Homeless Women: A Context for Health Planning

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HOMELESSNESS HAS IN RECENT YEARS CAPTURED the attention of the American public. Perhaps it is more accurate to say that homelessness has intruded itself upon the public consciousness. The growth of homeless populations on our city streets (Cummings 1982; Shipp 1985), in our suburbs (Graf 1985; Kerr 1985; McQuiston 1984; Montgomery County Department of Family Resources 1985), and even in remote and rural places (Bachrach 1983, 1986b; Young 1983) has forced society into awareness of a problem that many people would probably prefer to avoid altogether.

A rapidly growing body of literature on homelessness in America is emerging in response. Yet, although the homeless population of the United States consists of both men and women, several observers have noted that the literature concentrates primarily on men (Crystal 1984; Multnomah County 1985; Shulman 1981). Few professional contributions even acknowledge gender differences in the homeless population, and fewer still focus on homeless women's special circumstances.

Those writings on homeless women that do exist are remarkably consistent in their reiteration of several basic themes: that women are being evicted and displaced in increasing numbers all over the United States; that their meager personal resources are inadequate to sustain them; that their homelessness is somehow more "invisible" than that

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of men (Austerberry and Watson 1983; Brickner 1985; Teltsch 1986; Wynne 1985); that many of them suffer untold emotional deprivations in addition to their homelessness; and that for virtually all of them, whether they are impoverished single heads of household, battered spouses, or individuals with diagnosed chronic mental illnesses, ready access to adequate health care is a basic life necessity.

In this review of the current literature I shall explore the dimensions of homelessness for women in the United States and the implications of those circumstances for health planning. The narrative will begin with a general discussion of the nature of homelessness and move toward examination of the special circumstances that affect the health of homeless women. Finally, the need for relevant service planning and creative service-delivery strategies in a context of continuity of care will be stressed.

It should be noted that most written accounts of homeless women today—many of them graphic, informative, and poignant—are found in the popular press. That some of these media reports have actually been written by scientists, scholars, and direct service providers (Bassuk 1983; Breakey and Fischer 1985; Lynch 1986; Sidel 1986) perhaps reflects a tentativeness on the part of the authors. Since the state of the art is largely empirical, professional commentators may be reluctant to publish in scholarly journals. Yet, the problems of homeless women clearly require professional synthesis. The present review thus represents an early effort to place the body of knowledge in more academic perspective by sorting through a variety of reports and suggesting some directions in program planning and service delivery.

It is also appropriate at this point to say what this article is *not*. Many of the problems of homeless women are rightly perceived as the result of social policy that reduces these individuals to poverty and hopelessness. Other writers (Hopper, Susser, and Conover 1985; Rowan 1986; Snow et al. 1986) have described these forces eloquently. And, although I as a citizen deplore such inequities and have advocated their dissolution, I shall limit discussion of them in the present review to their immediate relevance to the health needs of homeless women.

Defining Homelessness

There is little consensus regarding the meaning of homelessness. I have actually been present when experts in health service delivery

have debated the question of whether a cardboard box, a reed hut, or an automobile might reasonably be construed as a home, particularly under benign climatic conditions such as those prevailing in southern California. There are similar debates over whether a simple lack of shelter is by itself sufficient to render an individual homeless. It is for this reason that some advocacy groups in Great Britain have introduced the concept of "houselessness" in contradistinction to "homelessness" (Bailey 1977). While houselessness implies a simple absence of physical residence, the term homelessness is reserved for a condition of more generalized deprivation. Thus, most definitions of homelessness appear to agree that, in order for a person to be classified as homeless, his or her lack of physical residence must occur under conditions of social isolation or disaffiliation (Bassuk 1983; Larew 1980; Segal and Baumohl 1985).

Homeless individuals, as Breakey and Fischer (1985, 16) note, "sleep in many different places." They may be found "under cars, in parks, in emergency rooms and libraries and subways, in dumpsters and doorways and abandoned houses. Some wander all night." And some, as these authors point out, are at any given time in jails or other correctional facilities. Bailey (1977) includes in his definition of homelessness individuals who unlawfully "squat" on property belonging to others, as well as those who reside in hospitals not because they must but because there is no other accommodation available to them.

Thus, it is obvious that the homeless population is a vastly heterogeneous one consisting of many subgroups. Certainly individuals with serious alcohol and drug problems are heavily represented within it. In addition, people in all regions of the country and individuals of all ages and ethnic origins are found among the homeless of America (Kerr 1985; Shipp 1985), as are pregnant women and mothers with newborn babies and dependent children (Bassuk 1986; Rangel 1985) and unhoused and inadequately served chronically mentally ill individuals (Bachrach 1984b).

In addition to its heterogeneity, the homeless population in the United States today appears to be undergoing extensive demographic changes (U. S. General Accounting Office 1985). Whereas in earlier decades the population consisted largely of middle-aged male alcoholics, today's homeless population appears to contain growing numbers of young adult individuals. In many parts of the country the homeless population is very youthful in its profile (Bachrach 1984b).

Today's homeless population is also, as previously noted, being saturated with increasing numbers of economically displaced individuals often called the "new homeless" (Kerr 1986)—people who have lost their jobs and are down and out (McCarthy 1986). Poverty, fueled by both increasing unemployment rates in certain segments of the American population and cuts in public assistance programs during the 1980s (Maine Task Force to Study Homelessness 1986; Multnomah County 1985; U.S. General Accounting Office 1985), is undoubtedly an important factor in the changing composition of today's homeless population. And with the growing "feminization of poverty" (Bassuk 1986; O'Connor 1986; Stein 1986), increasing numbers of impoverished single women, often together with their children, are becoming a significant element in that population.

Considerations of Time and Space

Homelessness may be quite temporary, or it may be a more or less permanent circumstance. Thus, Arce and his colleagues (1983) differentiate between "street people" and "episodically homeless" individuals in an emergency shelter setting in Philadelphia. The episodically homeless move into and out of the homeless population and are characterized by great residential instability as described by Chafetz and Goldfinger (1984).

Not only is there variation in the duration of homelessness; the members of this population also differ widely in their patterns of mobility. There are, in fact, three distinct mobility axes that interact to complicate precise identification of the homeless population (Bachrach 1987a). In addition to movement into and out of the population there may be distinctive patterns of diurnal or seasonal movement within defined geographic areas. Some homeless individuals live more or less constantly in one place; others, while they may remain essentially in the same neighborhood, branch out as shelters and other services become available to them, or as their specific needs for subsistence and health services shift. Some shelters impose a time limit on the number of days that individuals may remain in residence and thus add to this kind of mobility.

The third mobility axis, migration over wide geographic areas, causes even more confusion for those who would attempt to define, count, or track the homeless population. Although many homeless

people are relatively stationary, some—the exact proportion varies widely from place to place—move among the various regions of the country. The precise correlates of these gross migration patterns are poorly understood, but there is little question that they prevail and that they may characterize some of the sickest members of the population (Bachrach 1987a). In fact, they are probably reinforced—perhaps even precipitated—by certain informal practices. For example, there are reports of homeless individuals who have been recruited into migrant labor streams, transported over considerable distances, and then released to wander in the areas to which they were taken (Henry 1983; Herman 1979; Moore 1985). A practice jokingly referred to as "Greyhound therapy" (Cordes 1984; Shipp 1985; Van Winkle 1980)—providing homeless individuals with one-way bus tickets out of town—may similarly contribute to these gross migration patterns.

Chronic Mental Illness

It is prudent to explore the relation between homelessness and chronic mental illness as part of any discussion of how to define homelessness, since the two circumstances frequently overlap. In a moving first-hand account Pia McKay (1986), a former school teacher who has been homeless in Washington, D.C., for several years, writes, "Sometimes I am sharply aware of my surroundings; sometimes I am like a plastic doll, my staring eyes open but unseeing, or I am like a zombie, moving but unfeeling." Ms. McKay is obviously an accomplished and persuasive writer. She has also been diagnosed as having chronic schizophrenia. But it must be said emphatically that not all homeless individuals are chronically mentally ill.

Since homelessness is an issue with distinct political overtones, however, the relation between the two events, homelessness and chronic mental illness, has become a controversial and territorial matter. An article in the *Boston Globe,* for example, notes that psychiatric researchers in the area of homelessness often "draw fire" from advocates for homeless people "who consider economic issues, such as the cost of a shrinking number of low-cost apartments, the central problem. They accuse the medical people of blaming the victims" (Alters 1986).

Having thus moved into the arena of turf and territoriality, the question of the relation between homelessness and chronic mental illness has unfortunately become clouded with irrelevant observations

and special-interest rhetoric. Its resolution must await consensus about the precise characteristics of people who are simultaneously homeless and chronically mentally ill, a task that is fraught with complicated methodological problems (Bachrach 1984c).

Even in the absence of consensus, however, certain generalizations may be made about the relation between these two events. First, many homeless individuals—perhaps as many as half throughout the United States (U. S. Department of Health and Human Services 1983)—suffer from chronic mental illnesses. Some of these individuals have been enrolled in one or more mental health treatment facilities. Some have been released one or more times from state mental hospitals as the result of discharge policies associated with deinstitutionalization. Others, however, because of admission diversion policies also related to deinstitutionalization, have never been enrolled in mental health facilities at all. To identify deinstitutionalization as a factor in the homelessness of some individuals is neither to endorse nor to indict that policy; it is merely an acknowledgment of the oft-noted fact that the termination of state mental hospital programs has not uniformly, across the United States, been accompanied by the development of sufficient and adequate community-based service alternatives (Bachrach 1987c).

Second, many homeless individuals who are not the victims of chronic mental illnesses per se endure life circumstances that may serve to simulate the presence of those illnesses. Baxter and Hopper (1982, 402) write very persuasively, for example, that if some homeless individuals diagnosed with chronic mental illnesses were to receive "several nights of sleep, an adequate diet, and warm social contact, some of their symptoms might subside." It is not always easy to establish the presence of psychopathology in an individual who is suffering extreme physical deprivation.

Third, making a distinction, either theoretical or clinical, between homeless individuals who have chronic mental illnesses and those who do not is in no way either pejorative or discriminatory. It is merely an effort to identify some of the parameters of homelessness so that individuals who suffer from its effects may be offered the most appropriate services and supports. If errors in diagnosing homeless individuals are sometimes made, that must be regarded as a reflection of inadequacies in the state of the art and not as a political statement. Dr. William Breakey (personal communication 1986) of Johns Hopkins University

has aptly stated that a diagnosis is not an indictment. It is, rather, a working hypothesis that assists professionals who seek to prescribe relevant care for homeless individuals.

Characterizing Homeless Women

Women appear to constitute a distinct minority within the total homeless population. Using data bases from communities throughout the United States, Brickner (1985), the City of Boston Emergency Shelter Commission (1983), Roth et al. (1985), and the United Way of Greater Tucson (1984) all provide statistics showing that women constitute between 18 and 20 percent of the total homeless population. Depending on their socioeconomic, demographic, and other sociological characteristics, however, specific communities may deviate quite considerably from this statistical norm. Since a number of factors are associated with homelessness, any community will vary according to distributions on correlative variables. Thus, the community's demographics, the access of its female citizens to jobs and entitlements, the availability of low-cost housing, its patterns of family organization and disruption, and its mental health care policies and practices will all help determine the number of women within it who are homeless.

In those instances where research has investigated differences between homeless women and homeless men, a number of conclusions have been reported. Homeless women appear to be somewhat less transient than homeless men. McGerigle and Lauriat (1983) report, for example, that while fewer than half of the men in their one-day census of all Boston and Cambridge shelters had come from the Boston area, virtually all of the women had "local origins." Homeless women also appear less often than homeless men to be alcoholic (Barker 1986; Lenehan et al. 1985; McGerigle and Lauriat 1983; Morse et al. 1985). And men tend generally to have longer durations of homelessness than women (Drake, O'Brien, and Biebuyck 1981; Lenehan et al. 1985; McGerigle and Lauriat 1983; Morse et al. 1985).

On the other hand, homeless women are reported to exhibit more severe psychopathology than men (Crystal 1984). Lenehan et al. (1985, 1239–40) report, for example, that at the Pine Street Inn, a well-known 350-bed "model" shelter in Boston, 90 percent of women exhibit psychiatric illnesses, as contrasted with 40 percent of the men.

These authors report that the psychiatric problems of homeless women are often "more complex and severe" than those of men and speculate that it may take "a greater crisis to force them onto the street."

Some caveats must, however, be employed in interpreting these statistics and observations. It is possible that homeless women have greater reluctance to respond to researchers' questions than homeless men, so that relatively few generalizations may be made from existing field studies. McGerigle and Lauriat (1983) report, for example, that almost one-third of women residing in Boston and Cambridge shelters refused to answer some or all of interviewers' questions—about twice the percentage for men.

Another potential source of error comes from the fact that, although many generalizations about homeless women are based on counts or observations made in day or night shelters, soup kitchens, or other facilities serving homeless people, these women are frequently, as previously noted, "invisible"—hidden in places not known to researchers and thus largely unavailable to them. Thus, the characteristics of women in facilities may bear little resemblance to the characteristics of the total population of homeless women in a given community.

In addition, the existence of certain "gatekeeping" strategies may further serve to bias the distribution of homeless women in a facility-based population. A place that has an open door and admits any woman will obviously receive a different population from one that excludes women who are pregnant, drunk, physically disabled, or suspected of using hard drugs—all factors known to affect admission to facilities in some places (Baxter and Hopper 1982). To some extent the character of any facility's population will also be determined by the array of other facilities serving homeless women within the same community.

Correlates of Homelessness

Sociologically, many pathways lead to homelessness, and specific circumstances combine with general determinants in subtle ways to shape the careers of individual homeless women. Two general factors, poverty and the absence of adequate low-cost housing, however, serve as common denominators. The results of a survey of homeless women

in Portland, Oregon (Multnomah County 1985) document this situation. Ninety percent of these women are unemployed, and over half of them live on less then $2,000 per year.

Eviction and abuse are also frequent correlates of homelessness among women. Often, of course, the two are related, as in the case of a woman who is put out of her home by an abusive spouse. Indeed, as the Portland study shows, conditions of violence and physical abuse are common events in the everyday lives of homeless women. Over two-thirds of the women in that study have been abused at some time in their lives, and about one-third trace their current homelessness to an abusive relationship (Multnomah County 1985).

The threat of violence is, in fact, present for homeless women wherever they are—whether they live in facilities or on the streets (Ball and Havassy 1984; Fein 1986; McKay 1986), and it is reflected in this anecdotal field note from the files of an interviewer in the Portland study cited above: "As we were interviewing, a man came up and said, 'the only thing homeless women are good for is to be jackrolled on the street'" (Multnomah County 1985, 17).

Another general correlate of homelessness among women is the risk for severe physical illness. Homeless women are not, by and large, healthy people, and they tend to suffer from a variety of physical ailments (Strasser 1978). Like homeless men, they often experience such disorders as acute or chronic alcoholism, drug abuse, trauma, accidents, burns, respiratory infections, tuberculosis, cardiovascular disease, leg ulcers, cellulitis, acute gastrointestinal disease, seizure disorders, and insect infestations (Brickner 1985). Also, because of a sex-borne tendency toward varicose veins and veinous insufficiency, they often suffer from peripheral vascular disease and its consequences. It is not uncommon for women living on the streets to have massively swollen legs (Brickner 1985).

The several circumstances associated with women's homelessness noted here—poverty, inadequate housing, eviction, abuse, and risk for physical illness—form a backdrop of circumstances within which homeless women live their lives. These events may occur in various time sequences. For example, poverty may either precede or follow abuse. But their actual or threatened occurrence is an ever-present reality in the lives of homeless women. Most of these women simply cannot afford to maintain themselves; they overwhelmingly lack the

social and vocational skills as well as the ego strengths that might permit them to move into other circumstances; and they generally live their lives in fear and desperation.

Effects of Deinstitutionalization

For chronically mentally ill homeless women these general correlates are frequently complicated by the effects of deinstitutionalization. Broadly defined, deinstitutionalization includes more than the mere release of patients from state mental hospitals. It also encompasses a civil libertarian philosophy that is manifested in preclusive commitment procedures in many states. Accordingly, chronically mentally ill individuals are often caught in an ideological Catch-22 situation, and their needs for adequate treatment and assured housing are subordinated to their right to live "freely" in "nonrestrictive" settings (Bachrach 1980).

Thus, many chronically mentally ill individuals, disabled by their psychiatric illnesses, actually experience a unique form of eviction—i.e., exclusion from the state mental hospitals which in other times served as their homes. And, far too often, there has been a failure to provide adequate community-based substitutes for the many functions performed by those institutional facilities (Bachrach 1984a, 1987c).

The case of Rebecca Smith provides a prototypical example of what sometimes happens under such circumstances (Allen 1982). Several winters ago Ms. Smith, who was 61 years old, died of hypothermia in her "home," a cardboard box on Tenth Avenue in New York City. She had previously been a patient in a state mental hospital but had steadfastly refused to be readmitted. At the time of her death city officials were attempting to obtain a court order for her rehospitalization, but Ms. Smith refused to leave the streets. It is ironic that "independent living," a central goal of deinstitutionalization philosophy, was being vigorously pursued for chronic mental patients in New York State at the very time of Ms. Smith's death (Allen 1982).

Disaffiliated Women

For some women the precipitants of homelessness are lost in long histories of disaffiliation. Austerberry and Watson (1983) point out

that some of these women have never at any time in their adult lives been securely domiciled. They totally lack a home base, relatives, or a support system to which to turn. Other women may not necessarily have been homeless all their lives but currently lack the security of affiliative or supportive attachments. Bassuk (1986, 48), a psychiatrist who has surveyed homeless mothers in the Boston area, has found that two-thirds of her respondents grew up in disorganized families and experienced at least one early family disruption such as parental divorce or death. Although these women do not generally fit the diagnostic criteria for major psychoses, the majority do suffer from diagnosable personality disorders; they are "unable to form and maintain stable relationships, they have poor or nonexistent work histories, they have been unsuccessful establishing stable homes even when housing is available, and most important, they have extreme difficulty parenting."

The correlates of homelessness among women are thus numerous and complex. And it is often difficult, except in the most general terms, to sort out precisely how or why any one woman became homeless. Did gentrification (Harrington 1984) cause her to lose her home and then in turn lead to her stigmatization, disaffiliation, loss of employment, and loss of hope? Did eviction by an abusive spouse precipitate a transient but disabling mental disorder which led to the woman's loss of job and then to her homelessness? Did schizophrenia cause her to wander the streets in fear of unknown demons and lead her to withdraw from other people in despair? The career of a homeless woman might have followed any one of these courses or of countless others. Each homeless woman has a unique story to tell, and sometimes her special message is hard to decode.

Even a woman's appearance may afford few clues to those who would unravel her history and posit cause and effect. One formerly homeless woman, Ethel Frean, uses first-hand experience to illustrate how women who have been evicted or abused by their spouses may actually take on the characteristics of individuals with severe mental disorders. They may appear as disoriented and totally deprived people who "cannot think clearly, cannot hold an intelligent conversation . . . [and have] difficulty remembering and an attitude of despair, depression, bitterness" (Reynolds 1986).

Once homeless, many women lead lives totally beyond the comprehension of those not so afflicted. Degradation, uncertainty, fear,

and stigma are part of their daily existence (Walsh and Davenport 1981). McGerigle and Lauriat (1983, xvii–xviii) describe this situation: "Becoming homeless—no longer having a place to rest in privacy, prepare one's food, care for one's children, and store one's goods—is perhaps the most profound privation imaginable in our society."

Graves (1985, 3), a psychiatrist who moonlighted in two women's shelters in Washington, D.C., while she completed her residency, describes her work there as a "true transcultural experience." She explains: "Entering the shelter was what it must have been like to enter an asylum at the turn of the century. Acutely psychotic and volatile women were shouting obscenities at the workers or other women who roamed the halls. The odor was horrendous. But the irony of it was that this was 1985 in the capital of the richest nation on earth."

Life on the Streets

There is little doubt that, of all the subpopulations of homeless women, we have least knowledge of those who live on the streets—the "bag ladies" who are often featured in the popular media (Barker 1986; Kaplan 1984; McLaughlin 1984; Quindlen 1982). As noted above, so long as numerical and other generalizations about homeless women are based on observations made inside shelters or other facilities, the number and characteristics of these women who, either permanently or temporarily, live on the streets may be seriously misrepresented.

Why do these women live on the streets, even when, ostensibly, they could be sheltered in facilities? McKay (1986), who by no means underestimates the horrors of shelter life, nevertheless views the streets as infinitely less preferable—as a refuge for the "least socialized" among the homeless. Yet, many women do live on the streets, and the reasons for their doing so appear to be very complex.

Kates (1985, 208–9) provides some clues as to why some women avoid shelters, even when space is available, in his description of a 47-bed facility on the lower east side of New York City, where women must surrender all their money and have their bags inspected before they may be admitted. They are then subjected to an "interrogation by a bored aide with a blank form in front of her" and "led down a corridor without explanation, handed a cup of foul-smelling 'shampoo'

to kill lice, and ordered to take a shower." Finally, they are "forced to submit," without explanation, to gynecological examination.

Some women may be unable to observe stringent house rules in facilities and so are extruded from them and find themselves involuntarily on the streets (Baxter and Hopper 1982). I spoke with one such person in the ladies' room of the Pennsylvania Station in New York City—a 15-year-old girl who was hallucinating and obviously frightened after what she described as her "acting out" in a runaway youth hostel. This youngster seemed launched on a career of what would almost certainly turn out to be adult homelessness.

Other women may be "rotated" out of the facilities where they live; they may be on the streets temporarily while they await their turn to be readmitted to shelter. A nun describes this situation in the shelter in which she works in New York City: "You see, we only have beds here for twelve women and we let twelve more women sleep sitting up in chairs. But there are thousands of women out there—thousands who have no place to live. So many ladies come here for shelter that we can only let them stay for four days before we send them back out on the streets. We call it 'rotation.' Four days in, three days out. It's horrible, but we don't have much choice" (Kates 1985, 21).

For other women, being on the streets may be a temporary or permanent adaptation to poverty. Some of these women lack the know-how, the energy, and the skills to apply for or receive welfare benefits. In the absence of readily available shelter space, they are left with "little choice but to live off the bounty of the street" (Shulman 1981). Even those who have access to funds may lose their welfare checks or have them stolen. And, of course, there are times when, as McKay (1986) reminds us, the only available facilities for women are more dangerous, more violent, than living on the streets.

Still other women may, in a sense, "prefer" the streets (Nix 1985)—to the extent that choice is even a concept that is applicable to people who, by and large, live under conditions of abject poverty, fear, and frequently severe medical and psychiatric disabilities. According to Martin (1982), however, some women weigh the relative advantages of freedom, mobility, independence, and life space on the streets against the disadvantages of impending eviction, rigid rules, and preclusive admission policies in facilities and ultimately select the streets as the "least restrictive" environment.

Assessing Choice

The foregoing discussion contrasts the respective "benefits" of living in shelters or other residential facilities and living on the streets. Indeed, a number of homeless women live in a kind of limbo between these two alternatives. Some facilities for women that are ostensibly night shelters are not that at all, for they are not zoned for overnight occupancy. But that does not keep women from staying overnight. Conditions inside these places—with women "slumped in chairs and propped against walls" (Kates 1985, 177)—are probably unimaginable to anyone who has not visited them but take on reality in this vivid description:

> [The women have] the stunned look of refugees: confused, angry, listless. Their voices fill the room with a jumbled, high-pitched cacophony. Outbursts are common: obscenities shouted into the air, shrieks, screams, crying. Often these are simply ignored; the staff sometimes seem too overwhelmed to react except in the most extreme circumstances. Laughter is rare (Kates 1985, 178).

Baxter and Hopper (1982, 401) strongly reject the notion that homeless women are basically unresponsive to offers of help and suggest that "virtually all homeless women, like men, will accept shelter under conditions of care and tolerance." But in reality most homeless women have few options in where they live. They may "choose" life on the streets, life in unpleasant or dangerous residential facilities (when available), life in a correctional facility, or life in a state mental hospital—and the last of these is increasingly unavailable today. Once again, the words of McKay (1986) speak of their plight: "I don't think anyone except the sickest would wish for such an existence as a homeless person."

Disability and Barriers to Care

The foregoing discussion suggests that a variety of circumstances impede the access of homeless women to services that they desperately need. Together, such barriers underscore the fact that homeless women tend to be disabled persons—people who, according to a simple

dictionary definition of disability, are unable, unfit, or ineffective. In fact, disability and homelessness are clearly compatible notions. The homeless woman may be seen as a person who typically endures a variety of disabling life circumstances that derive from many sources.

Some disabilities, those that might be regarded as "primary" (Shepherd 1984; Wing and Morris 1981), result from her simply having no place to live, from her lack of affiliative contacts, or from the illnesses, both somatic and psychiatric, that she may endure. Other disabilities, the "secondary disabilities" described by Shepherd and Wing and Morris, are attributable to the woman's own responses to her primary disabilities. She may react, long after her primary symptoms have disappeared, to her lack of shelter, her disaffiliation, and her illnesses with fear, avoidance, and increasing withdrawal. And other "tertiary" disabilities, those described by Shepherd and Wing and Morris as "social disablements," are imposed by society; they consist of such conditions as stigmatization and an absence of adequate housing, jobs, medical and psychiatric care, personal counseling, and welfare benefits.

By and large, then, society makes few allowances for the straitened circumstances that homeless women endure—that is, for their multiple complex disabilities. The homeless woman is in reality often expected to change her life with little or no outside help—a denial of the seriousness of her disabilities.

In fact, such insensitivity toward homeless women may spring from more than one stereotype. It is very probable that some portion of the prejudicial treatment derives from the notion that women must not expect their domestic needs to be met by others, particularly strangers. Thus, when faced with the presence of women who obviously fail to function in their traditional roles, some service providers do not know what to do and respond by treating them like privileged guests. Strasser (1978, 2077) describes such a phenomenon in a soup kitchen and drop-in center:

> No services were asked from the women, although cooperation with procedures was expected. . . . [Men] were often expected to contribute some service as well as to follow routines. Women not only entered for meals ahead of all men, sick, injured, or well, but occasionally women who arrived late for meals were served, while men would be turned away if late. The service was regarded . . . as "lady's privilege."

Such differential treatment may, in fact, serve homeless women in poor stead. By reinforcing their helplessness, it may limit their chances for successful rehabilitation and may well be clinically contraindicated (Bachrach 1987b).

Service Needs

Each homeless woman has her own constellation of disabling circumstances that determine her unique service requirements. I believe, however, that it is accurate to conclude that in virtually all cases—whatever the specific correlates, precipitants, or antecedents of homelessness—the woman's economic, social, medical, and psychiatric problems point to the need for comprehensive interventions. Simplistic "quick-fix" answers will simply not go far in the design of programs that attempt to serve this population. Thus, it is essential that communities seeking to respond to the health needs of homeless citizens in general, and specifically to homeless women, provide an array of services to meet the diverse needs of this very heterogeneous population.

The provision of adequate housing is, obviously, a basic concern. It is a truism that any decent program that wishes to meet the health needs of homeless women must begin with the provision of basic shelter. And in this general area a service plan should, ideally, include a variety of options. Some women may require housing that affords them no more than temporary refuge and asylum in the face of precipitate crisis. Other women may need longer but still short-term temporary housing while they pull themselves together economically and emotionally. They may have been catapulted into homelessness by sudden economic or domestic developments and simply need a place to stay while they assess their futures. Still other women, particularly those who suffer from chronic illnesses, may require long-term residential arrangements, perhaps for the rest of their lives.

Cutting across duration of housing categories is a need for functionally differentiated residential settings. For example, it may be inappropriate to house homeless women whose behavior is volatile or unpredictable, or those who are alcoholic or drug dependent, with women accompanied by small children (Gillman 1986). Efforts must also be made to provide residential alternatives for homeless women who wish to live with their spouses. It is astonishing that a society that gives verbal

endorsement to family values should make it so difficult for couples, legally married or living together, to find adequate accommodation (Barker 1986).

There are no standard formulas for residential planning. Each community must consider the array of needs within its own specific population of homeless women. Thus, the Margaret Frazer House (1984) in Toronto, a residential facility for 10 mentally ill homeless women, designates five beds for women referred from hospitals, psychiatric facilities, or social service agencies. The remaining five beds are held for women who come from shelters or walk in from the streets. Noquestions are asked, and no formal paperwork is required from the latter.

The West Women's Hotel (undated), an emergency shelter in Portland, Oregon, attempts to reserve 25 of its 33 spaces for homeless women with children and the remaining spaces for victims of domestic violence. It offers food, clothing, information and referral services as well as child care and employment placements.

The Bethesda House in Paoli, Pennsylvania, a suburb of Philadelphia, responds to the needs of homeless women who require long-term housing. Initiated by volunteer and church groups, this facility for 14 women charges rent for its private rooms according to women's ability to pay. It receives referrals from a temporary shelter in Philadelphia that identifies women with "the capacity to live more independently" (Rogers 1985).

These three examples of special housing arrangements provide a glimpse of the approaches that are possible in residential planning. Housing, however, is only one of many kinds of services that are essential to the health of homeless women. Transcending the need for a variety of low-cost and dependable housing alternatives are two other major considerations.

First, there is the fact that shelter is not enough. Homeless women are generally, as this review has frequently noted, severely disabled individuals who need multiple services for their survival. They require not only residential accommodation but also access to the basic necessities of life: food, clothing, and health care. And, as part of their basic health and mental health care plans, they also generally require a full complement of social, vocational, and rehabilitative services. Additionally, some homeless women may also profit from psychotherapeutic interventions (Rhodes and Zelman 1986). Graves (1985) reports, for

example, that group therapy with some homeless women is practicable and that, despite the chaotic conditions in shelters, it follows the same therapeutic principles as group therapy conducted in other sites.

Continuity of Care

A second consideration is that the varied services provided to homeless women must be offered in a climate that is perhaps best described as one that enhances continuity of care (Bachrach 1981, 1986a). Continuity of care is a notion that is based in post-World War II health planning, and, properly realized, assures the provision of comprehensive, accessible, individualized and culturally relevant services over a long period of time and in a supportive and humane climate. Many of the barriers that impede the efforts of homeless women to receive needed services could be mitigated with the implementation of continuity of care.

In the achievement of continuity of care the dimensions of accessibility and individualization of treatment require special attention. There can be no such thing as continuity if individuals in need are unable to reach services in the first place. Accordingly, it is essential that psychological access be assured—that services be offered in such a way that the recipient will not be upset, frightened, or otherwise discouraged by the intervention. Medication and other treatment compliance is often a real problem within this population, and an effort must be made to reach individuals in a sensitive manner.

This may mean that the service provider will have to abandon traditional service delivery concepts and substitute new ones, perhaps through special assertive outreach efforts (Cohen, Putnam, and Sullivan 1984; Schwartz 1979). Marsha Martin (1982, 125), who is widely known for her work with homeless women, writes that these individuals are often "too disorganized" to utilize "highly structured and highly bureaucratized" agencies and services and that they often respond most effectively, at least initially, to interventions offered by nontraditional outreach workers.

In addition to psychological access, there must be geographical access (Bachrach 1986a); the service recipient must be able to reach the location where the services are offered. If service sites cannot be

physically located in neighborhoods where homeless individuals are concentrated, some method must be developed for transporting those persons to the services—by buses or vans or even private automobiles. Care must be taken, however, to assure that psychological access is not diminished with the introduction of special transportation. Many among the homeless are wary and unable to respond to seemingly invasive attempts to assist them. Indeed, it may take months of protracted contact to establish enough rapport for a service provider even to begin to intervene in the person's care (Bachrach 1984d).

These concerns require that careful assessments be made of the individual needs of homeless women. Health and supportive services must be coordinated in such a way that they are specifically responsive to service recipients' unique needs. Some in the population will require structured services where they are given a maximum of direct assistance; others will require the confidence that comes with encouragement to assume personal initiative. Cohen, Putnam, and Sullivan (1984) have, in fact, taken an important step toward promoting individualized treatments for homeless individuals by dividing those who have mental disorders into several clinical and program planning categories: those who are in acute need of emergency care; those who are not in imminent danger but nonetheless require inpatient services; and those who, although they are overtly psychotic, have adapted to life on the streets and may be approached by clinicians in a more deliberate manner consistent with their tolerances. These categories may be expanded and adapted in the planning of general and other specialty health services for homeless women.

Beyond the dimensions of accessibility and individualized care, continuity of care also implies to a high degree a working relationship among service providers so that they may consult with one another about the needs of individual women (Bachrach 1981). The case of Nancy Hopper, a 27-year-old homeless woman who bled to death in a seclusion room at a community mental health center in Boston (McLaughlin 1984), might have had a very different ending had continuity of care principles been implemented. Ms. Hopper's ruptured ectopic pregnancy had apparently gone undetected when she was admitted to the center.

Thus, the notion of continuity of care is a basic one in delivering health and supportive services to homeless women, and it is essential

that planners be encouraged to look beyond the need for residential accommodation in order to serve the members of this population effectively.

Conclusions

Homelessness among women is an exceedingly complex sociological phenomenon that devastates the individuals who endure it. Because its antecedents and correlates are numerous, complex, and highly interactive, improving the lives of homeless women depends on the simultaneous operation of several factors.

First, it is essential that progress be made in defining and delimiting the population of homeless individuals. Until we know more precisely who homeless women are, we shall not be able to assess their needs in an adequate manner nor plan an appropriate array of health and supportive services for them.

Second, the health problems of homeless women must be appreciated as multivariate circumstances. Each homeless woman has a unique history and a unique set of service requirements. Service planning must acknowledge, however, that whatever her special needs might be, the homeless woman almost invariably needs comprehensive and accessible services delivered in a sensitive manner and made available to her over a long period of time. Ensuring the protection and safety of these women and providing for their subsistence are of the most profound importance.

Third, because homelessness is often a political issue, it can easily become an arena for rhetoric and "gamesmanship." It is, indeed, an area where turf and territoriality often have more to do with service planning than do the needs of individual homeless women. A dramatic example of this is reported from California where Roman Catholic social workers in Los Angeles County were ordered to stop referring homeless women to a shelter operated by a nun with a reported "proabortion position" (*Washington Post* 1985). Although some might question the rational motivation for such a move, the fact that it even occurred holds a lesson for those who attempt to formulate and implement health and social policy in the midst of political controversy. Care must be taken to avoid confounding issues with extraneous variables.

Fourth, when the handicaps arising from gender discrimination are superimposed on the severe and multiple disabilities associated with homelessness, the difficulties of homeless women increase. For the most part, homeless women have constituted a relatively "invisible" portion of the homeless population. Their characteristics and needs have been mistakenly inferred from observations of homeless men. Yet, homeless women have unique needs that must be acknowledged if appropriate services are to be provided to them.

The image of a confused, frightened homeless woman in need of a full complement of health and mental health services; unable to defend herself against violence; unsure of where she will spend the night; and having little hope for the future is perplexing and disturbing. It is also an image that should propel us to action; for, with the development of adequate health and supportive services, that woman's life circumstances may possibly, at least to some extent, be improved.

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