why homeless families are increasing every year even they are on TANF program.

The findings of this study show that homelessness is just around the corner of poverty. We cannot prevent or protect the poor people or families from becoming homelessness without social safety net providing proper poverty related programs or policies. According to Rossi (1989), poverty is the pool where homelessness comes from and a major root of it. He said that the extremely poor constitute the pool from which the homeless are drawn; those who are at risk of becoming homeless and from time to time find themselves in that condition. Therefore, according to him, extreme poverty is at the root of both literal homelessness and being precariously housed. Census data showed that, between 1978 and 1993, the number of poor people grew from 24.4 million to 39.2 million, an increase of over 60 percent, and poverty rate increased from about 12 percent to 15 percent at the same period (U.S. Census Bureau, 1999).

Model I shows that among the structural/societal risk factors causing homelessness, poverty is the most crucial factor affecting a high level of homelessness. The poverty rate is closely related to homelessness at a statistically significant level and explain almost 25 percent of

homelessness ($R = .491$, $R \text{ square} = .241$, $Beta = .637$, and $p = .002$). These results are quiet staggering. According to the results of model I, one percent increases in the poverty rate increase 1.9 homeless persons for every 10,000 people in 52 metropolitan areas.

Model III also supports the result of model I. According to model III, two indicators measuring poverty, poverty rate (the person below poverty level) and the number of female-headed households below poverty level explain 10.4 percent ($R \text{ square} = .104$) of the variation in homelessness. Therefore, two poverty related indicators impact on homelessness by 10.4 percent in model III (see Table 27).

However, in model III, the number of female-headed households below poverty level had a higher $R \text{ square}$ change (.089) than that (.015) of the poverty rate. This result has two possible answers. First, like the unemployment rate, the poverty rate is also a broad indicator for showing the poor people likely to becoming homeless. It is possible that the variation in the total number of individuals below poverty level is weakly or not related to aggregate variation in homelessness in state levels. Thus, if possible, we need more specific indicators such as the number of female households without workers below poverty

level, the number of poor people without a high school diploma or the number of poor people with poor physical or mental health or with a lack of family support networks in order to examine the dynamic relationship between poverty and homelessness in broad areas like the state level.

Second, the increasing number of female-headed families may be directly impact on a high level of homelessness. Since 1980s, the female-headed family has grown as a major group of homelessness. According to the U.S. Conference of Mayors (2001), homeless families are 40 percent of homeless people in 2001. Among the homeless families, the number of single headed homeless families, especially female-headed families under poverty level, has also dramatically increased. In 1997, among 35.6 million people lived below the official government poverty level, more than half of the poor families were female-headed households (The Bureau of the Census, 1998). Therefore, the number of female householder families without workers below poverty level will be a good predictor to show the relationship between poverty and homelessness in the 1990s.

Finally, I found that a number of AFDC recipients in 51 states are closely related to the homeless rates. The increasing number of AFDC recipients (a higher AFDC recipient rate) leads to an increasing number of

homelessness. This result shows that AFDC benefits were not a protective factor to prevent poor families to becoming homelessness. From 1980 to 1993, average monthly AFDC families increased from 3,574,000 to 4,981,000 (39 percent increase, U.S. House of Representatives Committee on Ways and Means, 1994). According to the 1996 national survey conducted by Interagency Council on the Homeless (1999), 58 percent of homeless families with children received AFDC benefits in 1996. The most possible reason explaining the high correlation between the number of AFDC recipients and homelessness is a low level of the AFDC benefit. That is, a benefit level of government assistance may be a crucial risk factor forcing the welfare families to become homeless. It is also a protective factor, which, improving the economic status of welfare families or individuals, thus prevents them to becoming homeless.

The results of model I and III also explain the relationship between two different indicators showing the AFDC program on homelessness: the AFDC recipient rate and AFDC benefit level. The results show that the AFDC recipient rate with a low benefit level used in model III gives a more meaningful explanation than just AFDC benefit levels used in model I. Therefore, how many AFDC recipients

have a low level of benefits in the units is a good predictor for showing the rate of homelessness.

Between 1970 and 1991, AFDC benefits were declining by 42 percent in real terms (Elwood, 1993). The average AFDC benefits for a family of four fell from \$799 in 1970 to \$435 in 1992 dollars. DeParle (1992) also showed that the national average combined payments for AFDC and food stamps was \$ 10,169 in 1972 compared to \$7,471 in 1991, a decreased of 27 percent.

In 1990, an American single mother with two children received an average AFDC monthly payment of \$388 with no housing allowance and no universal child allowance. The total number of AFDC families of single mothers with two children was 3,974,000 (U.S. House of Representatives Committee on Ways and Means, 1994). Therefore, 3,974,000 AFDC families could spend their living expenses, including monthly rent, food, clothing, medicine, and education, within only \$388 of the AFDC monthly payment if they had no extra earnings.

In 1990, renter occupied housing units renting at \$200 or below totaled only 2,815,090 (U.S. Census Bureau, American FactFinder, <http://factfinder.census.gov.../>). As a result, more than one million AFDC families of single mothers with two children had to live a month with less

than \$100 if they paid rent of more than \$300 a month. Gugliotta (1992) pointed out that, in thirty-nine of the forty-four cities surveyed, housing costs alone normally exceeded the entire grant for a family of three receiving assistance from the AFDC program. This low level of the AFDC grant was decreasing every year. Now the program no longer exists if the beneficiaries have been on it more than 5 years.

In 1996, Congress enacted the Personal Responsibility and Work Opportunity Reconciliation Act to reform the U.S. welfare system, with primary goal to get as many people as possible off welfare rolls and reduce welfare costs. One of the most important of the Act's many complex provisions replaces Aid to Families with Dependent Children (AFDC) with Temporary Assistance for Needy Families (TANF). As a result, AFDC was dismantled and replaced with a system of block grants to states, thus ending the entitlement of direct federal assistance to low-income families.

Under the block grant known as the TANF grant, states receive a fixed amount based on what they spent on welfare programs in 1994, without regard to subsequent changes in need in the states. The TANF program reduces the federal commitment of resources by \$55 billion by 2002 (Blair, Jacobs, and Quiram, 1999). Furthermore, TANF provisions

limit the total lifetime maximum for receiving federal welfare benefits to 60 months and specify parental work requirements. Able-bodied parents must engage in work activities after receiving benefits for a maximum of 24 months. Because of new limitations of each state, the average monthly number of TANF families decreased in all states and reflects an overall 22 percent decrease from 4,058,000 families in October 1996 - June 1997. During FY 1998, 2,897,000 TANF families had their assistance terminated (U.S. Department of Health and Human Services, 2001). Therefore, a low benefit level of AFDC or a reduction of TANF benefits may be a factor forcing single-headed families living with welfare benefits to leave their homes because poor single mothers with children who lack education and job skills inevitably depend on cash benefits such as TANF as a major income source.

The National Coalition for the Homeless observed that the primary victims of this new legislation will be families teetering on the edge of homelessness, as well as those who are already homeless (National coalition for the Homeless, 1996). Work requirements will be especially difficult for this population, whose access to jobs and training is often hampered by the lack of affordable child care or a fixed address. According to the report of

National Coalition for the Homeless and the Children's Defense Fund (1998), only 8 percent of the former welfare recipients had jobs paying wages above the poverty level, two-thirds of former recipients had lower income than during the three months before they left welfare, the National Governors' Association found that 40 to 50 percent of families who left TANF did not have a job at the time of the study, and the number of children living below one-half the poverty level grew by 400,000 between 1995 and 1997.

Over 80 percent of welfare parents are single mothers, female household heads, who will have to cope simultaneously with the demands of being a parent and a breadwinner (Cook and Dagata, 1997). Thus, TANF limitations severely impact on this group and force them to leave the program. Homes for the Homeless and the Institute for Children and Poverty (1998) surveyed about 800 homeless mothers in 10 cities and reported that in 1998, 59 percent of homeless parents received TANF. Eight percent of families did not receive TANF benefits and had their benefits cut off entirely. Twenty-nine percent of all parents who ever received TANF had experienced a reduction or elimination of public assistance in the six months prior to the study. Forty-nine percent said they became homeless as a result of their public assistance cuts.

According to a nationwide survey of the International Union of Gospel Missions (1998), 20 percent of the sampled homeless people became homeless due to losing their government benefits in the last 12 month in 1997, and 22 percent became homeless because of the same reason in 1998.

The number of affordable housing units subsidized by governments also is insufficient in needs of TANF or homeless families. Fewer than 1 in 4 TANF families nationwide lives in public housing or receives a housing voucher to help them rent a private unit (Blair, Jacobs, and Quiram, 1999). For most families leaving welfare rolls, housing subsidies are not an option.

In 1997, 5.4 million very low-income households were unassisted. These households have incomes below 50 percent of the area median income and pay more than half their income for rent and utilities (HUD, 2000). Consequently, housing assistance remains unavailable to meet most poor renters including welfare families. Only about one-third of poor renters live in assisted housing units and many poor households seeking federal assistance wait long periods (average two years in most cities, see Table 1) before receiving aid (Blair, Jacobs, and Quiram, 1999).

As a result, family poverty forces the welfare and poor families to find family resources or a family safety

net such as their friends, parents, or relatives for help. If they consume all their resources, they become homeless. The results of model III support this process. I found in model III that the AFDC recipient rate explained eighteen percent of homelessness and was a statistically significant level ($R = .420$, $R \text{ square} = .177$, $\text{Beta} = .654$ and $p = .001$). A one percent increase in poor families, the AFDC recipient rate, increases 4.4 homeless persons for every 10,000 people in each state.

Regression results of model III also mean that AFDC benefits could be a protective or preventive factor in becoming homelessness. If AFDC families of single mothers with two children without extra earnings receive proper benefits, they can maintain their living conditions including their rents. Bassuk, et al. (1997) pointed out that families with limited economic resources may be at a heightened risk of homelessness if they do not receive economic help during times of need from social or family safety net systems. Government assistance, whether in the form of cash assistance or housing subsidies, may protect poor families from losing their homes.

The findings of this study are meaningful consideration for the policy implications. Homeless problem continues to worsen for past decades. Policy makers should

response to the problem of homelessness. The findings of this study clearly suggest that poverty is one major reason to force people to homelessness. That is, homeless people are much poorer than their homeless predecessor, and among them are substantial numbers of homeless families, especially female-headed households. The findings also suggest that TANF loses its function as a buffering effect of social safety net system. And most significantly, this study found that structural/societal risk factors have significant relationships with homeless rates in sampling areas and individual risk factors have weak orderings among the factors. That is, the variety of direct services for emergency care including emergency shelters, health services, and case management services focusing mainly on curing individual deficits are not good long-term solutions.

Emergency services for the homeless people who are suffering from physical or sexual abuse and drugs or alcohol abuse should be reexamined in terms of the complexity of homelessness at the macro level. These services for the homeless would be work to reduce homelessness but the effects of these services, which are the temporary remedies focusing on the individual deficits of the homeless people, would probably be small and not cost effective.

In model II, the relationships between homelessness and these individual factors were not statistically significant and explained only four percent of the variation in homelessness. Also in model III, four individual factors explained only 1.4 percent of the variation in homelessness if the data include structural/societal factors. That is, social and economic consequences of the risk factors becoming homelessness would be considered. Prior studies also indicated that preventive measures and long-term solutions are inherently more cost-effective in the long run than emergency shelters and services (Lindblom, 1996).

Accordingly, policy makers identify that emergency shelters and shelter-based services focusing on particularly psychological or individual issues of alcohol and drug abuse and mental health are now to turn to societal/structural issues such as poverty, the lack of affordable housing units, unemployment, and the low levels of welfare benefits.

The findings of the study showed that poverty in 52 sampling areas in model I has a significant independent effect on the rates of homelessness. This is an important finding since it demonstrates that overall high poverty level is a structural condition, which leads to high

homelessness in an area. Therefore, clearly homeless people may come from the poor population living under the poverty level.

In order to prevent and reduce homelessness, the findings of the study indicate that reducing the poverty rate is the priority of the services for the homeless and also suggest the need of providing multi-services for future policy goals for improving the living conditions of the homeless persons. For example, variation in the extent of community supports for the poor in terms of subsidized housing and food, health care, child care, and job training should be examined because a greater availability of such programs may prevent the very poor from becoming or remaining homeless.

In addition, available jobs that pay decent wages and the increase of the minimum wage level are also policy priorities for poor people and those near poverty. In no state does a full-time minimum wage job cover the cost of a one-bedroom unit at fair market rent (Blair, Jacobs, and Quiram, 1999). Jobs with decent wages and increases of the minimum wage up to livable level will function as protective factors to prevent poor people to becoming homeless in the social safety net system.

The findings also suggest that many TANF families with the low level of benefits may be a heightened risk of homelessness if they do not receive social or family supports whether in the form of cash assistances or housing subsidies for them. Policy makers should identify that the TANF families with no extra earnings are the most vulnerable subgroup in becoming homeless family. And the low benefits or low incomes from low paying service jobs based on the workfare program are not enough to pay even their rents in most states. TANF families also are limited by the total lifetime maximum for receiving benefits to 60 months and parental work requirements. Even though welfare parents have jobs they can hardly pay their rents because most parents have low education levels and little work experience or skills without remedial education and training. This means that only service or entry-level jobs with the minimum wage are available for the prior welfare parents.

According to a report of National Low Income Housing Coalition (1999), a household with one person working at the minimum wage for 35 hours a week can afford \$235 monthly for rent and utilities. \$235 is only 41% of the median state average FMR for a two-bedroom unit (\$576). The real value of the minimum wage is declining and the

purchasing power of it has not kept with living costs. Shapiro (1995) also indicate that the minimum wage would need to be about \$5.75 to have the same purchasing power as it did in the 1970s. And three of five minimum wage workers are women.

Thus, policy makers should reexamine the social safety net system, especially cash assistance programs in each state, to alleviate prevalence of homelessness. One of the most important roles of the social safety net prevents people to become homeless or help people get out of the permanent poverty. As a protective factor to prevent homelessness in the social safety net system, the TANF grant should be increased and secured up to the minimum living arrangements. More than half homeless families are on TANF program and the real dollar value of TANF benefits is decreasing every year. The welfare families cannot pay their rent with their benefits. Only one of four welfare families are receiving subsidized housing benefit programs. The payment levels of welfare program should response to the need of beneficiaries to work as a preventive factor of social safety net system. That is, public benefit programs provide enough support to let the recipient pay for housing at prevailing local prices.

Furthermore, in order to avoid the increasing number of single-headed homeless families, especially among TANF families, policy makers should identify sufficient access to safe and affordable child care and housing units, providing a livable income during the job training and education, and helping welfare families find full-time jobs in the local labor market to absorb new unemployed and involuntary part-time welfare entrants without displacing non-welfare workers.

And also policy makers could consider other cash assistance programs. The TANF grant would be combined with other cash assistance program such as family allowance, child allowance, or housing allowance to improve the quality of life for the poor family.

In brief, policy makers need to concentrate public policies on the core roots of homelessness and poverty. Policy priorities are housing subsidies and permanent housing and income enhancement and stabilization for poor individuals and families, especially welfare families with children. Policy makers should focus more on the affordable housing units for people living below or near poverty level including permanent housing and housing subsidies, livable welfare benefit levels, jobs that pay decent wages for the poor enough to keep up with their minimum living conditions

including local housing costs, and affordable child care for children who live in single-headed households. And they should identify that the housing subsidies, jobs with decent wages, the increase of the minimum wage and welfare benefits, and affordable child care are interrelated in the social safety net system.

Consequently, one of the major steps toward expanding assistance to prevent homelessness is to offer community-based prevention programs which provide not emergency intervention and shelter-based services but more comprehensive assistance that target poor single persons and families in the community. The community-based prevention programs contain complex programs including cash assistance at the livable income level, food, affordable health care and child care for a female breadwinner, clinical treatment programs for substance abusers and mental illness homeless persons, job training and subsidized housing units or permanent housing for low-income persons in the community. Expanding and shifting existing funding from emergency services including shelter grants to prevention efforts would be inevitable for this community-based prevention programs.

VI. The Limitations of the Study

Like other homeless studies, this study also has flaws. First, the dependent variable used in three models, the number of contact emergency shelter beds in 52 sampling areas and 51 states, is limited. The number of contact emergency shelter beds is not an exact number of homeless people at any given day in February 1996 or 1990 because 1996 and 1990 survey excluded the hidden homeless such as homeless persons on the streets, in abandoned areas, or doubled-up with relatives or friends. Furthermore, some homeless people do not want to use shelters, thus, a count of the contact emergency shelter beds underestimates the true number of homeless people.

The measure based on the contact emergency shelter beds count also will be affected by the jurisdiction's response to homeless problem. For example, some cities have been reluctant to open shelters, preferring to ignore local homeless people or send them elsewhere. And because of data unavailability of independent variables in the rural sampling areas, I did not include the rural areas to estimate the rate of homelessness in model I. The 1990 national survey also did not include the rural areas.

Second, it would be desirable to have collective original data on direct measures of all risk factors mentioned in this study, since most studies of homelessness have explained the increases or causes of homelessness with these factors. However, the most relevant available information was used for some indicators showing the relationship with homelessness. For example, in order to show the relationship of the substance abuse (alcohol and drug abuse) indicators and homelessness, the rate of substance abuse clients in each state will be a good examiner. However, because of unavailability of the data, I used substance abuse treatment admission rates in each state stemming from National Association of State Alcohol and Drug Abuse Directors (NSADAD) and Substance Abuse of Mental Health Services Administration (SAMHSA).

Also, to examine the relationship between the family violence and homelessness, the number of abused women among homeless persons in each state will be a good indicator. However, because of the data unavailability, the number of shelters (shelter rates) for abused women was used. The number of shelters for abused women will be affected by local governments' response to the problem. Therefore, this indicator showing the relationship between the family violence and homelessness in state levels is also limited.

Third, because of limited data availability, I choose indicators of independent variables, which are not contemporaneous with the homelessness rate in 1996 and 1990 in model I and model II. Especially, the data about the FMR in 1999 and the TANF grant in 1999 are limited. In model II, an indicator of total expenditures by state and county mental hospitals in 1986 is also limited. However, the purpose of the study is to predict the dynamic relationships between variables and the effects of the predict variables on the criterion variable, so the year gap will not seriously defect on the results of this study. If the study is to try to explain the causal relationships between variables, the causal ordering of the variables is important. Logically, a causal variable must precede any variable that it supposedly affects (Mertler and Vannatta, 2001). For example, path analysis explaining the causal relationship between variables might more accurately reflect the actual causal sequence.

Fourth, even though prior studies suggested that the lack of a family safety net is associated to homelessness, I could not examine the relationship between this factor and homelessness in this study. Examining the lack of a family safety net of the individual is extremely difficult, since there is no such data to show this individual

condition in each state level. This is also a limitation for showing the more accurate relationship between individual risk factors and homelessness.

Finally, the results indicated that structural/societal factors such as the poverty rate was a key indicator of homelessness and individual factors such as substance abuse rates and rates of mental illness were not related to homelessness. Some of this may be based on the measurement of the variables. Poverty rates are measured on the base of more standardized criteria and measurement at the national level. Substance abuse and mental illness rates are softer measures and are much more affected by differences in measurement and data collection on a state level and may be more biased measures.

Also, other possible risk factors, which are not mentioned in this study, based on the theoretical backgrounds, including individual and structural/societal factors, are obviously needed to explain more concrete reasons for becoming homelessness. This is a future goal for the next homeless study that can be conducted in the nation wide or certain localities.

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