Goldman, Robert Greenstein, Kim Hopper, Stephen Jencks, Edward Lazere, Bruce Link, Jane Mansbridge, Susan Mayer, William McAllister, Brendan O'Flaherty, Kathryn Nelson, Peter Rossi, Michael Schwartz, Robert Silvers, David Whitman, Christopher Winship, and Barbara Wolfe. I am also indebted to all those who participated in a day-long discussion of the manuscript at the Russell Sage Foundation in October 1993, and to those who commented on earlier public presentations at Northwestern University and the University of Chicago. Some of these individuals agreed with my arguments, while others were highly critical. Together they saved me from more errors than I care to recall.

I have also received unusually generous institutional support while working on this and related issues. The Center for Urban Affairs and Policy Research at Northwestern University has given me stimulating colleagues, research assistants, and time off from teaching since 1979, despite the fact that all my projects, including this one, took at least twice as long as I promised. A grant from the Rockefeller Foundation to the Social Science Research Council's Committee on the Urban Underclass, of which I was at one time a member, paid for some of David Rhodes's time.

Finally, the Russell Sage Foundation allowed me to spend ten blissful months as a visiting scholar at its headquarters in New York City during 1991-92. Living in New York gave me a new perspective on homelessness, and working at the foundation gave me time to start writing. Throughout that year the president of the foundation, Eric Wanner, provided both moral support and thoughtful suggestions. He also displayed exemplary self-restraint when he discovered that my work on homelessness would further delay the long overdue book I had promised to complete during my year at the foundation.

I doubt that I will ever be able to repay all of these debts, but acknowledging them is a small step toward setting the balance right.

Contents

Another big change was that in 1958 something like 8000 people slept in what were politely known as cubicle hotels. These hotels housed their patrons in windowless 5-by-7-foot rooms, furnished with a bed, a chair, and a bare lightbulb. Rooms were separated by wooden walls and ventilated through wire mesh near the ceiling and floor. Because of the wire mesh, such places were popularly known as cage hotels. They were always noisy, usually verminous, and frequently smelled of urine, vomit, or both.

Nonetheless, almost all skid-row residents preferred these hotels to the free missions run by evangelists. The missions were cleaner, but a cubicle of one's own, however small and noisy, provided more privacy and security than the open dormitory rooms in a mission. The cubicle hotels also treated their patrons more like paying guests and less like charity cases, allowing them to come and go as they pleased and making no effort to improve their character. A cubicle cost roughly $2 to $4 a night in today's money.

Chicago's cubicle hotels housed eight times as many people as its shelters did in 1958. By 1986 Chicago's shelters housed something like three times as many people as its two remaining cubicle hotels did. Thus while the great majority of Chicago's poorest citizens had a private place of their own in 1958, that was no longer true in 1986. Almost all accounts suggest that this pattern recurred in many other cities. The puzzle we need to solve, therefore, is not just why more people lived in public places during the 1980s than during the 1950s, but why fewer people lived in the cage hotels that had traditionally served men with hardly any money.

3. Emptying the Back Wards

As soon as Americans noticed more panhandlers and bag ladies on the streets, they began trying to explain the change. Since the most noticeable of these people behaved in quite bizarre ways, and since everyone knew that state mental hospitals had been sending their chronic patients "back to the community," many sidewalk sociologists initially assumed that the new homeless were mostly former hospital inmates.

Taken literally, that theory turned out to be wrong. Table 4 shows that less than a quarter of the homeless have spent time in a mental hospital. But this is not the right way to assess the impact of deinstitutionalization. Although deinstitutionalization mostly meant that patients were released from mental hospitals after a few weeks instead of remaining there for months, years, or even a lifetime, it also meant that some people who would once have been sent to a mental hospital were now sent to the psychiatric service of a general hospital or were treated as out-patients. It follows that considerably more than a quarter of today's homeless might have spent time in a mental hospital if we still ran the system the way we ran it in the 1950s.

Who Is Mentally Ill?

Freud thought that health meant the ability to work and to love. By that standard the homeless are often in bad shape. A third of the Chicago homeless told Rossi they could not work because of "mental illness" or "nervous problems." Another 10 percent said they could not work

Table 4. Percent of Homeless Adults with Selected Characteristics

Characteristic	Large cities, 1987	All local surveys, 1981–88
Demographic		
Male	84%	74%
Black	45	44
Hispanic	10	12
Over 65	3	na
Mental health		
Spent time in mental hospital	22	24
Attempted suicide	24	na
Diagnosed as currently mentally ill	na	33
Substance abuse		
Currently addicted to alcohol	na	27
Spent time in residential treatment program	na	29
Social ties		
Never married	53	na
Not currently with a spouse	97[a]	na
No friends	na	36
No contact with relatives	na	31
Spent time in jail or prison	41	41
Current health "fair" or "poor" (self-report)	44	38

Source: Column 1 is the weighted mean of estimates for service users and nonusers in cities of 100,000 or more, taken from Martha Burt and Barbara Cohen, *America's Homeless: Numbers, Characteristics, and the Programs That Service Them* (Washington: Urban Institute Press, 1989), pp. 69–71. Column 2 is the unweighted mean of 14 to 40 local surveys, depending on the measure, and comes from Anne Shlay and Peter Rossi, "Social Science Research and Contemporary Studies of Homelessness," *Annual Review of Sociology*, 18 (1992), 129–160. Many of Shlay and Rossi's samples are restricted to shelter residents, who are more likely to be women and tend to be in better mental and physical health than those not in shelters.

a. Adults using shelters or soup kitchens.

because of alcoholism.[1] Only 6 percent of Burt's homeless respondents had steady jobs.[2] While more could have found steady work in a tighter labor market, the homeless are clearly the last hired and the first fired.

The homeless have almost as much trouble maintaining relationships with loved ones as with employers. More than half the Chicago homeless told Rossi that they had no good friends, and 36 percent reported no friends at all. A third also said they had no contact with their relatives, even though they almost all had kin in the Chicago area.[3]

Table 4 shows that the homeless in other cities were also quite isolated. Less than half had ever married, and only 3 percent were still with their spouse at the time they were interviewed.

Some advocates argue that these problems are a byproduct of homelessness itself. That is surely true in some cases. When natural disaster or war drives randomly selected people from their homes, many become acutely depressed, and some grow suicidal or have mental breakdowns. When economic misfortune drives people from their homes, they are even more likely to have such reactions, because they are more likely to blame themselves for their fate.

This argument should not be overdone, however. Rossi asked the Chicago homeless whether they had had any of the following experiences within the past year:

- Hearing noises or voices that others cannot hear.
- Having visions or seeing things that others cannot see.
- Feeling you have special powers that other people do not have.
- Feeling your mind has been taken over by forces you cannot control.

About a third of those whom Rossi interviewed reported having at least one of these delusions at a time when they were neither drunk nor taking drugs.[4] Even when victims of famine and war spend years in refugee camps far worse than any Chicago shelter, no one has ever reported that a third of them saw visions or heard voices. The fact that a third of the Chicago homeless suffer from such delusions must mean, therefore, that a lot of them had such problems before they became homeless.[5]

How many of these people would have been hospitalized in earlier times? Even in the mid-1950s, when the United States hospitalized a larger fraction of its population for mental illness than at any other period in its history, some avoided this fate. A schizophrenic woman who lived quietly with her parents was not likely to be hospitalized if her parents wanted her at home. Nor was a skid-row resident who muttered to invisible strangers likely to be hospitalized if he paid his rent and kept to himself.[6]

When the mentally ill became homeless, however, their chances

of landing in a state hospital rose sharply. Free missions seldom took men and women who appeared to be crazy. Since sleeping in public places was illegal, the homeless mentally ill had a lot of contact with the police. If they had no fixed address and acted crazy, they were usually taken to a state hospital for evaluation. Most admitting psychiatrists assumed that anyone who showed signs of mental illness and could not keep a roof over his or her head needed professional care. The homeless mentally ill were therefore quite likely to be locked up even if they were only mildly disturbed from a clinical viewpoint.

Clinicians who examine the homeless today usually conclude that about a third have "severe" mental disorders. Since the homeless were often hospitalized in the 1950s even when their symptoms did not reach this threshold, well over a third of today's homeless might have been locked up at that time. Recreating the mental-health system of the 1950s would therefore cut today's homeless population dramatically. No one believes that such a change would benefit most of the mentally ill, but it might benefit some of those who are now homeless.

The Many Faces of Deinstitutionalization

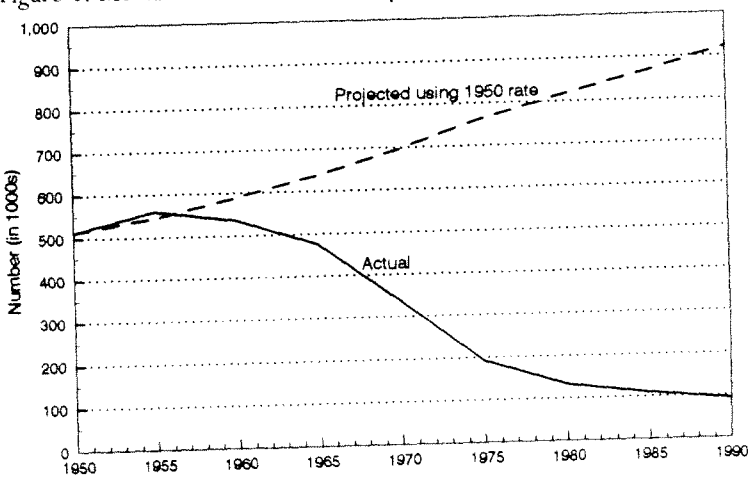
Before blaming homelessness on deinstitutionalization, however, we must explain one awkward fact: hospitalization rates for mental illness began to fall in the late 1950s, not in the late 1970s or early 1980s. Since deinstitutionalization caused very little homelessness from 1955 to 1975, how could it have suddenly begun to cause a lot of homelessness after that? The answer is that deinstitutionalization was not a single policy but a series of different policies, all of which sought to reduce the number of patients in state mental hospitals but each of which did so by moving these patients to a different place. The policies introduced before 1975 worked quite well. Those introduced after 1975 worked very badly.

Figure 1 shows the progress of deinstitutionalization from 1950 to 1990. The broken line shows how many people would have been in state mental hospitals on an average night if adults' chances of being admitted and discharged had remained constant. The solid line shows the actual numbers. The gap between the two lines provides a rough measure of how many people who would have slept in a state hospital under the

1950 rules slept elsewhere in later years.[7] I refer to these people as having been deinstitutionalized. Readers should remember, however, that some of them never set foot in a mental hospital. They are deinstitutionalized only in the sense that people like them would have been in state hospitals in 1950.[8] Readers should also remember that some of the people I describe as deinstitutionalized merely moved to another institution, such as the psychiatric service of a general hospital, a nursing homes, or a halfway house. Although these individuals have not been deinstitutionalized in the strict sense, no better term seems to exist.

The initial impetus for deinstitutionalization arose in the late 1940s and early 1950s, when the intellectual leaders of the psychiatric profession became convinced that hospitalizing patients who were undergoing an acute episode of mental illness often did more harm than good. That observation had two implications. First, anyone who could be cared for as an out-patient should be. Second, when patients with episodic mental illnesses had to be hospitalized, they should be discharged as soon as possible. The history of deinstitutionalization is the story of America's

Figure 1. Mental Patients in State Hospitals, 1959–1990



Source: Projections are based on the rate of growth in the civilian, noninstitutional population aged 14 and over. Actual counts for 1950–1985 are taken from David Mechanic and David Rochefort, "Deinstitutionalization: An Appraisal of Reform," *Annual Review of Sociology*, 16 (1990), 307. The 1990 estimate was provided by NIMH.

collective search for other places to send these disturbed and disturbing people.

In a few places (notably Great Britain and Massachusetts), the first round of deinstitutionalization began in the late 1940s and early 1950s, as psychiatrists changed their recommendations for treatment. In most states, however, the process did not gather momentum until the mid-1950s, when the advent of new drugs made out-patient treatment much easier. Thorazine, which became widely available in 1955, did not cure anyone and ultimately produced grisly side effects in some patients, but it did reduce hallucinations and paranoia, making it somewhat easier for families to care for their schizophrenic relatives. Thorazine and its cousins also allowed more schizophrenics to live on their own. Antidepressants also became available during this period and had dramatic effects on some victims of acute depression. Lithium, which was in widespread use by the mid-1960s, had a similar impact on many manic-depressive patients. After lithium, progress in psychopharmacology slowed.

Figure 1 suggests that if admission and discharge rates had not changed, the number of state hospital inmates would have risen from 513,000 in 1950 to 635,000 in 1965. In fact, the number fell to 475,000. One could argue, therefore, that the revolution in psychopharmacology cut the number of people in state hospitals by 25 percent. But that overstates the effect of drugs per se. Part of the decline simply reflected psychiatrists' growing skepticism about the benefits of hospitalization.

Alternative Institutions

The second round of deinstitutionalization began in 1965, when Congress established Medicaid to cover the bills of many poor patients. Congress did not want the federal government to assume responsibility for patients whose bills were already being paid by the states, so Medicaid did not cover anyone in a state mental hospital; but it did cover short-term psychiatric care in general hospitals. As a result, the proportion of poor patients getting short-term care from state hospitals began to fall, while the proportion getting care from the psychiatric service of a general hospital rose.

Medicaid also covered patients in nursing homes. In an effort to prevent mass transfers from state mental hospitals to nursing homes, Medicaid rules excluded nursing homes that provided psychiatric care. But before 1965 indigent patients had often been sent to state mental hospitals even when their problems were primarily physical, simply because these hospitals were free. Once Medicaid became available, states began transferring as many of these patients as possible to nursing homes, in order to shift part of the bill to Washington. Many of these homes provided even worse medical care than the state hospitals, but both patients and their families preferred them nonetheless, because the other residents were saner. In the end, the shift from state hospitals to nursing homes was probably driven as much by consumer choice as by state policy.[9]

Like the effects of new drugs, the effects of Medicaid were accentuated by changing professional attitudes. By the mid-1960s the young psychiatric residents who made day-to-day decisions about admitting and releasing patients were increasingly likely to believe not only that patients suffering from short-term problems would recover faster if they could be kept out of a hospital, but that even "chronics" would be better off living with their families or in residential hotels. Americans were also growing more tolerant of bizarre behavior, so state hospitals were under less political and social pressure to lock up everyone who acted crazy. Gradual increases in public-assistance benefits also made it easier for the mentally ill to survive outside hospitals.

Congress set off a third round of deinstitutionalization in 1972, when it established Supplemental Security Income (SSI). SSI provided a federally financed monthly check for everyone whom the Social Security Administration judged incapable of holding a job because of a physical or mental disability. Recipients also got food stamps and a Medicaid card, and their cash benefits rose automatically with inflation. In 1992 the combined value of federal SSI payments and food stamps was about $500 a month.

Inmates of state mental hospitals became eligible for SSI as soon as they were discharged. That gave states a new financial incentive to move the mentally ill out of hospitals. SSI also made it easier for poor families to care for their disturbed relatives, and it allowed some mildly disturbed patients to live on their own. If the mentally ill could not care

for themselves and had no relatives who were willing and able to do so, SSI made it easier to place them in private "board and care" facilities (which are just nursing homes without nurses). When patients entered such a facility, they usually signed over their SSI check to the management and lived pretty much as they would have lived on the chronic ward of a state hospital: eating, sleeping, taking their medication, watching television, playing cards, and staring into space. But now Washington paid most of the bills.

SSI was conceived primarily as a program for people who were too old or too physically disabled to work and whose past earnings had been so low that they got little or nothing from Social Security. Congress never expected SSI to cover the full cost of caring for people with serious mental disorders. At $500 a month, SSI is enough to keep the frugal elderly off the streets. (Only about 10,000 people over the age of sixty-five appear to have been homeless in 1987–88.[10]) But $500 a month will not pay for much beyond room and board, so a facility that relies exclusively on SSI to pay residents' bills cannot afford to admit anyone who requires much staff attention. If such a place admits the mentally ill, it must restrict itself to patients who can care for themselves and who cause no trouble. In order to do more, it needs extra money from the state for extra staff.

Figure 1 shows that the number of adults in state mental hospitals fell 60 percent between 1965 and 1975. Many elderly mental patients moved to nursing homes. Many younger mental patients returned to their families. Others ended up living alone or in board-and-care facilities.[11] If there was a significant increase in homelessness during this era, no one commented on it.

By 1975 most state hospitals had discharged almost everyone they thought they could house elsewhere. Their 200,000-odd remaining inmates were of two kinds: long-term residents who were so disturbed nobody else would take them, and short-term patients who were admitted, medicated, observed for a couple of weeks, and discharged. Some of these short-term patients were readmitted fairly regularly, often because they stopped taking their medication, but they spent the bulk of their time outside hospitals.

While patients often cycled in and out of mental hospitals in the early 1970s, relatively few hospitals discharged patients who had nowhere to go. That was because the police in most states still brought those who ended up on the streets back to the hospital that had discharged them. The psychiatric staff saw no point in discharging patients who would be back in a matter of days. Readmission required a lot of paperwork, so it was easier just to keep these patients in the hospital.

The End of Involuntary Commitment

Although the number of patients in state mental hospitals fell from 468 per 100,000 adults in 1950 to 119 in 1975, advocates of deinstitutionalization were far from satisfied. Rather than simply continuing their campaign to alter physicians' clinical judgments about who should be hospitalized, reformers increasingly turned to the courts, challenging physicians' right to commit anyone at all. These challenges began to influence medical practice in some states during the early 1970s, but their main impact came in the late 1970s, when they precipitated a fourth round of deinstitutionalization.

During the 1960s writers like Erving Goffman, Thomas Szasz, R. D. Laing, and Michel Foucault tried to convince the public that mental hospitals were oppressive places and that psychiatrists were agents of social control. Since many mental hospitals really did deprive patients of rights accorded almost every other human being, and since the therapeutic rationales offered for many hospital rules seemed unpersuasive, many people (including me) found these antiauthoritarian critiques quite persuasive. By the early 1970s most civil-liberties lawyers endorsed Szasz's argument that we should lock up the mentally ill only if they broke the law. The Supreme Court encouraged such thinking throughout the 1970s. In 1975, for example, the Court ruled in *O'Connor v. Donaldson* that mental illness alone was not sufficient justification for involuntary commitment. By the end of the 1970s almost every state had made it impossible to lock up patients for more than a few days unless they posed a clear danger to themselves or others.

This was a sharp break with the past. The Anglo-American conception of individual rights rests partly on the premise that each of us is the best judge of our own interests. This assumption leads directly to the idea that adults should be free to manage their own lives so long as

their behavior does not threaten others. But even those with a strong commitment to individual rights usually made exceptions for people who did not seem to know their own interests. Among these people were children, the mentally retarded, and those we called insane, crazy, mad, or mentally ill. Endowing such individuals with the full panoply of legal rights that we gave a "rational" adult was thought dangerous, both to the recipients and to others.

Limiting the rights of the mentally ill on the grounds that they are too confused to know their own interests or to respect the rights of others led to many abuses. But the fact that a principle is often abused does not mean it is wrong. The presumption that parents know their children's interests better than the children do has also been widely abused, but it does not follow that children are better off when they can run their lives as they please. Like the line between childhood and adulthood, the line between sanity and insanity is fuzzy. But it does not follow that mental illness is merely a myth invented to keep deviants in line, any more than childhood is. The boundary separating India from China is also uncertain and contested, but hardly anyone doubts that Calcutta is in India or that Shanghai is in China.

For the civil-liberties lawyers who led the fight against involuntary commitment, all this was irrelevant. They thought individual autonomy so important that they could hardly imagine patients who would be better off when other people told them what to do. They also identified so strongly with the oppressed that they could not take seriously the idea that releasing mentally ill patients from hospitals might make the rest of us worse off.

Many other people supported restrictions on involuntary commitment for more sensible reasons. Some thought mental hospitals were bound to be bad for patients, because forcing the mentally ill to live with one another made them even crazier. Others thought mental hospitals could become therapeutic institutions, but only if staff members stopped relying on coercion to change patients' behavior. These reformers, who included experienced therapists as well as lawyers, hoped that curtailing involuntary commitment would force hospitals to do their job better. Unlike most of the hopes raised by deinstitutionalization, this one was actually realized. Almost everyone agrees that curtailing involuntary commitment improved the quality of life inside

mental hospitals, just as almost everyone agrees that it reduced the quality of life outside them.

Once America restricted involuntary commitment, many seriously disturbed patients began leaving state hospitals even when they had nowhere else to live. When their mental condition deteriorated, as it periodically did, these patients were also free to break off contact with the mental-health system. In many cases they also broke with the friends and relatives who had helped them deal with public agencies. The mentally ill are seldom adept at dealing with such agencies on their own, so once they lost touch with the people who had acted as their advocates, they often lost (or never got) the disability benefits to which they were theoretically entitled. In due course some ended up not only friendless but penniless and homeless.

The Dangerous Mentally Ill

In theory, psychiatrists can still lock up people who pose a danger to themselves or others. In practice, legal and budgetary changes have made this less common than it used to be. A recent study by Daniel Martell and Park Elliott Dietz provides a vivid illustration of how casually the mental health system now deals with mental patients who engage in violence.[17]

Martell and Dietz studied thirty-two individuals arrested between 1975 and 1991 for trying to push a stranger onto the New York City subway tracks. The police referred twenty-six of these people for psychiatric evaluation. Martell and Dietz tried to follow up these cases. The New York state mental-health system had no records for six of the twenty-six offenders referred to it. Of the twenty offenders whose records the state could locate, nineteen had been diagnosed as psychotic. All nineteen had been hospitalized before, and thirteen had previous arrests for violent crimes. Yet even those whose histories included both psychotic delusions and violent crimes had all been released. Half were homeless at the time they pushed their victim onto the tracks.

The reader might think that these were precisely the kinds of people who should be subject to involuntary commitment. They were clearly crazy. They had histories of violence. Their behavior posed a

danger to others. So why were they released? The answer seems to be partly legal and partly budgetary.

Legally, it is now impossible to lock people up forever simply because they were both psychotic and violent at some time in the past. If they are no longer psychotic today—if, that is, physicians are willing to say they have recovered—they are entitled to another chance. The fact that people with histories of schizophrenia and violence tend to have relapses, when they once again lash out at others, does not have a comfortable place in American legal thinking. America has always been a land of second chances. Violent psychotics now get a second chance just like everyone else.

Even when a legal case can be made for long-term confinement, fiscal austerity makes it rare except in the most extreme cases. If mental hospitals are trying to close wards, they have a strong incentive to decide that asymptomatic patients have recovered, no matter what the patient's past history suggests about the likelihood of a recurrence. Discharging such patients might not pose a great danger to others if they could be monitored closely after leaving the hospital. But monitoring out-patients is difficult even when they have stable housing, and it is impossible when they have no fixed address. That is presumably one reason why Martell and Dietz found that the risk of being pushed onto the subway tracks was three times as high in the 1980s as in the late 1970s.

Something has gone badly wrong with a system that produces these results. Part of the problem is that we now have too few beds in state mental hospitals. But we also seem to have forgotten a fundamental truth about society, namely that someone has to be responsible for every individual's actions. In most cases, of course, we hold adults responsible for their own actions. But when people are too young, too retarded, or too deranged to be held responsible, society has to designate someone else to assume responsibility. When people's relatives cannot or will not play this role, society needs to create an institution to act *in loco parentis*. This institution needs the same broad discretionary powers that parents have over their children, not the more circumscribed powers that courts have over those whom they can punish for their sins after the fact. For patients with a history of violence, that discretionary power probably has to include preventive detention.

Yet while we need to do something about the fact that mental patients with histories of violence often end up homeless, we should not exaggerate the magnitude of this problem.[13] The homeless mentally ill are probably a bit more prone to violence than the average American, but they are by no means the most dangerous people on the streets. Indeed, while I know no statistics on the matter, I suspect that when the homeless mentally ill are involved in violence they are as likely to be victims as aggressors. Assaults on the homeless in general and the homeless mentally ill in particular are common throughout the United States. In a growing number of cases, supposedly sane people have set the homeless afire. Even Martell and Dietz found that while most of the individuals who pushed someone onto the subway track were mentally ill and many were homeless, there were three incidents in which gangs of youths had pushed a homeless individual onto the tracks.

The Tax Revolt

Soon after the rules restricting involuntary commitment began taking effect, a nationwide tax revolt precipitated a fifth round of deinstitutionalization. Faced with rising costs and slow growth in their tax base, state governors and legislators kept pressing mental hospitals to trim their budgets. Most hospitals responded by closing wards. These hospitals had already transferred all the chronic patients they could house elsewhere. The only way they could close more wards was to cut the time short-term patients spent in the hospital or discharge chronic patients who had nowhere else to go.

Hospitals had started discharging chronic patients with nowhere to go because the courts said these patients had a legal right to leave. But once the taboo was broken, the practice soon spread to patients who had not insisted on leaving. As time went on, even patients who were willing to stay in the hospital got pushed out, on the grounds that a hospital was not a hotel. Today some state hospitals do not even bother to discharge such patients. They simply write a weekend pass and tell the patient not to come back.

States could have kept most of the mentally ill off the streets by finding them rented rooms and paying the rent directly to the landlord. But once civil libertarians endowed the mentally ill with the same legal

rights as everyone else, state politicians felt free to endow them with the same legal responsibilities as everyone else, including responsibility for paying their own rent. The mentally ill are seldom good at planning ahead or managing their money, so even those who got monthly disability checks were often unwilling or unable to set aside enough money for rent. Those who did not get a disability check, or whose checks stopped coming because they failed to file a form or show up for a hearing, had even more trouble paying their rent.

States compounded this problem by cutting their cash payments to the mentally ill. Most states had supplemented federal SSI benefits for the disabled during the 1970s. Almost all states let these supplements lag behind inflation during the 1980s.[14] Some states tried to replace cash SSI payments with various kinds of subsidized housing, but as far as I know no state guaranteed the deinstitutionalized mentally ill a place to live.

This transformation of America's mental-health system could not have happened without two decades of bipartisan propaganda suggesting that deinstitutionalization would save huge sums of money without hurting patients. That claim turned out to be greatly exaggerated. Most experts agree that out-patient care yields better results than equally expensive in-patient care.[15] It seems to follow that one should be able to achieve equally good outcomes at somewhat lower cost using out-patient care. But the general rule is that good care costs quite a lot regardless of where patients sleep. Deinstitutionalization saves big money only when it is followed by gross neglect. That was why neglect became so common during the 1980s.

Mental hospitals are certainly expensive. State mental hospitals spent a total of $7.7 billion dollars to care for about 90,000 patients a day in 1990. That means they were spending about $234 per patient per day.[16] Nursing homes, board-and-care facilities, SROs, and municipal shelters all spent far less. But that does not suffice to prove that mental hospitals are wasting money. They do, after all, perform different functions from all these other institutions. First, they diagnose patients with acute problems, prescribe drugs for them, and make recommendations about their care, which means they need far more doctors, nurses, and paper shufflers than nursing homes, board-and-care facilities, SROs, or shelters. Second, state hospitals provide custodial care for some people who are so disruptive or dangerous that other institutions

refuse to deal with them. Any institution that plays this role is bound to need a lot of attendants.

A mental hospital's budget goes to meet its patients' need for three things: subsistence, supervision, and treatment. There is no obvious reason why feeding and housing mental patients should cost more in a hospital than in any other institution. The cost of food and shelter does fall when patients live with their families, but that is not an option for those who concern us here. Shelters staffed by volunteers or board-and-care facilities staffed by minimum-wage workers can put meals on the table and keep floors cleaned more cheaply than state hospitals, but these are economies that harm a society in the long run. Furthermore, the main way that states cut mental patients' subsistence costs is to offer less. Forcing schizophrenics to sleep in group shelters or giving them only one meal a day instead of three does save money—but at what cost?

Mental-health planners have also tried to cut the cost of supervising the mentally ill. Because supervision costs are high in mental hospitals, planners often imagine that it would be cheaper to house hospital patients in less-supervised settings. That makes sense if moving patients to new settings improves their behavior. But if patients go on acting the same way, simply moving them to a new setting is unlikely to save money. If those who were disruptive in the hospital remain disruptive, the board-and-care facility will have to hire more supervisory staff and become more like a hospital. The same will be true if patients are sent to shelters, which is why many shelters refuse to admit them.

Nor will transferring patients who can look after themselves necessarily save money. Suppose a hospital spends $1000 a day supervising a ward with fifty chronic patients, half of whom need constant supervision and half of whom need none. That works out to $20 per patient every day, so transferring the patients who need no supervision to a place that spends a quarter as much seems like an obvious economy. But transferring the patients who require no attention will not in fact cut the cost of running the hospital ward, because demands on the staff will not decline. If the hospital ignores this fact and tries to fill the ward entirely with patients who need a lot of attention, it will soon have to double the ward's staff.

Readers who remember Ken Kesey's *One Flew over the Cuckoo's Nest*

may wonder whether mental patients really need all this supervision. In the 1960s, when Kesey wrote, many did not. But by the end of the 1970s state hospitals were discharging almost any patient who could get along without supervision. The patients still living in state hospitals in 1980 were either there for very short periods or needed so much supervision that no other institution would take them.

When mental patients who need supervision do not get it, they often become embroiled in serious conflicts with other people. Some of these conflicts lead them to engage in violence against others. Others lead to violence against the mentally ill. Keeping such patients out of trouble is costly no matter where they live. For most patients the cost will be less than $234 a day. But so long as we have to pay someone to provide care, the cost will be substantial. We can reduce these costs if we harden our hearts and let these lost souls fend for themselves. But that is like feeding people once a day or letting them sleep on a steam grate.

Although hospital planners have tried to cut state spending on subsistence and supervision over the past twenty years, they have not tried as hard to cut expenditures for medical treatment. Discharging chronic patients did not appreciably reduce treatment costs, since these patients seldom saw the medical staff. Cutting the length of stay for new patients made equally little difference, since admitting a patient, deciding on a course of treatment, changing the medication when the initial treatment does not work, discharging the patient, and doing all the relevant paperwork consumes about the same amount of professional time regardless of whether the process is compressed into a week or spread out over several months.

Once we look at what mental hospitals actually do, it becomes easier to see why deinstitutionalization saved less money than its advocates promised. Between 1975 and 1990 state mental hospitals cut the number of patients they sheltered on an average night by 54 percent, but they cut their staffs by only 20 percent, and their real expenditure rose 5 percent.[17]

Federal Cutbacks

Although the Republican Party played a central role in creating the political climate in which deinstitutionalization unfolded during the

1980s, it was unable to cut federal support for the mentally ill anything like as much as it wanted. The Reagan Administration did get Congress to fold federal money for Community Mental Health Centers (CMHCs) into block grants to the states, but that did not appreciably reduce the resources available for treating people with severe mental problems. Indeed, it may have created more such resources.

The CMHCs were created during the 1960s to provide out-patient care for the severely disturbed patients who were being moved out of state hospitals. But since few therapists wanted to work with psychotic patients, the CMHCs soon redefined their role as preventing rather than treating severe mental illness. Under the banner of prevention they began working with patients who were depressed, angry, anxious, or in the midst of some family crisis, paying little attention to schizophrenics. After 1981, when Reagan made CMHC funding a state responsibility, some CMHCs decided that their best hope for survival was to treat more psychotics. By caring for people who would otherwise be in a state hospital, they could claim that they were saving the state money. That may also have been true when they worked with less disturbed patients, but the case was harder to make because the payoff was farther in the future.

The Reagan Administration also tried to tighten eligibility standards for federal disability benefits. The percentage of working-age adults getting disability benefits had risen steadily during the 1970s. Even before Reagan was elected, Congress had told the Social Security Administration that it should conduct periodic reviews to see if disabled beneficiaries were still unable to work. Two months after Reagan took office, the SSA accelerated this process and began purging the disability rolls of people it judged capable of working. Many of these reviews were scandalously perfunctory. Some 300,000 people were dropped from the rolls between 1981 and 1983, including perhaps 100,000 with mental problems.[18] Very few found work.[19] Some presumably became homeless.

This assault on the disabled was one of the low points of modern American social policy, but it did not last long. In mid-1983, after hundreds of lawsuits and a great deal of bad publicity, the SSA suspended its effort to purge the rolls. By the time Reagan left office, the fraction of the working-age population collecting disability benefits was as high as it had been in 1980.[20] The fraction of new beneficiaries with mental rather than physical disabilities was also twice as high in the late 1990s

as it had been a decade earlier.[21] Thus the percentage of working-age adults getting federal benefits for a mental disability was higher at the end of the 1980s than ever before in American history.

Why should the number of people getting benefits for a mental disability have grown during a period when the administration was trying to cut back? Some conservatives think that civil servants who made eligibility decisions grew more soft-hearted with the passing of time. So far as I have been able to discover, no lawyer who actually dealt with the Social Security Administration during the 1980s believes this. A more convincing explanation, I think, is that many other traditional sources of support for the mentally ill were drying up during the 1980s, making more people eligible for federal benefits.

States cut the proportion of adults living in state mental hospitals from 76 per 100,000 in 1980 to 47 per 100,000 in 1990. Almost all these people became eligible for disability benefits. States were also trying to cut their expenditures on General Assistance (GA), which provides state money to jobless adults who do not qualify for any kind of federal support. One way states cut GA was to help recipients qualify for SSI disability benefits, which came largely from Washington.

Meanwhile, a combination of legal and illegal immigration was creating more competition for casual unskilled jobs. In the past, men with episodic mental problems had often taken such jobs when they were asymptomatic. Even occasional work made them ineligible for disability benefits. As casual jobs became harder to get, the fraction of the mentally ill who had not worked for a year rose, making more of them eligible for benefits. The deinstitutionalized mentally ill also began using crack in significant numbers after 1985. That not only reduced their chances of finding work but often made their symptoms worse, increasing their chance of qualifying for benefits.

What Went Wrong?

Although the federal government spent more to support people with severe mental illnesses in 1990 than in 1980, the increase was clearly inadequate to offset the effect of changes in the way states ran their hospitals. The best available data suggest that in 1987 at least 1.7 million working-age Americans had mental problems so severe they could not

hold a job.[22] Roughly 100,000 of these people were homeless. No other affluent country has abandoned its mentally ill to this extent.

If the courts had not limited involuntary commitment and if state hospitals had not started discharging patients with nowhere to go, the proportion of the adult population living in state hospitals would probably be about the same today as in 1975. Were that the case, state hospitals would have sheltered 234,000 mental patients on an average night in 1990 rather than 92,000. It follows that 142,000 people who would have been sleeping in a state hospital under the 1975 rules were sleeping somewhere else by 1990. On any given night, some of these people were in the psychiatric wards of general hospitals, and a few were in private psychiatric hospitals, but many were in shelters or on the streets.

Almost everyone agrees that what happened to the mentally ill after 1975 was a disaster. Both liberals and conservatives blame this disaster on their opponents, and both are half right. It was the insidious combination of liberal policies aimed at increasing personal liberty with conservative policies aimed at reducing government spending that led to catastrophe. It is important to remember, however, that while liberals succeeded in curtailing involuntary commitment and deinstitutionalizing most of the mentally ill, their conservative opponents failed to cut government spending on mental patients. All the conservatives did was slow the rate of budgetary growth.

The bulk of state mental-health budgets has always gone to hospitals, and that did not change during the 1980s. Measured in 1990 dollars, state hospitals spent $7.7 billion in 1990, up from $6.5 billion in 1979.[23] Expenditures on residential services for out-patients also rose. Measured in constant dollars, the average state spent about $50 a month for each out-patient in 1987 compared to $30 in 1981.[24] Such sums were obviously inadequate, but the trend was up. The main area where states cut back was in their SSI supplements. Measured in 1992 dollars, the median state supplement fell from $74 a month in 1980 to $32 a month in 1992.[25]

Statistics of this kind suggest that the problems of the mentally ill were at least partly traceable to political and institutional inertia. States could have cut their hospital spending substantially by merging or closing hospitals. But local legislators fought hard to prevent this, so

states kept most mental hospitals open and let them serve fewer patients. Hospitals could also have served the mentally ill better if they had continued to offer custodial care for patients with nowhere else to live. But those who ran state hospitals were professionally committed to the idea that they should provide better treatment rather than running a better hotel. This stance was reenforced by self-interest. Spending more on treatment and less on subsistence allowed those who cared for the mentally ill to improve their standard of living at a time when the mentally ill themselves were experiencing more material hardship.[26]

Needless to say, the mental-health establishment does not see the last twenty years in these terms. From its perspective, the continuing shift from in-patient to out-patient care made medical sense. The problem was that callous state legislators refused to appropriate enough money for out-patient programs. In a sense, this analysis is correct. But it says nothing about where the extra money for out-patient care should have come from. Assuming that out-patient care is no more expensive than in-patient care, the answer seems clear: the money should have come from state hospital budgets.

While deinstitutionalizing the mentally ill should not save much money overall, it should allow states to shift resources from in-patient to out-patient services. No realist expects hospitals themselves to propose such changes, but state governors and legislators could have done so. The number of mental patients sleeping in state hospitals fell by 100,000 between 1975 and 1990. Had politicians been committed to keeping the mentally ill off the streets, they could have used the money that hospitals once spent on these patients to provide SRO rooms and out-patient services. Some states did try this. In most states, however, political leaders mouthed clichés and looked the other way.

4. The Crack Epidemic

While deinstitutionalization of the mentally ill was the most widely cited explanation for homelessness in the early 1980s, drugs got more attention later in the decade. Until the mid-1980s, the very poor had relied largely on alcohol to forget their troubles. This was not because they all found alcohol more satisfying than other mind-altering chemicals; it was just cheaper. Indeed, hard drugs were so expensive that many surveys of the homeless in the early 1980s did not even bother to ask about the subject. When interviewers did ask, the homeless were far more likely to report alcohol than drug problems.

Alcoholism has been a significant cause of homelessness for generations, but I found no good evidence that it became more common during the 1980s, either in the nation as a whole or among the very poor. Surveys of the homeless conducted in the early 1980s typically concluded that about a third of them had serious alcohol problems.[1] Surveys of skid-row residents earlier in the century usually came up with similar figures. Thus if our task is to explain why the very poor have moved from skid-row hotels to shelters and the streets over the past generation, alcohol is not a promising explanation.

The arrival of crack in the mid-1980s changed this picture substantially. Crack produced a shorter high than earlier forms of cocaine, but it was also much cheaper. When it arrived on the streets in the mid-1980s, a single hit typically cost $10. Today the price is often $5 and sometimes as low as $3. Like the half-pint whiskey bottle, crack made the pleasures of cocaine available to people who had very little

cash and were likely to spend it on the first high they could afford. Within a few years, crack was available almost everywhere the homeless congregated.

Antidrug propagandists often try to convince the public that everyone who uses crack becomes an addict, but that is not true. Ethnographic studies suggest that crack users are in fact a lot like alcohol users: some use crack constantly (at least until their money runs out), some use it only occasionally, and some fall in between. Nor is crack necessarily worse for people than alcohol—the jury is still out on that question. But it is clear that some people who were not alcoholics found crack very seductive. That means a society in which people can get both alcohol and crack will have more chemical dependency than a society in which only alcohol is available.

How Many of the Homeless Use Crack?

Surveys that ask people how much alcohol they use always end up with far lower estimates of total consumption than surveys that ask manufacturers how much alcohol they have sold. Because the production and distribution of cocaine is illegal, manufacturers do not provide the Treasury Department with data on their total output. Nonetheless, it seems safe to assume that those who rely on users to provide information about their level of drug consumption will underestimate the extent of the problem.

Unlike surveys, urine samples provide relatively reliable estimates of cocaine use. In 1991 the Cuomo Commission asked a large sample of New York City shelter users for anonymous urine samples. Participation was voluntary. Among single adults in general-purpose shelters who agreed to participate, 66 percent tested positive for cocaine.[2] In family shelters, the figure was 16 percent. According to the commission, earlier surveys that had asked shelter residents direct questions about drug use yielded far lower estimates of cocaine consumption.

Cocaine remains in a user's urine for only two to three days, so the Cuomo Commission's tests missed some occasional users. But while more than two thirds of the single adults in New York shelters probably used crack occasionally, fewer than two thirds were likely to have been daily users.

Since many people assume that New York is the crack capital of the world, and since no other city has collected urine samples from its shelter users, it is tempting to dismiss the Cuomo Commission's findings as atypical. But New York is not as atypical as most people imagine. Among men arrested during 1990 in Manhattan—the only New York borough for which I could find data—65 percent tested positive for cocaine. America has seven other cities with more than a million inhabitants: Los Angeles, Chicago, Houston, Philadelphia, San Diego, Detroit, and Dallas. Among men arrested in these seven cities, 49 percent tested positive for cocaine in 1990.[3] Figures for arrestees in smaller cities are usually lower, but not a lot lower.

New York City's statistics suggest that cocaine use is about as common among single homeless adults in general-purpose shelters as among arrestees. If that rule holds for other cities of more than a million, about half the single men and women who went to shelters in these cities during 1991 had used cocaine within the past couple of days. Nationwide, a reasonable guess might then be that a third of all homeless single adults use crack fairly regularly. If so, crack is now as big a problem among the homeless as alcohol.

New York's general-purpose shelters are notoriously bad places, so the foregoing calculations may somewhat overstate the level of cocaine consumption. But even if only a quarter of the homeless are using crack regularly, it still seems likely that the overall rate of substance abuse among the homeless is higher today than it was in the early 1980s. That may help explain the otherwise puzzling increase in homelessness between 1984 and 1988, when unemployment was falling.

Does Crack Cause Homelessness?

Advocates for the homeless usually argue that drug use, like mental illness, is a product of homelessness. Big-city shelters are full of crack, and so are many of the public places where the homeless gather. In some of these places, sharing drugs has apparently become the nexus of social life, in much the way that sharing a bottle was a decade ago. This could mean that a lot of people begin using crack because they are homeless rather than the other way around.

Just as with mental illness, this line of argument captures an

important truth. But just as with mental illness, it also ignores another important truth: heavy drug use can cause homelessness. Heavy use makes marginally employable adults even less employable, eats up money that would otherwise be available to pay rent, and makes their friends and relatives less willing to shelter them. We have no reliable data on how many of the homeless were already heavy users before they became homeless, but the proportion must be higher than in the general population.

Furthermore, while we have no hard evidence about crack's role in pushing people onto the streets, it clearly helps keep them there. Burt found that half the single adults who used shelters or soup kitchens in large cities reported that their cash income for the month prior to being interviewed was less than $70. That works out to about $2.30 a day. Only one in six reported taking in more than $10 a day.[4] Thus if homeless crack users were paying in cash, drugs must have consumed most of their income.

A bed in a New York or Chicago cubicle hotel currently costs about $8 a night. Most people who have enough money to buy substantial amounts of crack could therefore afford to rent a cubicle instead. A large fraction of the single adults in the New York shelters who test positive for cocaine presumably think that a crack high, however brief, is worth more than a scuzzy cubicle.

Some of the homeless may, of course, be getting their crack free because they work for a distributor in some menial capacity. I have no idea how common this is. We badly need more reliable information on where the homeless get their money and how they spend it. But the only way to collect better information is to spend endless hours with the homeless, observing what they do instead of just asking them about such matters on surveys. Living with the homeless is both disagreeable and dangerous, so only the adventurous want to do it. And adventurers seldom want to keep track of other people's money.

Whatever their current budgets look like, we have to assume that a significant proportion of today's homeless will spend any additional cash they receive on drugs or alcohol. This is likely to be true regardless of whether the extra money comes from a government check or from individual handouts. It is hard to be sure how large this group is. It might be as small as a third of the homeless or as large as two thirds.

But even if two thirds of the homeless were using all their extra cash to buy more drugs or alcohol, that would leave a third who were not. One cannot, then, build a case against either public or private charity on statistics of this kind. Only a fool imagines that every dollar spent on doing good has the intended effect. If even a third of the money we give the homeless ends up improving the quality of their lives, it would yield more happiness than most of what we spend on ourselves.

Nonetheless, some conservatives push the argument a step further, claiming that by giving the homeless free shelter we are, in effect, helping them buy more alcohol or drugs. That argument surely contains a grain of truth, but probably not much more than that. Even when shelters are free, fewer than half of all homeless single adults use them on an average night. This makes it hard to believe that eliminating shelters would persuade many homeless drug or alcohol users to spend their limited funds on renting a room. The main effect would probably be to push the proportion who sleep in public places back to what it was in the early 1980s.

We could, of course, revive the traditional practice of jailing people who sleep in public places. But judges who cannot find enough cells for people who steal automobiles and television sets are unlikely to hand out long sentences to those who merely sleep in doorways. If mayors tell the police to arrest such people, judges will have to release them the next day, just as they did thirty years ago. The prospect of a night in jail did deter some alcoholics from spending all their money on drink during the 1950s and 1960s, and it might keep a few drug users from spending all their money on crack in the 1990s. But I see no reason to think that this deterrent effect would be large.

Indeed, jailing people who sleep in public places could conceivably encourage substance abuse. That possibility arises because in some respects jails provide better accommodations than shelters. A survey conducted in New York City during the early 1980s found that those who had spent time in both shelters and jails rated the jails superior to the shelters on cleanliness, safety, privacy, and food quality. Shelters ranked ahead of jails only on personal freedom.[5] Although shelters are probably cleaner and almost certainly provide better food today than in the early 1980s, they offer no more privacy and are probably more dangerous.

Because punishment does so little to deter chemical addiction, liberal reformers usually prefer detox centers and twelve-step programs. The Cuomo Commission strongly endorsed more services of this kind, but neither the Commission's report nor any of the other books I have examined provides convincing evidence about how well these services work. The Commission simply assumed that services would work. Such optimism represents a triumph of hope over experience. Without hope, the world would be a worse place than it is. Still, experience does suggest that while some services work some of the time, many are ineffective. When advocates fail to mention this risk, taxpayers should check their bank balance.

Drugs, Madness, Luck, and Blame

Despite all the evidence that mental illness and substance abuse play a big role in homelessness, some knowledgable people still insist that the homeless are mostly people "just like you and me" who happen to be down on their luck.[6] The homeless are indeed just like you and me in most respects. But so are saints and serial killers. Members of the same species inevitably have a lot in common. We all need food to survive, put on our socks one at a time, remember our childhood with mixed feelings, and worry about dying. But important as such similarities are, our differences are also important. To ignore them when we talk about the homeless is to substitute sentimentality for compassion.[7]

The theory that the homeless have just hit a patch of bad luck is at best a partial truth. Both success and failure are the cumulative product of many influences, of which luck is only one. If you study people who have climbed to the pinnacles of power and influence in American society, you usually find that they have had "all the advantages." Most started life with competent parents, had more than their share of brains, energy, or charm, and then had unusual good luck. Without any one of these advantages they might still have done well, but not as well as they did.

The same rule applies at the bottom of the economic ladder. Those who end up on the street have typically had all the disadvantages. Most started life in families with a multitude of problems; indeed, many came

from families so troubled that they were placed in foster care. Many had serious health and learning problems. A large number grew up in dreadful neighborhoods and attended mediocre schools. After that, most had more than their share of bad luck in the labor market, the marriage market, or both. It is the cumulative effect of all these disadvantages, not bad luck alone, that has left them on the streets.

When we try to understand this issue, it helps to remember that if bad luck were the main cause of homelessness, good luck would suffice to end it. Luck is by definition always changing. Thus if bad luck were the main cause of homelessness, most people would be homeless occasionally, but few would be homeless for long. In reality, most people are never homeless, a sizable number are homeless briefly, and a few are homeless for long periods. The long-term homeless are mostly people for whom almost everything imaginable has gone wrong for many years. Many are heavy drug or alcohol users. Many have severe mental disabilities. Even those who do not have such easily labeled problems have the kind of bad luck that recurs over and over, causing them to lose one job after another and one friend after another. In such cases it makes more sense to speak of bad karma than of bad luck.

Sympathetic writers and advocates often dwell on bad luck because they want to convince the public that the homeless are victims of circumstances beyond their control and deserve our help. This strikes me as a myopic strategy. It inspires incredulity among the worldly, and it leads the credulous to underestimate how much help the long-term homeless really need. If bad luck were the main cause of long-term homelessness, we could solve the problem by giving everyone on the street a shower, clean clothes, a job at McDonald's, and a roommate. Sometimes that is all the homeless need, and surely we should offer it. But many need a great deal more.

Debates about the relative importance of luck and character are often just covert arguments about the assignment of blame. Americans have always thought their country perfectible, so when something goes wrong we look for scapegoats. In the case of homelessness, conservatives want to blame the homeless, while liberals want to blame conservatives. Both explanations are correct. If no one drank, took drugs, lost contact with reality, or messed up at work, homelessness would be rare.

If America had a safety net comparable to Sweden's or Germany's, homelessness would also be rare. It is the combination of personal vulnerability and political indifference that has left people in the streets.

In trying to explain this situation, we need to replace our instinctive either-or approach to blame with a both-and approach. Consider drugs. Homelessness spread during the 1980s partly because criminal entrepreneurs made cocaine available in smaller doses at lower cost. They clearly deserve lots of blame. Those who succumbed to this new form of temptation must also take responsibility for what crack did to them. But that does not mean either our culture or our political institutions can escape blame. America has had high levels of drug and alcohol abuse for generations. No one knows exactly why this is, but it is an integral part of our culture. Most societies prepare children for competitive failure, for example. We nourish the illusion that everyone can win the race if they have "the right stuff," so economic success becomes a measure of personal adequacy. Other political systems also make more effort to help those who succumb to drugs or alcohol. We see the modest success rates of such programs as evidence of their futility rather than evidence that they need to be improved.

The same both-and logic applies to the homeless mentally ill. Homelessness spread during the 1980s partly because states pushed a lot of very sick people out of hospitals without offering them anywhere else to live. The legislators who endorsed this policy have much to answer for. But that does not mean the mentally ill bear no responsibility for their fate. Only a small minority of the mentally ill ended up on the streets. This was partly because they had no family members willing to look after them and partly because their particular symptoms were more conducive to homelessness. But the mentally ill, like children, must still take some responsibility for their own actions and share some of the blame for the consequences. If they are not sane enough to do that, they really do need to live in hospitals.

Even in America, the world's most commercialized society, blame is still free. That means there is always plenty for everyone.

5. *Jobs and Marriage*

When homelessness first became a national issue during the early 1980s, many people blamed the problem on the economy, which was producing unemployment rates near 10 percent for the first time since the 1930s. When economic recovery failed to make a perceptible dent on homelessness, such explanations lost some of their appeal. But many Americans still attribute the spread of homelessness to the dearth of job opportunities for unskilled workers.[1] In addition, some think cutbacks in government benefits have made it harder for people without jobs to keep a roof over their heads.

Changes in the labor market could also have contributed to rising homelessness among women, but hardly anyone makes that argument. Instead, most observers blame the spread of homelessness among women on the decline of marriage, which left more women fending for themselves. The fact that fewer women have husbands seems particularly likely to have pushed up homelessness among children, since men seldom do much to support their children unless they live under the same roof, and unskilled women can seldom support themselves and their children on their earnings alone.

Any given individual's chances of being homeless obviously fall on a continuum that runs from very high to very low. If you have no salable skills, no claim to government benefits, no friends or relatives willing to help out, and spend whatever money you have on crack, you are likely to become homeless. If you have skills that employers value,

general weakening of family ties that left more of the very poor without relatives willing to help them (see Chapter 7). Fourth, as more communities opened shelters, more of the people who were doubled up in high-stress situations may have chosen to move to these shelters (see Chapter 10).

6. *The Destruction of Skid Row*

Soon after homelessness emerged as a national problem in the early 1980s, a small but influential group of housing advocates began arguing that changes in the housing market had played a major role in creating the problem. They told two stories. The first, which I discuss in this chapter, tried to explain why single adults who once lived in skid-row hotels now live in shelters and bus stations. The villains of this drama were the politicians and planners who let developers replace "single room occupancy" (SRO) hotels and rooming houses with shopping malls, office buildings, and up-scale apartments. The housing advocates' second story, which I discuss in Chapter 8, tried to explain why more families with children were showing up in shelters. This account emphasized the growing shortage of what advocates called "affordable" housing for families.

How Many SRO Rooms Were Lost?

Almost everyone who tries to explain the spread of homelessness mentions the destruction of SROs, but hardly anyone says precisely what an SRO is. This ambiguity seems to reflect the bureaucratic origins of the term. Over the past century most cities have adopted increasingly stringent rules about the kinds of housing developers can put up. In most cases these rules apply only to new units. Existing units are usually exempt under some kind of grandfather clause. The term SRO typically

describes older buildings divided into single rooms that do not meet a city's current standards for new construction.

Because building codes vary from city to city and are constantly changing, what gets counted as an SRO varies both from place to place and over time. Indeed, different agencies in the same city sometimes define an SRO differently. In one case it may be a cubicle hotel in which the rooms have no windows or have less than 60 square feet of floorspace. In another case it may be any hotel or rooming house in which the rooms do not have their own bathroom. In a third case the term may cover all one-room units without their own bathroom and kitchen.

If we want to understand what happened to the supply of one-room rental units, we need to impose some order on this chaos. The simplest approach is to use Census data to trace changes in the number of one-room rental units with different characteristics. Three kinds of rooms seem especially relevant to the problems of the poor: rooms without kitchens, rooms without bathrooms, and rooms in hotels and rooming houses. Cheap hotels and rooming houses are important because they usually rent by the day or the week as well as the month, and few demand security deposits.

The Census Bureau's American Housing Survey (AHS), which began in 1973, provides the best available data on one-room rental units, but it has three important limitations.[1] First, it does not survey many one-room units in any given year.[2] Second, it does not cover tenants in hotels patronized mainly by transients unless they have been there—or expect to be there—for at least six months. Third, the AHS changed the way it counted rooms in 1985. From 1973 through 1983 the AHS let tenants decide for themselves how many rooms they had.[3] If an apartment had a main room plus a kitchen set into an alcove, for example, the tenant could say the apartment had either one or two rooms. Starting in 1985, the AHS began asking respondents whether their home had specific kinds of rooms, such as a living room, a dining room, a bedroom, a kitchen, and so on. As a result of this change, a quarter of the nation's one-room units became two-room units.

Most discussions of rented rooms concentrate on what the Census Bureau calls dwelling units, and I do the same in this chapter. A room constitutes a separate dwelling unit only if a tenant can reach it directly

Table 7. Number of One-Room Rental Units with Various Characteristics, 1973–1989
(Numbers in thousands)

	Old room definition			New room definition		Net change	
Characteristic	1973	1979	1983	1985	1989	1973–83	1985–89
Total	1114	1134	1134	816	789	+20	−27
Occupied units	920	991	981	713	672	+61	−41
In hotel or rooming house[a]	314	221	171	116	162	−143	46
No complete bathroom	328	233	236	155	175	−92	20
No complete kitchen	442	306	298	256	238	−144	−18

Source: Tabulations by David Rhodes from the American Housing Survey.

a. Covers rooms in rooming houses and nontransient hotels, plus rooms in transient hotels occupied by the same person for six months or more.

from the street or from a common hall. If a tenant has to walk through someone else's home to reach a room, it is not a separate dwelling unit and the tenant is counted as a member of the household in which the room is located. (I discuss people who rent such rooms later.)

Table 7 shows that the AHS count of one-room rental units hardly changed from 1973 to 1983, hovering around 1.1 million. When the AHS was redesigned in 1985, the count fell to around 800,000.[4] After that, the count remained stable through 1989. Since there was no decline in the number of one-room rental units between 1973 and 1983 or between 1985 and 1989, the apparent decline between 1983 and 1985 is almost certainly a byproduct of the change in survey design (or in the sample).[5] The decennial Census confirms this judgment. The 1990 Census let tenants decide for themselves what counted as a room and found 1.2 million occupied one-room units, which was only 100,000 fewer than the 1970 and 1980 Censuses had found using the same question (see Appendix Table A.2).

While the total number of one-room units was essentially stable from 1973 to 1989, the number of people living in hotels and rooming houses declined from 314,000 in 1973 to 171,000 in 1983. There was another sharp decline between 1983 and 1985. Because this simply

continues the earlier downward trend, and because very few rooms in hotels or rooming houses have their own kitchen, I assume this drop was real. The decline was reversed after 1985, however, and the 1989 count was almost as high as that for 1983.[6] Taken at face value, the AHS suggests that the number of people living in hotels and rooming houses fell by about 90,000 between 1973 and 1979, and by about 60,000 during the 1980s.

The decennial Census tells roughly the same story. The Census found 640,000 people with no other permanent address in hotels and rooming houses in 1960. The figure was down to 320,000 in 1970 and 204,000 in 1980. The exact 1990 figure is uncertain, but it was on the order of 137,000 (see Appendix Table A.2). The Census therefore implies that the number of hotel residents fell by 120,000 during the 1970s and 60,000 during the 1980s, which is consistent with the AHS.

The number of one-room rental units without a kitchen or a complete bathroom declined at roughly the same rate as the number of rooms in hotels and rooming houses.[7] If we concentrate on the years between 1979 and 1989, Table 7 shows that the number of occupied one-room units without complete bathrooms declined by 58,000, while the number without complete kitchens declined by 68,000. The changes between 1973 and 1979 are much larger, but blaming the destruction of SROs in the 1970s for increases in homelessness a decade later raises obvious problems.

Those who believe that tearing down SROs played a major role in the spread of homelessness usually claim that far more than 60,000 rooms were lost. Indeed, the most widely cited estimate is that 1.1 million rooms were lost between 1970 and 1982. More than 100,000 rooms are often said to have been lost in New York City alone.[8] Losses of 10,000 or more rooms have been reported in a number of other large cities.[9] These estimates differ from mine in two important respects. First, the biggest numbers – notably the nationwide decline of 1.1 million units – come from a study that included two-room apartments. Second, the big losses all occurred during the 1970s rather than the 1980s.

Treating the disappearance of SRO rooms during the 1960s and 1970s as a cause of increased homelessness during the 1980s poses the same logical problem we encountered with deinstitutionalization. How,

the skeptic must ask, could tearing down SROs during the 1960s or 1970s drive up homelessness ten or twenty years later? Where were the former SRO residents living in the meantime? If they found alternative housing when the old SROs vanished, what happened in the 1980s to make them homeless? I think all these questions have logical answers, but the answers transform our understanding of the whole process in a fundamental way.

Price Changes

Most of the old SROs were torn down during the 1960s and early 1970s, when both real wages and government benefits were rising. Because real wages were going up, even irregularly employed single adults were increasingly able to afford a room with a bathroom and kitchen. Because a growing proportion of the aged and disabled were eligible for federal benefits and these benefits were becoming more generous, they too could afford better accommodations. Noting this, most people who wrote about SROs in the 1960s and 1970s assumed they would all be gone within a couple of decades.

After 1974 both real wages and government benefits stopped rising, so demand for SRO rooms probably stopped falling. But because there was still a lot of excess capacity in the SRO system, prices did not rise and the process of destruction continued. As far as I can tell, no general shortage of cheap rooms developed until around 1980, when the number of extremely poor single adults began to climb.[10] (In this as in everything else, New York City was apparently an exception.)

The evidence available to document this argument is far from ideal. The decennial Census has never asked people who live in hotels or rooming houses how much rent they pay, so we have no systematic data on rent levels in these places before 1973, when the AHS began. The AHS sample is quite small; it does not cover most people in transient hotels; and it cannot tell us anything reliable about what happened between 1983 and 1985.

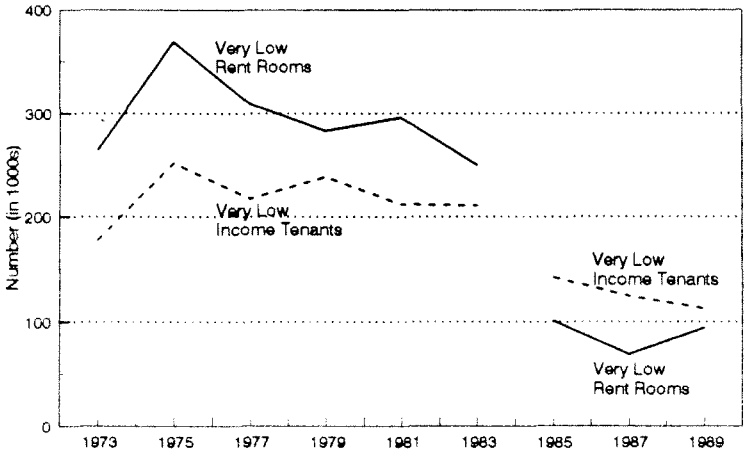
For simplicity, I compare changes in the number of very cheap rooms to changes in the number of very poor tenants who lived in a single room. I call rooms very cheap when the tenant's rent and utility bills ("gross rent") came to less than $150 a month in 1989 dollars. I

call tenants very poor when their personal income was less than 80 percent of the federal poverty line for a single individual. This puts my cutoff at $5000 in 1989.

Figure 2 shows that there were 178,000 very poor tenants and 265,000 very cheap rooms in 1973. Both numbers rose dramatically between 1973 and 1975. That was not because rents or incomes fell. Rather, the jump in oil prices after the 1973–74 embargo drove up prices in most sectors of the American economy much sooner than it drove up rents or incomes. As a result, "real" rents and incomes both fell. But the balance between the supply of very cheap rooms and the incomes of the people likely to live in them does not appear to have changed much.

Although inflation continued through the rest of the 1970s, Figure 2 suggests that the balance between supply and demand remained fairly stable. There were 87,000 more very cheap rooms than very poor tenants in 1973. In 1981 the difference was 84,000. Other measures also suggest that the supply of cheap rooms kept pace with demand. The

Figure 2. Changes in the Number of Very Low Rent Rooms and Very Low Income Tenants Living in One-Room Units, 1973–1989



Source: American Housing Survey. Very low rent rooms cost less than $150 per month (1989 dollars) for rent and utilities. Very low income tenants are those in one-room units with annual income below $5000 per year (1989 dollars).

median rent for a single room was 33 percent of the median tenant's income in both 1973 and 1981, for example.

After 1981 both the housing situation and the data describing it took a marked turn for the worse. The AHS recorded a 15 percent decline in the number of very cheap rooms between 1981 and 1983, while the number of very poor tenants remained constant. As a result, the median rent for a single room jumped from 33 to 40 percent of the median tenant's income. What happened between 1983 and 1985 is anybody's guess. The revamped AHS counted only 101,000 very cheap rooms in 1985, down from 250,000 in 1983. Part of this decline was a byproduct of the Census Bureau's new approach to counting rooms, which cut the total number of one-room units by 28 percent. But the proportion of single rooms costing less than $150 also fell from 26 percent in 1983 to 15 percent in 1985, which is by far the biggest two-year change recorded in the AHS. Some of this decline was undoubtedly real, but some of it may have been a byproduct of changes in the survey.

The number of very poor tenants in one-room units also fell between 1983 and 1985, but far less than the estimated number of very cheap rooms. After 1985, therefore, very poor tenants were more numerous than very cheap rooms. Figure 2 suggests that this situation may have improved a little between 1985 and 1989, but given the small number of cases it is hard to be sure.[11]

My best guess, then, is that a modest decline in the supply of cheap rooms interacted with a significant increase in potential demand to drive up room rents much faster than the general price level. The increase in demand was, in turn, driven by the forces described in the previous chapter: increases in long-term male joblessness and lagging government benefits for those without jobs.

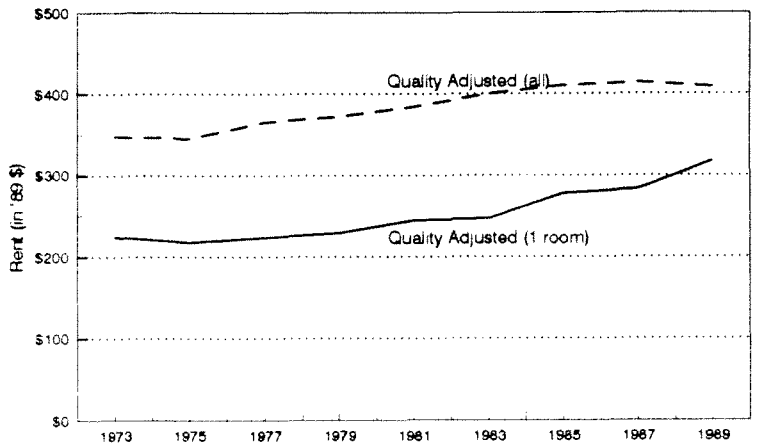
We can test this claim by tracing changes in mean rent for unsubsidized rooms of constant quality. If we convert rent and utility charges to 1989 dollars, the observed mean for all unsubsidized rooms rises from $225 a month in 1973 to $332 in 1989. Part of this increase is traceable to the fact that single rooms were increasingly likely to have their own bathroom, their own kitchen, and other amenities. To control for the effect of these changes, Figure 3 shows trends in what I will call

"quality-adjusted" rent. This is what tenants paid in different years for rooms with the characteristics of the rooms they rented in 1973. For comparison, Figure 3 also shows the quality-adjusted mean for all rental units, regardless of size.[12]

Once we adjust for qualitative improvements, mean rents for unsubsidized one-room units remain virtually constant during the 1970s. This is consistent with my argument that the destruction of cheap SRO rooms during the 1970s was a response to weak demand. After 1979, quality-adjusted rents rise quite rapidly, even after adjusting for the general level of inflation. As we have seen, the number of low-quality rooms did not decline much after 1979. The price increases shown in Figure 3 must therefore have been driven primarily by rising demand rather than falling supply. This judgment is reinforced by comparing quality-adjusted rents for one-room units to those for the rental market as a whole. Quality-adjusted rents for one-room units rose less than those for the market as a whole during the 1970s. After 1979 this pattern was reversed, with quality-adjusted rents rising faster for one-room units than for the market as a whole.

These data all suggest that a shortage of SRO rooms developed in the early 1980s. That change probably contributed to the increase in

Figure 3. Mean Monthly Rents in 1989 Dollars for Unsubsidized Units of Constant Quality, 1973–1989



Source. American Housing Survey. For details see Appendix Table A.3.

homelessness after 1981. But the shortage appears to have been created largely by rising demand and only secondarily by falling supply.

How Could the Homeless Afford SROs?

Those who think the destruction of SROs played a major role in the spread of homelessness must also solve another puzzle. Although SRO residents are extremely poor by mainstream American standards, few were ever as poor as most of today's homeless. Four fifths of all homeless single adults took in less than $2500 in cash during 1987. Only 100,000 people that poor were living in single rooms during the 1970s. Since nearly 50,000 people that poor were still living in single rooms in the late 1980s, only 50,000 appear to have been pushed out of one-room units. That could explain part of the increase in homelessness after 1979, but not a large part.[13]

Another way to assess the likely impact of tearing down the old SROs is to ask what might happen if they were rebuilt. Suppose HUD were to rebuild all the SROs torn down between 1975 and 1985 and rent them for what they cost in 1975, adjusted upward for general inflation. Roughly speaking, that would mean creating 150,000 rooms of extremely low quality and renting them for an average of $150 a month. (The figure would obviously be higher in cities like New York and Los Angeles, lower in cities like Omaha and Memphis.)

Advocacy groups seldom suggest that rooms costing $150 a month would get many of the homeless off the streets, but that may not prove much. Most advocates are committed to the principle that nobody should have to spend more than 30 percent of their income on rent – a doctrine rooted in the fact the federal government sets subsidized rents at 30 percent of the tenant's income. By this standard people need an income of $500 a month before they can afford a room costing $150. Less than 5 percent of the homeless single adults who used big-city shelters and soup kitchens in 1987 reported incomes that high.

In reality, however, nearly two fifths of the nation's tenants currently spend more than 30 percent of their income on rent, and the proportion is even higher among the poor. What people are willing to spend on rent depends not on what Congress deems reasonable but on how much they value shelter relative to other things, and how adept

they are at getting other things free. If the big-city homeless have time, bus fare, and a modicum of experience, they can often get the bulk of their food, clothing, and medical care free. If they do not crave caffeine, nicotine, alcohol, or cocaine, they can in principle spend a very large fraction of their cash on rent. But they may prefer to get their shelter free and spend their meager income on food, clothing, transportation, and stimulants. People's choices are almost as variable when they can spend $10 a day as when they can spend $1000.

It is also important to bear in mind that for the poorest of the poor daily rents often matter more than monthly rents. A drug user who takes in $10 a day panhandling will not save his money until the end of the month to rent a room. Whether he rents a room will depend on how he assesses the tradeoff between cocaine and shelter on a particular night. Renting rooms by the night is considerably more expensive than renting by the month. A hotel that rents cubicles for $175 a month may charge $8 a night for the same space. The price differential reflects both the fact that rooms rented by the day are often vacant and the greater risk that people who pay by the day will vomit in the hall.

The 1980 Census found 28,000 people living in rooms costing less than $4 a night. Allowing for inflation, such rooms would cost about $7 a night today. Not many of today's homeless could pay more than that on a regular basis. The 1990 Census did not report the number of rooms renting for such prices. Everyone agrees that they were scarce, but if only 28,000 people lived in such rooms in 1980, one can hardly argue that their elimination made a major contribution to homelessness.

Why No More Cheap Hotels?

While the number of very cheap rooms destroyed after 1980 was quite small, the fact that we lost any cheap rooms at all during a period of rising homelessness requires explanation. When extreme poverty increases and more people turn to free shelters, one also expects more people to seek out cheap hotels and rooming houses, which provide more privacy and make less effort to regulate their patrons' behavior. The 1980 Census found slightly more people in cheap hotels and rooming houses than in shelters. The number of single adults in shelters

rose by a factor of about five between 1980 and 1990. One would therefore expect the number living in cheap hotels to have risen at least fivefold. Instead, the number apparently declined.

Going back to the 1950s sharpens the puzzle. In 1958, eight times as many Chicago residents lived in cage hotels as in shelters (see Table 3). By 1986 there were something like three times as many people in Chicago's shelters as in its two remaining cage hotels. The physical differences between a cage hotel and a shelter had not changed much. Why, then, did cage hotels lose clients while shelters gained new ones?

The most obvious answer is price. Chicago's cage hotels charged 50 to 90 cents a night in 1958.[14] If monthly discounts were the same then as now, a man could have gotten a room for $12 to $20 a month. The minimum wage was $1 an hour, so it probably took between twelve and twenty hours of minimum-wage work each month to pay for a cubicle. By 1992 Chicago had only one cage hotel with a listed telephone (the Wilson Men's Club Hotel). It charged $7.50 a night (or $162 a month). Similar places in New York, where they are officially called lodging houses, charged about the same amount.[15] The minimum wage was $4.25 an hour, so paying for a cubicle required forty hours of minimum-wage work a month instead of twelve to twenty.

I do not know how much the Wilson Hotel charged in 1958, but even if it was then a "top of the line" cage hotel charging 90 cents a night, its prices have risen by a factor of more than eight. The price of alcohol rose by a factor of less than three during this same period.[16] A six-pack of beer cost more than a cubicle in 1958, making privacy cheaper than oblivion. By 1992 a six-pack cost less than half as much as a cubicle, making oblivion cheaper than privacy. Price changes of this kind surely encourage the poor to spend more on booze and less on shelter. The same pattern holds if we compare the price of a cubicle to the price of cocaine.

There are two logically possible explanations for the rapid increase in cubicle prices: higher costs and higher profits. One way to estimate cost changes is to look at rents for conventional housing, which are generally set in a highly competitive market with many buyers and sellers. Rent increases in this market are likely to be roughly proportional to cost increases, at least over the long run. Rents for one-room apartments rose by a factor of eight between 1960 and 1989.[17] If

landlords' costs also rose by a factor of roughly eight, cage hotels may not have significantly higher profit margins today than in the past.

This comparison is somewhat misleading, however, because Chicago's cage hotels do not seem to have improved their physical facilities since the 1950s, whereas most other one-room units have. In 1960, for example, only 30 percent of America's one-room rental units had a complete bathroom. By 1990, the figure was over 95 percent (see Appendix Table A.2). If the qualitative difference between a cage hotel and the average one-room dwelling widened, one would expect the cost differential to have widened as well.

Cage hotels' costs may, of course, have risen for reasons that had nothing to do with the quality of the service they offered. Increased violence and drug use may, for example, have forced these hotels to hire more staff. But drugs and violence have pushed up costs in all kinds of urban housing. Tenants have become more destructive, and they also demand more protection from outsiders.

The fact that rents rose at least as fast in cage hotels as in classier places may, then, be evidence that the market for cubicles was not functioning as textbooks say it should. Political considerations may have created an artificial shortage of cheap rooms, allowing the owners of the few remaining cage hotels to reap windfall profits.

In *New Homeless and Old* Charles Hoch and Robert Slayton describe how greed, politics, and ideology combined to destroy most of Chicago's cage hotels in the 1970s and early 1980s. These hotels were concentrated on West Madison Street just west of the Loop. In the 1960s developers began arguing that if the city would clear this neighborhood, they could fill it with up-scale housing that would keep affluent young people in the city and eventually repay the city's investment. The city agreed and began leveling the area in the late 1970s. The last cage hotels on West Madison were torn down in the early 1980s.

Because redevelopment eliminated so many cheap rooms so quickly, a temporary shortage was inevitable. But if this had been a textbook market, the story would not have ended there. Everything in Chicago is constantly being torn down, but almost everything that is profitable reappears somewhere else. If pulling down the cage hotels on West Madison had made the ones that survived elsewhere in the city more profitable, entrepreneurs should have created new ones. Many

poor Chicago neighborhoods have vacant buildings that could easily be converted into cubicles. Had such conversions occurred, competition would have driven prices down again. Since that did not happen, we must ask why.

The simple answer is that entrepreneurs can no longer build cage hotels in Chicago because building-code requirements have changed. The same is true in most other cities. The nominal goal of these rules was to ensure that nobody would have to live in conditions as wretched as those in the old hotels, but I doubt that the issue was ever quite that simple. Even the dimmest Chicago alderman must have known that these rules would eventually mean higher rents, and that many skid-row residents could not afford such rents. Why, then, did they vote for such rules?

One way to answer this question is to ask who benefited from the new rules. The main beneficiaries were the owners of existing cheap hotels, who were allowed to remain in business and were protected from new competitors. The losers were the very poor, who had fewer housing options than before. Had the press described the costs and benefits of rules governing cheap hotels in these terms, Chicago politicians might have been reluctant to adopt them. But no one seems to have made arguments of this kind either in Chicago or elsewhere. Liberals who would ordinarily speak up for the very poor usually defended higher standards on the grounds that existing conditions were unconscionable. Perhaps they assumed that landlords would absorb the cost of improvements rather than passing them along to the poor, although it is hard to see why any sensible person would make such an extraordinary assumption.

Once homelessness became a major problem, cities like Chicago could have changed their rules, making it possible to create more rooms that the poor could afford. Few did so. Many decent people opposed such changes, on the grounds that private landlords should not be allowed to get rich renting rotten rooms to poor people. Most neighborhoods also supported restrictive rules, because they did not want anyone building a hotel nearby that would lure more deadbeats into their area.

Fifty years ago, when most cities still had an economically viable skid row, the restaurants, bars, and pawnshops in these areas prospered

by catering to people who lived in nearby hotels. If an old hotel burned down, nearby businesses were eager to see it replaced, and the city was usually cooperative. Even the fire code was often bent to keep cheap hotels open. But once a city has redeveloped its skid row, creating a new one elsewhere is almost impossible. An entrepreneur who tries to create a flophouse will meet fierce opposition both from those who claim to have the interests of the poor at heart and from those who want the poor to live as far away as possible.

While tearing down cubicle hotels in the 1960s and 1970s did not make many people homeless at the time, I believe that the destruction of skid-row neighborhoods did make it harder to create housing for the very poor when their numbers began to grow again. Had cities been able to mothball skid rows during the affluent 1960s and 1970s the way the Navy mothballed old battleships, entrepreneurs could perhaps have created new cubicle hotels when demand revived in the 1980s. But once skid row was gone, it was hard to find any other area that viewed the very poor as a commercial asset rather than a liability. That fact, combined with changes in the laws about panhandling and vagrancy, encouraged destitute single adults to spread out over the entire city, turning every doorway into a potential flophouse.

Municipal policies that bar the creation of new cubicle hotels force the people who once patronized such places to live in shelters and public places. Yet a city that listens to its citizens has few alternatives. The very poor are a tiny minority, and they hardly ever vote. Citizens who want the poor to live as far away as possible are a large majority, and they vote regularly. That leaves the poorest of the poor with nowhere to go.

7. *Social Skills and Family Ties*

Although cubicle hotels were traditionally the cheapest form of shelter available to people who wanted to live alone, they never housed more than a small fraction of the nation's poor unmarried adults. Living alone has never been as cheap as living with other people, so most poor unmarried adults have always lived in someone else's home.

A room in a nonrelative's home cost about 20 percent less than a room in a hotel or rooming house in 1989. Partly for this reason, working-age adults were five times as likely to rent rooms in a nonrelative's household as in a hotel or rooming house.[1] Unfortunately, the Census Bureau did not collect data on roomers before 1985, and we do not know how either the number or the price of rented rooms in other people's homes has changed.

People who want to minimize their housing costs can save even more money if they find housemates and rent space together. Hotels and rooming houses charged an average of $283 a month in 1989, while rents averaged $392 a month in one-bedroom apartments, $476 in two-bedroom apartments, and $494 in three-bedroom apartments.[2] Thus if three typical SRO residents had rented a typical three-bedroom apartment, they could have cut their monthly rent from $849 to $494—a reduction of 42 percent. Living together in a three-bedroom apartment would also have provided them with more space per person, a bathroom shared with only two other people, a kitchen, and other amenities that are rare in hotels and rooming houses.