Special Populations of Homeless Americans

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Abstract

Surveys conducted over the past two decades have demonstrated that homeless Americans are exceptionally diverse and include representatives from all segments of society—the old and the young; men and women; single people and families; city dwellers and rural residents; whites and people of color; and able-bodied workers and people with serious health problems. Veterans, who are among the most honored citizens in our society, appear in substantial numbers among the homeless, as do former criminal offenders and illegal immigrants. Each of these groups experiences distinctive forms of adversity resulting from both societal structures and personal vulnerabilities, and has unique service delivery needs. All, however, experience extreme poverty, lack of housing, and a mixture of internally impaired or externally inhibited functional capabilities. Attention to the distinctive characteristics of subgroups of the homeless is important in facilitating service delivery and program planning, but may also diffuse attention away from shared fundamental needs, and generate unproductive policy debate about deserving vs. undeserving homeless people.

Lessons for Practitioners, Policy Makers, and Researchers

- People who are homeless reflect the nation's diversity, and their special characteristics and needs must be identified, respected, and addressed.
- In addition to responding to basic needs for shelter, food, clothing and medical care, the unique needs of each subgroup of homeless person should be sensitively addressed.
- Systematic assessment is frequently required to identify the specific needs of each subgroup among the homeless population.
- Despite their diversity, almost all homeless people are extremely poor and lack decent affordable housing and an adequate income. Regardless of their other difficulties, practitioners must address their basic tangible needs for material resources.
- Although it is essential that providers help facilitate homeless people's access to basic resources, they also should advocate for increasing the overall pool of resources. Providers are often in a position to be powerful advocates.

Introduction

Surveys conducted over the past two decades have demonstrated that homeless Americans are exceptionally diverse and include representatives from all segments of society—the old and young; men and women; single people and families; city dwellers and rural residents; whites and people of color; and able-bodied workers and people with serious health problems (Rossi, 1989; Burt, 1992; Robertson & Greenblatt, 1992). This diversity illustrates how difficult it is to generalize about the needs of homeless people, and how challenging it is to assist them.

Homeless People Reflect the Diversity of Society

· Age: Children, Adolescents, Elderly
· Gender: Men and Women
· Living Units: Single Individuals and Families
· Location: Urban vs. Rural
· Racial or Ethnocultural Minorities

· Health Status: Medial, Psychiatric, Addictive Disorders, AIDS, Good Health
· Social Status: Veterans, Criminal Offenders, Illegal Immigrants

In contrast to the diversity, two characteristics are remarkably consistent across subgroups of homeless people: a lack of decent affordable housing and a lack of adequate income. In view of the homogeneity of homeless people with respect to these characteristics, and the obvious relationship of poverty to homelessness, their diversity is striking and deserving of review. Because policy priorities are largely determined by the relative emphasis placed on the diverse rather than the common characteristics of homeless people, it is important to consider the validity of each approach before reviewing the literature on variations in subgroups.

Advantages of Evaluating Differences

Examining differences among subgroups of homeless people has some clear advantages. First, each subgroup has unique service needs and identifying these needs is critical for program planning and design. Detoxification programs, for example, are of little relevance for programs assisting homeless children, and job counseling has limited value for people with severe addictions. Even psychosocial characteristics, such as demoralization, lack of self-confidence or self-esteem, may have distinct roots for people with different backgrounds.

Subgroup Focus: Advantages

· Identify specific service needs
· Guide staff selection
- Specific skills
- Common background facilitates empathy and understanding
· Guide interagency network development

Second, identifying subgroup needs can guide agencies in hiring staff with skills that are matched to their client's needs. Programs serving people with mental illness need access to clinicians with expertise in treating these disorders, while programs serving latinos and other minorities must hire linguistically and culturally competent staff.

Finally, identifying group-specific service needs can provide crucial information to guide development of responsive interorganizational service networks. Homeless people typically need assistance in multiple areas, often involving distinct agencies. Building alliances among agencies with different missions, goals and values can be complex and time consuming, and it is important that these efforts are appropriately targeted.

Drawbacks to Evaluating Differences

Focusing attention on subgroup differences also has potential risks. While differenting subgroup needs may assist some types of service planning and delivery, attention may also be distracted from the basic needs homeless people have for safe, decent housing and income resources. Attending to differences may numb awareness of the inevitability that in a market-oriented industrial nation with a limited commitment of resources to safety net services, some people inevitably fall into extreme poverty and homelessness. Scholars and researchers consider declining employment and public support of the poor, and reduced availability of low-cost housing to be the primary reasons for the increase in homelessness since the late 1970s (Jencks, 1994; Rossi, 1989; Burt 1992; Koegel, Burnam & Baumohl, 1996; O'Flaherty, 1995). Programs that target special needs may blur awareness of the structural causes of homelessness and may lead policy makers to erroneously explain homelessness as a result of personal or subgroup failings. Who is vulnerable in a particular housing market should not be confused with why homelessness occurs at all. “Social poverty”, although it may appear differently in different subgroups, is often derived from long exposure to demoralizing relationships and unequal opportunity (Tilley, 1998).

Subgroup Focus: Disadvantages

· Distracts attention from common needs for housing, income, employment
· Results in focus on personal failing
· Reinforces concept of different levels of deservingness

Populations that are prominently represented among the homeless are poor and lack access to low cost housing. These subgroups may be better characterized as being systematically under-served by our society's social safety net programs and opportunity structures rather than being uniquely burdened by individual incapacities. Personal characteristics often found among homeless people may represent markers of societal neglect and bias. Historical surveys of the changing faces of homelessness indicate that the subgroups most vulnerable to losing their homes change with societal attitudes, safety net programs, and medical technologies. The profile of homeless people reflects, in part, our social history. For example, at the turn of the century the homeless population included amputees from the Civil War and railroad accidents, the blind, and many people with syphilis (Bassuk & Franklin, 1992).

Commonalities: The Need For Adequate Housing And Income Support

Before we consider research on subgroup-specific needs of homeless people it is important to briefly review the critical impact of policies and interventions that directly address housing and income needs of all types of homeless people.

- During the Great Depression of the 1930s, large numbers of able bodied men were forced into homelessness due to unemployment rates that approached 25 percent. With the outbreak of World War II, however, the federal government provided employment for almost 18 million men and many millions of women, and virtually eliminated homelessness from the American landscape.
- During the early 1950s, homelessness in urban skid rows was largely a problem of older alcoholic men. With the advent of social security retirement and disability benefits poverty among the elderly declined from 50 percent in 1955 to 11 percent in 1975 (Weir et al., 1988) and the risk of homelessness for older Americans was vastly reduced (Rossi, 1989).
- A study comparing homeless and non-homeless people who used the same soup kitchens in Chicago documented that the major difference between these two groups was that those who were not homeless were receiving income through supplemental security income (SSI) (Sosin & Grossman, 1991).
- A prospective study of homeless mentally ill applicants for social security disability benefits found that among those who received benefits, 50 percent exited from homelessness within three months of the initial disability determination as compared to only 20 percent among those who were turned down for benefits (Rosenheck, unpublished data).
- A study of housing vouchers and intensive case management for homeless people with chronic mental illness found that vouchers, but not intensive case management, improved housing outcomes and that neither intervention affected clinical outcomes (Hurlburt, Hough & Wood, 1996).
- A recent epidemiologic study of risk and protective factors for family homelessness indicated that factors compromising a family's economic and social resources were associated with increased vulnerability to homelessness. Specifically, being a primary tenant, receiving a housing subsidy or cash assistance, and graduating from high school were protective against family homelessness (Bassuk et al., 1997a).

An evaluation of a nine-city services-enriched housing program for homeless families (N=781) with multiple problems, many of whom had been recurrently homeless, found that the vast majority of these families were still in Section 8 housing at an 18-month follow-up. The authors concluded "that it may be an investment in helping families to regain their stability and ultimately perhaps, their footing in the workforce." (Rog et al., 1995b, p.513)

In each of these cases, in spite of the heterogeneity of the populations, income or employment support substantially contributed to resolving the problem of homelessness. In the sections that follow we consider empirical evidence on the background and needs of specific subgroups of homeless people. We conclude by reconsidering the relative importance of homogeneity vs. heterogeneity in policy development and service planning for homeless people.

Subgroups Of Homeless People

People who are homeless can be differentiated along six dimensions: (1) developmental phase of life (age); (2) gender; (3) social unit (families vs. single individuals), (4) racial or ethnocultural groups; (5) health status (psychiatric illness, substance abuse, HIV/AIDS, and the multiply diagnosed); and (6) social status (veteran vs. citizen vs. criminal vs. illegal immigrant). In the sections that follow, we review empirical research on the specific experiences and circumstances of each subgroup.

Developmentally Differentiated Groups: Children, Youth, and the Elderly

The loss of "home"—a place that nurtures development and provides safety across the lifespan—is especially troubling to homeless children, youth, and elderly persons. Being without a home challenges the unique developmental tasks of each age group. In addition, all these subgroups are particularly vulnerable to the exigencies of shelter or street life because of their age, frailty, and dependence on others.

Children

Prompted by increasing numbers of children living in poverty in the United States (Danzinger & Danzinger, 1993), research in this areas has grown since the mid-1980s (McLoyd, 1998; Duncan & Brooks-Gunn, 1997). In general, studies indicate that persistent rather than transient poverty is more detrimental to children, and that children experiencing either type of poverty do less well on school achievement, cognitive functioning, and socioemotional measures than children who have never been poor (McLoyd, 1998).

Homeless children are among the poorest children nationally (Rossi, 1989; Wright, 1991). Researchers have noted the similarities between homeless and poor housed children; homeless children look worse on only some parameters (Ziesemer et al., 1994; Buckner & Bassuk, 1997; Bassuk et al., 1997; Masten et al., 1993; Rubin et al., 1996). These findings suggest that homelessness may be only one stressor among many in the lives of poor children and that cumulative effects of multiple stressors may be more detrimental. In addition, one recent study of sheltered homeless and poor housed (never homeless) children and families conducted in Worcester, Massachusetts [henceforth called the Worcester Family Research Project (WFRP) (Bassuk et al., 1996)] found that the most powerful independent predictor of emotional and behavioral problems in both homeless and housed poor children was their mother’s level of emotional distress (Buckner & Bassuk, 1997). Clearly, interventions that support the healthy development of poor children must address the well-being of their mothers as well.

Homeless children are generally young children. According to a study of homeless families in nine major American cities, the typical homeless family is comprised of a single mother, 30 years of age, with two children under the age of five years (Rog et al., 1995). Research indicates that homeless children have high rates of both acute and chronic health problems. They are more likely than their poor housed counterparts to be hospitalized, to have delayed immunizations, and to have elevated blood lead levels (Alperstein, Rappaport, & Flanigan, 1988; Parker et al., 1991; Rafferty & Shinn, 1991; Weinreb et al., 1998). They also have high rates of developmental delays (Molnar & Rath, 1990; Bassuk & Rosenberg, 1990), and emotional and behavioral difficulties (Bassuk & Rosenberg; Molnar & Rath, 1990; Zima, Wells & Freeman, 1994; Buckner & Bassuk, 1997). In the WFRP, the cognitive functioning of homeless infants was comparable to their non-homeless peers. However, as children became more aware of their environments, and the stresses of poverty and homelessness accumulated, mental health and behavioral problems began to develop. Twenty-one percent of homeless preschoolers and almost 32 percent of older homeless children (ages 9-17) had serious emotional problems. In addition, violence was endemic in the lives of both homeless and housed poor families, with the majority of children either witnessing violence or being directly victimized.

Homeless, more than poor housed children, face the formidable challenges associated with residential instability and related family and school disruptions. Children who have moved three or more times are more likely to have emotional and behavioral problems, be expelled from school, or be retained in the same grade for more than one year (Simpson & Fowler, 1994 ; Wood et al., 1993; Baumohl, 1998). A typical trajectory into homelessness is marked by multiple moves, with almost 90 percent of families frequently doubling up with relatives and friends in overcrowded situations prior to becoming homeless. The WFRP, found that homeless preschoolers had moved 3.1 times in the previous year, while the average homeless school age child had moved 3.6 times (Bassuk et al., 1997b, Buckner & Bassuk, 1997).

In addition, many homeless children experienced other significant disruptions in their family and school lives. In the WFRP, 9 percent of homeless infants and toddlers, 19 percent of preschoolers and 34 percent of school age children had been placed outside their homes. Not only is this rate significantly higher than among their housed counterparts, but predictive modeling has shown that foster care is an independent predictor of a myriad of adverse outcomes, including later homelessness (Bassuk et al., 1997a). The WFRP also found that nearly three-quarters of homeless school-age children changed schools at least once in a given year and nearly one-third repeated a grade. Consistency in schools or daycare arrangements is associated with academic competence and later achievement (Baumohl, 1998).

Several researchers have looked at the adverse effects of shelter on children's development. While often qualitative in nature, these studies generally underscore the importance of quiet, private space, the potential negative impact of congregate living on parenting and the mother/child relationship, and the negative impact of homelessness and shelter life on self esteem (Boxill & Beaty, 1990, also see section on families); Hausman & Hammen, 1993).

Children spending time during their developmental years without the safety and stability of a permanent home are at risk for various negative outcomes. Whether they are victims or witnesses to violence, have learning difficulties or struggle with asthma or other health conditions, these children need to gain access to developmentally appropriate services. In addition, permanent housing and adequate incomes for their families are critical. An integrated approach toward designing a comprehensive system of care that serves the well-being of the whole family is crucial.

Youth

Consolidation of one's identity, separation from one's parents and preparation for independence are key developmental tasks of adolescence and critical for becoming a well-functioning adult in our society. Most adolescents prepare for this transition to adulthood in their homes and schools. However, a growing segment of young people leave their families prematurely, joining the ranks of homeless and runaway youth (Powers & Jaklitsch, 1993). Whether by choice or forced to leave, these adolescents are generally ill-equipped for independent living and many become easy prey for predators on the streets.

Despite increasing numbers of homeless youth and their growing proportion among the overall homeless population (US Conference of Mayors, 1987), this subgroup was considered among the most understudied and undeserved until relatively recently (Institute of Medicine, 1988; Farrow et al., 1991). Although empirical studies have been methodologically limited, the growing literature suggests that homeless youth are a special population that require innovative programmatic and policy solutions (Robertson, 1991).

Pathways onto the streets are multiple and complex and include: 1) strained family relationships, including family conflict, communication problems, abuse and neglect, and parental substance abuse and mental health problems; 2) economic crisis and family dissolution; and 3) instability of residential placements like foster care, psychiatric hospitalization, juvenile detention, and residential schools. (Robertson, 1991; Camino & Epley, 1998). While terms and definitions vary, the essential distinction between homeless and runaway youth appears to rest on assumptions about choice in leaving home, access to the home of origin or an alternative home, and time away from home. Distinctions such as these can be problematic because of presumptions about motives and options. Most definitions of homeless youth refer to unaccompanied young people under age 18; the legal status of minor distinguishes them in terms of access to services, employment, housing, and many other resources (Robertson, 1991).

To survive, many homeless youth resort to drug trafficking, prostitution, and other forms of criminal activity (Janus, McCormack, Burgess & Harman, 1987). Homeless youth are at risk for health and mental health problems, including substance abuse (Robertson, 1989; Windle, 1989; Yates, MacKenzie, Pennbridge & Cohen, 1988), HIV/AIDS (Pennbridge, Yates, David & Mackenzie, 1990; Robertson, 1991; Rotheram-Borus, Koopman, & Ehrhardt, 1991), pregnancy (AMA, 1989; Edelman & Mihaly, 1989), and suicidal behaviors (Shaffer & Caton, 1984; Yates et al., 1988). Their high rates of exposure to various forms of violence, both as witnesses and victims, increases the likelihood of developing post-traumatic stress disorder and depression (Kipke et al., 1997). Many homeless youth have high rates of mental health, alcohol and drug problems often in combination (Miller et al., 1980; National Network, 1985). Special needs groups within the population include: pregnant teens and young mothers, physically and developmentally disabled youth, sexually exploited youth, gays and lesbians, and youth with serious mental health, alcohol and drug problems (Robertson, Koegel, & Ferguson, 1990).

Limited shelter placements, fear of providers and shelters, and distrust of highly structured, rule-bound programs, present unique challenges to service delivery. Streetlife makes it particularly difficult for youth to access health and mental health services as well as educational programs (Powers & Jaklitsch, 1993). In addition, the multiple problems of homeless youth often bring them into contact with unintegrated health, education, mental health, and law enforcement services. Rarely do these agencies respond to the psychosocial and developmental needs of the whole person (Lindsey, Jarvis, Kurtz & Nackerud, 1998). Homeless youth would benefit from programs that meet their immediate and basic needs first, and then help them to address other aspects of their lives; both approaches should minimize institutional demands and offer a broad range of services (Hughes, 1998). Also specially designed programs that include street outreach, job training and employment, education, transitional housing, youth staffing and mentors, and health care services have been described as especially important (Camino & Epley, 1998).

Elderly Homeless

Although the proportion of older persons in the total homeless population has declined in recent years, the numbers of homeless elders, age fifty and older, have grown (Susser, Moore & Link, 1993; Cohen et al., 1997). While still a relatively small subpopulation, their numbers are likely to escalate as homelessness continues unabated, increasing numbers of babyboomers reach older adulthood, and the demand for affordable housing continues to outstrip supply (Cohen et al., 1997; Gilderbloom & Mullins, 1995).

Elderly homeless persons are of special concern because of their vulnerability to victimization both in shelters and on the streets, their frailty due to poor mental and physical health, and the reluctance of traditional senior service systems to incorporate them into ongoing programs (Ladner, 1992). Homelessness uniquely challenges elderly persons. Not only does their vulnerability make meeting basic human needs for food, shelter, and safety more problematic, but it interferes with resolving the later developmental tasks of the lifecycle: the opportunity to reflect on one's life, consolidate personal integrity, and experience completeness rather than despair (Erickson, 1963, 1986; Martin, 1990).

The research on homeless elders remains limited (Crane, 1994). With the declining age of the homeless population, studies have primarily addressed the needs of younger individuals and families. Earlier research that contained samples of older men among the single adult population focused on alcoholism or "skid row" lifestyles rather than their age or life-cycle challenges. In addition, declining rates of poverty among the elderly and a federally mandated system of targeted benefits and programs for older Americans, coupled with the stigmatization of this subgroup, has made the elderly of limited concern to policy makers.

Where studies exist, the age limit used for definition of elderly homeless people varies, from 50 to 65 years (Hudson et al., 1990; Kutza & Keigher, 1991; Cohen et al., 1988). Regardless of chronological age, due to the harsh living conditions and the resulting magnification of acute and chronic physical ailments, the elderly homeless appear older than individuals of the same age living in housing (Tully & Jacobson, 1994). Depending on study samples, the proportion of men and women in the elderly homeless population differ widely. Women are estimated to comprise 20 percent of the older homeless population nationally, with numbers ranging from 8-33 percent, but make up a larger proportion of older homeless individuals who use services (Cohen et al., 1997; Burt, 1992; Douglass, 1988; Ladner, 1992; Roth Toomy & First, 1992; Kutza & Kreigher, 1991). Older homeless women's levels of alcoholism, drug abuse and criminality are low compared to homeless men and younger women, while levels of serious mental illness appear higher than among men and younger women (Cohen et al., 1997; Fisher, 1991; Wright & Weber, 1987; Crystal, 1984).

Factors that have been identified as contributing to the presence of elderly persons among the homeless include deinstitutionalization (Boondas, 1985), poverty, especially among elderly women (Kutza & Keigher, 1991), and the lack of affordable housing (Boondas, 1985; Kutza & Keigher, 1991; Tully, 1994). Limited access to affordable housing and supportive services is especially problematic for minority elders (Bell et al., 1976; Bowling, 1991; Heuman, 1984; Tully, 1994). While elderly homeless are generally thought to have more consistent income from pensions or social security than younger homeless individuals, poor older women who have never worked, individuals with very limited benefits, and elders whose meager incomes have been exploited by others, are still too poor to support themselves in stable housing. In addition, based on information from service providers, many elderly become homeless for the first time after the death of a spouse, child, or friend who had served as their caretaker or

provided financial support (Rafferty, 1986).

Older homeless adults experience various health and mental health problems, are more likely targets for victimization and consequent injury, and lack networks of relatives or friends that could provide emotional or material support (Hudson et al., 1990). One early report indicated that more than 50 percent of homeless individuals over age 50 suffered from chronic mental illness (U.S. House of Representatives, 1984); other studies indicate that these individuals suffer from cognitive impairments, degenerative mental diseases, and other psychiatric problems (Doolin, 1986; Kutza & Keigher, 1991). Complications of aging may increase the stress of homelessness; for example, the decline in hearing and vision that accompanies old age may create a general lack of trust and heightened anxiety since older homeless people need to maintain vigilance to survive (Hudson et al., 1990). In addition, since older shelter users are more likely to be crime victims than non-users (Keigher et al., 1987), some elders choose to remain on the streets rather than use shelters. (Cohen & Sullivan, 1990)

Elder homeless need a complex and coordinated system of care that includes: specialized outreach, help in meeting basic needs and sometimes routine activities of daily living, 24-hour crisis assistance, health and mental health care, transportation services, assistance with the development of social relationships and social ties, and a range of housing options with easy access to services. Studies indicate that some elders do not trust service providers and fear limitations to their independence and the possibility of institutionalization (O'Connell, 1990; Kutza & Keigher, 1991, Tully & Jacobson, 1994). For homeless elders in hospitals, drug treatment programs or nursing homes, policies must ensure that they are discharged only when adequate residential services are secured and that they are never discharged to shelters or the street. In addition, cost reimbursement policies should not encourage premature discharge or discharge without housing in place (Ladner, 1992).

Gender Issues

Since the mid-1980's, many more women have become homeless with the ratio of men to women approaching 3:2. Women now comprise more than one-fifth of the overall homeless population (Burt & Cohen, 1989, Rossi, 1990; US Conference of Mayors, 1991). The rapidly growing numbers of homeless mothers (i.e., families with children in tow) and homeless women alone (“singles”) account for these numbers. Although the majority of “single” women have children, they reside in shelters without them. In contrast only an estimated 40 percent of single men are fathers who are less likely to have been married and are not active caretakers (Burt & Cohen, 1989; Calsyn & Morse, 1990). Burt & Cohen concluded that “women bring their gender responsibilities into the homeless situation” (p. 521). As a result, many authors have called for programming to meet their unique needs (Stoner, 1983; Bachrach, 1987; Merves, 1992).

In part, the transformation of homelessness by women reflects the feminization of poverty. Many extremely poor women have limited earning power, job skills, and education and are overwhelmed by childcare responsibilities. If they are raising children alone, these burdens are compounded. Female-headed families are generally poorer than two-parent families because of the presence of a single income and the cost of child care. Despite these facts, poor women do not have a realistic place in the current labor market, which is designed to support nuclear families with male breadwinners. For example, the gap between women’s and men’s income remains wide, and occupational and gender-related discrimination is rampant. Women earn less over their lifetime than men, and the economic burden of divorce often falls on their shoulders. Service sector jobs do not pay a livable wage or provide essential benefits and TANF benefits, which will be cut as a result of the passage of the 1996 welfare reform legislation, do not help women climb out of poverty (Merves, 1992; Bassuk, 1995; Buckner & Bassuk, in press).

For women with limited education and job skills the picture is even bleaker. Improved technology coupled with job competition from third world countries have led to reduced wages and higher unemployment for these women. The availability of fewer jobs paying decent wages has particularly affected the standard of living of young adults and minority group members (Buckner & Bassuk, in press). Many homeless mothers have worked sporadically at low-paying service jobs such as sales clerks, waitresses, cashiers, and babysitters, but generally not in the year before becoming homeless. Even if a woman were working full-time and was able to arrange free child-care, her housing expenses are likely to comprise an inordinate proportion of her income—far more than the 30 percent allotment that is considered feasible; women comprise a disproportionate percentage of households who are “cost-burdened” (Merves, 1992).

Various researchers have demonstrated that motherhood (in particular, pregnancy and the recent birth of a baby), especially when parenting alone, may jeopardize a woman's ability to maintain her home (Knickman & Weitzman, 1989; Hausman & Hammen, 1993). Women must juggle many roles—worker, homemaker, and mother—often without adequate resources and social support. Raising children is a financial burden and without government-sponsored childcare and enforceable child support laws, it further constrains a mother's already limited job possibilities and earning power. Poor women who manage to work are often on the edge of a precipice: a missed paycheck, medical emergency, unreliable childcare, or other complication, may lead to job loss, eviction, and homelessness.

Although eviction and housing-related problems are a common precipitant of homelessness, domestic violence is also a major factor. The risk of victimization is heightened in neighborhoods plagued by extreme poverty, in situations where women are alone and lack protection, and in relationships with men who suffer addictions (Bassuk & Rosenberg, 1988). Once on the streets, homeless women, especially the "singles," are constantly vulnerable "to crime, street hazards and the elements" (Merves, 1992, p. 230). A vast majority of single women who have been on the streets for longer than 6 months are likely to have been assaulted and/or raped. As described in the section on homeless families, interpersonal violence is also rampant in the lives of poor women and must be addressed in program planning.

Not surprisingly, many homeless people have various personal difficulties as well. Both single women and men are far more likely to have histories of mental disorders, hospitalization, and suicide attempts than women with children in tow (Hagen & Ivanoff, 1988; Burt & Cohen, 1989). As a result, many single women have had their children placed in foster care or other out-of-home placements. With regard to substance use disorders, single men have double the rate of single women who have double the rate of mothers with children. It is also more likely that men are on the streets because of substance use problems and involvement with the criminal justice system. Calsyen & Morse (1990) described that men as compared to women tend to be on the streets longer, suffer a poorer quality of life, and receive less housing and income assistance. They also found a "service gender gap" and speculated that "homeless men are at the bottom of the hierarchy (of deservingness), in part, because of their greater abuse of alcohol and drugs, and their criminal difficulties (Calsyn & Morse, 1990, p. 607). Culhane & Kuhn (1998) also reported that an estimated one half of homeless men in comparison to one third of women will be readmitted to the shelter system within two years.

In sum, although pathways into homelessness may be different for homeless men and women, each has unique service needs that require innovative programming. "Homeless women suffer disproportionately from every catastrophe specific to their gender and race. The problems they experience mirror those of low-income women and are further compounded for women of color. These problems obstruct all women, but not with the same intensity and frequency. Homelessness specifically demonstrates how gender-related inequalities in large measure shape women's experiences." (Bassuk, p. 238). Although pathways into homelessness are somewhat different for homeless men, they too suffer inordinately and require comprehensive programming to address their complex service needs.

Social Units: Homeless Families

Family homelessness is a relatively new American social problem. Not since the Great Depression have significant numbers of families and children been on the streets. Beginning in the early 1980's, families with young children in tow have become one of the fastest growing segments of the homeless population and now comprise approximately 36 percent of the overall numbers (U.S. Conference of Mayors, 1997).

The rapidly increasing gap between the incomes of rich and poor in America has jeopardized the stability of large numbers of families. With limited education, job skills, child support and child care, their only options for survival are low wage jobs or public assistance, neither of which provide sufficient resources to keep a family stably housed. Often employed at minimum wage jobs, these families tend to pay an inordinate percentage of their income on housing, thus increasing the pool of families at risk for losing their homes (Buckner & Bassuk, in press).

Homelessness is a devastating experience. Losing one's home is a metaphor for disconnection from family, friends, and community. Not only have homeless people lost their dwelling, but they have also lost safety, privacy, control, and domestic comfort (Somerville, 1992). Homelessness disrupts every aspect of family life, damaging the physical

and emotional health of parents and children and sometimes threatening the intactness of the family unit. For example, many family shelters exclude men and adolescent boys. To avoid the stress of homelessness, some parents voluntarily place their children with family, friends or even in foster care. Others lose their children to the foster care system just because they are homeless (Shinn & Weitzman, 1996).

Goodman et al. (1991) have argued that homelessness is psychologically traumatic; it is a life event that is "extraordinary, overwhelming and personally uncontrollable" (p. 1219). The stresses of living in shelters are devastating for most people, but especially for women with young children. Although some shelters involve residents in governance, overcrowding, curfews and other rules, as well as "public parenting" tend to diminish any real sense of autonomy or personal control. Families have little privacy and generally live in cramped quarters, sometimes with the entire family sleeping in one bed. In accord with some shelters' policies, parents must relinquish responsibility for setting rules for their own children. Severely stressed by the loss of a home, these mothers are often less able to protect and support their children under these circumstances. Boxill and Beatty (1990) have described how the mother-child relationship tends to unravel, in part because of the necessity of mothering publicly, and sets up a cycle that is harmful to both. In an attempt to cope, it is not unusual for older children to assume the role of parent—trying to nuture and protect their younger siblings and even their mothers from a dangerous, uncertain and unreliable world (Bassuk & Gallagher, 1990).

Most research describing the needs of homeless families has been conducted in single cities, such as Boston, New York, St. Louis, Minneapolis, Los Angeles, and Philadelphia. All have defined a family as a pregnant mother or a parent with a child in tow. The samples include families residing in family shelters. An important exception is the nine city assessment of the Robert Wood Johnson/HUD Homeless Families Program; these families were residing in services enriched housing for longer than 4 months (Rog et al., 1995a, 1995b). Despite the difference in sampling frames, the findings are remarkably similar to those previously reported.

When evaluating research on homeless families, it is important to be aware of certain limitations; the samples generally exclude women residing in shelters for adult individuals, "singles"; the vast majority of these women have children who are currently not residing with them. Smith & North (1994) documented that homeless women have more personal vulnerabilities than homeless mothers such as higher rates of psychiatric and substance use disorders (i.e., alcoholism), and some may have lost their children as a result. In contrast, they describe homeless mothers as more socially vulnerable because of their lack of employment and the stress of caring for dependent children. As Johnson and Krueger (1989) concluded, homeless "singles" need more intensive psychosocial services, including mental health and alcohol treatment, than homeless mothers with children in tow. (See section below on Gender.)

Who are homeless families and what are their needs? Most are headed by women in their late 20's with approximately 2 children, the majority of whom are less than 6 years old. Their race/ethnicity reflect the composition of the city in which they reside, with minority groups disproportionately represented. The majority of mothers did not graduate from high school and were not currently working. However, most had some work experience. Not surprisingly, homeless families were extremely poor, with incomes significantly below the federal poverty level (Bassuk et al., 1996, Rog et al., 1995b, Shinn & Weitzman, 1996)

In the year before seeking shelter, many had become increasingly residentially unstable and had moved 3-5 times. Just before seeking shelter, most were doubled up in overcrowded apartments. When asked why they lost their homes, Rog's sample most frequently mentioned eviction, inability to pay rent, and domestic violence. Researchers agree that all families require decent affordable safe housing, adequate income, education and job training, jobs that pay livable wages, and reliable high quality childcare.

In addition to these basic needs, other aspects of these family's lives must be addressed. Interpersonal violence may well be the subtext of family homelessness. Abuse and assault seem to be the salient feature of homeless mother's childhood and adult experiences. Women suffer its devastating medical and emotional consequences for the rest of their lives. The Worcester Family Research Project (WFRP) (Bassuk et al., 1996) documented that a staggering 92 percent of the homeless (N=220) experienced severe physical and/or sexual abuse as measured by the Conflict Tactics Scale. More than 40 percent had been sexually molested by the age of 12. As adults, almost 2/3 of the overall sample had been severely physically assaulted by an intimate partner and 1/3 had a current or recent partner who was abusive. More than one-fourth of homeless mothers reported having needed or received medical treatment because of these attacks (Bassuk et al., 1996). Supporting these findings, Rog et al. (1995b) reported that almost two-thirds of

her sample of 743 women described one or more severe acts of violence by a current or former intimate partner. Many women are fleeing violent relationships when they enter shelter. Others are unable to leave these relationships without extensive support and as a result are unable to maintain jobs. To be effective, policy makers must account for the pervasiveness of interpersonal violence in program planning.

In addition to violence, homeless mothers suffer from other extreme stresses associated with poverty. Similar to low-income women generally, they "experience more frequent, more threatening, and more uncontrollable life events than does the general population (Belle 1990, p. 386). Unfortunately, they often do not have adequate support to buffer these stresses. Compared to housed mothers, homeless mothers had fewer non-professional network members, extremely small networks, more conflicted relationships, and were less willing to seek support. In addition, the network members of the homeless had fewer basic resources such as adequate housing and jobs, two meals a day and money to pay bills (Goodman et al., 1991, Bassuk et al., 1996).

Given the high levels of stress and the pervasiveness of violence, it is not surprising that homeless mother's have high lifetime rates of major depressive disorder (twice the rate of the general female population), post traumatic stress disorder (PTSD) (three times compared to the general female population), and substance use disorders compared to the general female population. Currently (within the past 30 days), more than one-third had an Axis I diagnosis. In contrast to single adult homeless individuals, homeless mothers do not suffer disproportionately from psychoses, such as schizophrenia. Given the oppressive systemic and personal circumstances that engulf many homeless women, it is also not surprising that they have astonishingly high rates of attempted suicide. In the WFRP, nearly one-third of homeless mothers reported that they had made at least one suicide attempt before age 18 (Bassuk et al., 1996). In Rog's (1995b) sample, more than one-quarter had attempted suicide, with 57 percent reporting multiple attempts particularly by overdose.

Why do some very low-income families become homeless while others do not? Using univariate statistics, researchers in New York City (Shinn, Knickman & Weitzman, 1991; Weitzman, Knickman, Shinn, 1992), Los Angeles (Wood et al., 1990) and Boston (Bassuk & Rosenberg; Goodman 1991a, 1991b) have examined variables, such as social support, violence, and mental health, which may account for a family's increased risk of becoming homeless. The results have been inconsistent across these domains. Discrepancies may be due to differences in the timing of assessments, the type of comparison group, and macro-level factors within the city (Buckner & Bassuk, in press).

A recent epidemiologic study (WFRP) investigated factors that might be protective against family homelessness. Using multivariate modeling, protective factors included housing subsidies, TANF, graduating from high school, having more people in one's social network and having fewer conflicted relationships. Factors that reduced a family's economic and/or social capital were also associated with homelessness. For example, mental hospitalization within the last two years and frequent use of alcohol or heroin were risk factors although they were uncommon among the sample (Bassuk et al., 1997).

In response to the growing crisis of family homelessness a safety net of family shelters and transitional housing facilities have sprung up in the United States. Based on the latest HUD shelter survey (1989) conducted in areas with populations greater than 25,000, the number of family shelters had doubled between 1984 and 1988—from 1900 to 5000 and are now the most common shelter type. More recent estimates are unavailable, but with the continuing growth of homeless families, it is likely that the number of family shelters has continued to climb, "although probably at a lower rate of annual increase" (Weinreb & Rossi; p.88, 1995). In addition to housing assistance, most programs provide a broad array of programs including social services (e.g., case management, counseling) and life skills training. Almost half of the shelters provide follow-up to their residents (Weinreb & Rossi, 1995). In addition to shelters, most communities also provide transitional or bridge housing for families who need more services and support. Lengths of stay tend to be longer (6 months to 2 years) and services address both basic and complex service needs. Rarely, permanent service enriched housing is also available, but these programs tend to target families already living in subsidized housing who need additional services to become self-supporting (Bassuk, 1990; Shlay, 1993). Although this continuum of care is a good beginning, the data indicate that the emphasis in program planning should be on permanent housing with services and supports available to families who chose them. (See section on gender). Until more comprehensive programming is accomplished the well-being of these families will continue to be compromised.

Racial and Ethnocultural Subgroups

Racial and ethnocultural minorities have long been at a serious disadvantage in the United States. In a trenchant analysis of the ways in which intergroup patterns of social interaction become institutionalized, Charles Tilley has described the process through which "durable inequality" emerges from exploitation of categorically defined subgroups. Through this process persistent disadvantage becomes institutionalized, appearing inevitable, intrinsic, and deserved—a basic fact of the way things are (Tilley, 1998). Perhaps the perniciousness of this processes and its ability to shape social perception has contributed to our inattention of homelessness among minority groups—as if it were expectable and therefore, in some sense, acceptable. Thus although minorities are at dramatically greater risk for homelessness than other Americans, there has been virtually no specific study if minority pathways into homelessness. Studies that address minority issues, have been, almost exclusively, sub-analyses of other, more general surveys. For this reason alone, it is important that a report on subgroups of homeless people not overlook the importance of race and ethnocultural group identity.

Blacks and latinos in America are far more likely than other Americans to be poor and therefore, more likely to be homeless. In 1980, as the numbers of homeless began to grow, 30 percent of African Americans lived in poverty and 23 percent of Hispanics, as compared to only 9 percent of non-Hispanic whites (Baker, 1996). A government study released in 1998, based on a careful analysis that included government and job-related benefits, found the gap between rich and poor, black and white, to be increasing, even as the stock market soared (Passell, 1988).

Consistent with these income statistics, surveys conducted in the 1980s all showed that about half of all homeless people were black, almost five times their representation in the general population (Hopper & Milburn, 1996). Hispanics, paradoxically, were not over-represented among the homeless in most localities and were under-represented in some (Baker, 1996). Therefore, we must consider the specific circumstances of minority groups separately.

Homelessness Among African Americans

It is important to note, at the outset, that poverty alone does not account for the high risk of homelessness among blacks. A systematic comparison of the proportion of blacks among the homeless and among domiciled people living in poverty in US cities with populations of 100,000 or more, showed that poor blacks living in urban settings were twice as likely to be homeless as poor whites in the same cities (Rosenheck et al., 1996). Several factors may explain this additional difference: (1) wealth is likely to be more important than income in the etiology of homelessness, (2) white flight and the departure of middle class blacks to the suburbs have left pockets of concentrated poverty and reduced job opportunities in urban areas, and (3) extreme segregation of housing by race and class seriously augments the adverse effects of other types of economic disadvantage.

First, the gap in wealth between white and blacks is considerable. Oliver and Shapiro (1995) point out that typical poverty statistics focus exclusively on income (e.g., average annual earnings, dividends and government benefits) and exclude data on wealth - the totality of accumulated assets. While the income gap between blacks and whites has narrowed considerably in recent years (black married couples earn 80 percent of white married couples, an annual difference of $6,500), the gap in wealth has not (black married couples own only 27 percent as much as white married couples, a difference of $47,600). Differences in wealth reflect differences in the long-term accumulation by assets in families. The major asset of non-hispanic whites is their personal home, an asset whose value has increased markedly since the end of World War II. Blacks however had little chance of owning a home in the immediate post-war period; this partially explains why the wealth gap has yet to be narrowed.

Racial differences in wealth are important because, while income reflects resource availability in an average week or month, wealth (savings) is what allows people to survive periods of adversity such as job loss or recession. Thus, the much larger gap between blacks and whites in wealth can be expected to result in far greater vulnerability among blacks to residential displacement during economic downturns and lower levels of resource buffering capacity in their social networks.

Second, as documented by William Julius Wilson (Wilson, 1987, 1996), the loss of jobs in inner cities has dramatically reduced employment opportunities for black men. This loss has been compounded as upwardly mobile

blacks have followed whites to more prosperous communities in the suburbs. Thus, many inner city communities have lost their internal cultural strength.

Third, housing segregation has contributed substantially to the exceptionally high risk of homelessness among blacks. As chronicled by Massey and Denton (1993) "redlining", the official government policy during the 1930s that kept blacks from moving into white neighborhoods, and continuing patterns of de facto discrimination in housing markets (Turner & Reed, 1990) have kept blacks and whites separate. The separation is increasing and it seriously compounds problems associated with poverty and limited employment opportunity (Massey & Denton, 1993). In a racially and socio-economically integrated community, even though the disadvantaged suffer disproportionately especially during economic downturns, neighborhood institutions and functioning are little affected because of the contributions of better off residents. In contrast, in segregated communities, when poor people experience an economic downturn or a reduction in public support, their communities suffer devastating losses of material resources, infrastructure, and institutional capital. Although briefly sketched, factors operating at the community level are likely to account substantially for the increased risk for homelessness among blacks beyond income differences.

Several studies have noted systematic differences between homeless blacks and homeless whites—differences that underline the relevance of these broad structural factors. Studies of two separate national samples of homeless veterans (Leda & Rosenheck, 1995; Rosenheck et al., 1997) and a sample of several thousand homeless people from 18 cities who are participating in the ACCESS demonstration program (unpublished data from R Rosenheck & J Lam) have shown that homeless blacks are less likely to have severe mental illnesses than whites, and have more social supports and stronger employment histories. These strikingly consistent findings suggest that while disabling mental illness and social isolation are major factors in the genesis of homelessness among whites, blacks are also affected by the historical legacy of discrimination (e.g., in their lack of accumulated assets) and current urban dynamics which push them over the edge into homelessness. In addition, an outcome study that compared black and white veterans found that while admission to residential treatment in addition to case management had little impact on outcomes among whites, black veterans had substantially better outcomes when they were admitted to residential treatment programs (Rosenheck et al., 1997). Although not conclusive, these data suggest that depletion of community social and economic resources may require additional interventions at both the community and individual levels.

We have presented these issues at length for two reasons. First, they suggest that interventions seeking to address homelessness among African Americans may require special consideration of institutional and structural contexts. Second, they demonstrate that examination of the specific needs of subgroups of homeless people must not stop at descriptions of individual susceptibilities, but must also examine group-specific social issues.

Homelessness Among Latinos

The under-representation of latinos among homeless people in spite of their high poverty levels has been deftly explored by Susan Gonzalez Baker (1996) who coined the phrase "The Latino Paradox". She suggested four possible explanations for the low numbers of latinos among the homeless: (1) survey methods may systematically undercount latinos in homeless samples, (2) latinos may have lower levels of personal risk factors such as psychiatric or substance abuse disorders that reduce their risk of homelessness, (3) latinos may face fewer social disadvantages than other groups, particularly compared to blacks and (4) exceptionally strong traditions of mutual familial support may be protective against homelessness. Baker suggests that the evidence does not support survey bias or differences in personal risk factors, although a recent epidemiologic study conducted in California suggested that mental illness was far less common among new immigrants than among those who had been in this country for many years or had been born here (Vega et al., 1998). Although not definitive, available data most strongly suggest that latinos may be subject to less housing and job discrimination than blacks, and that they are more likely to incorporate additional family members in a single household (Greene & Monahan, 1984; Mindel, 1980).

In the brief period since Baker's study, considerable attention has been focused on the large and growing number of hispanic immigrants in this country, both legal and illegal, especially in California and the Southwest. Originally "invited" to provide a new source of low-wage labor, the rapidly growing numbers of immigrants from Latin America has generated a formidable backlash (Suro, 1997). Studies of the new immigrants have documented several

characteristics that may affect their risk for homelessness. (1) Immigrants from the same towns in Latin America are tightly bound to one another and are deeply committed to mutual protection (Suro, 1998). (2) They are often apprehensive about using conventional governmental services for fear of being identified as illegal residents (either correctly or incorrectly). Finally, epidemiologic studies suggest that recent migrants, especially those in the Southwest, have fewer health problems (including mental health problems) than latinos who were born in this country (Vega et al., 1998).

A recent study from the Northeast, however, also found that Puerto Rican single mothers who were poor had experienced less violence and had fewer mental health problems (with the exception of major depression) than whites (Bassuk, Perloff & Coll, 1998). Each of these factors could result in a reduced risk of homelessness among recent immigrants and among less acculturated latinos. Little is known about the specific risk of homelessness among recent immigrants. The possibility that the Latino paradox may reflect specific conditions faced by more recent immigrants will hopefully generate additional discussion and research. The findings of Vega et al., (1998) may suggest that as acculturation proceeds, the risk of homelessness among latinos may become similar to that of the impoverished populations.

Native Americans Among the Homeless

Although blacks and latinos are the most numerous minority groups in this country, they are not the only ones that face adverse circumstances. The presence of other subgroups among the homeless and the documentation of their needs have received minimal attention. We note, however, a large national study of homelessness among Native American veterans because it further illustrates many of the themes we have been exploring (Kasprow & Rosenheck, 1998). This study of almost 50,000 homeless veterans showed that Native Americans are substantially overrepresented among homeless veterans (even without considering the prevalence of homelessness on reservations) and that, unlike other groups, they suffer overwhelmingly from alcohol abuse, with far lower rates of diagnosed psychiatric disorders. Alcohol abuse has been widely identified as a substantial problem in Native American populations, and is viewed by many as one consequence of the genocidal treatment of Native Americans by European conquerors (White, 1992).

Homelessness and Health: Psychiatric, Substance Abuse and Medical Disorders

As in our review of literature on generational, gender and familial circumstances and needs of homeless persons, we have found that examination of racial and ethnocultural subgroup experiences also reveal both distinctive vulnerabilities and service needs specific to each subgroup, as well as more common experiences of social disadvantage and personal deprivation. As we turn to an examination of illness, and specifically mental illness among homeless people, we move from issues which reflect major features of societal organization that have received only limited attention, to issues that have been at the center of public understanding of the problems of homeless people and have been thoroughly and carefully researched.

The prevalence of psychiatric and addictive disorders among homeless people has probably been studied more intensively and more rigorously than any other problem. Early accounts suggested that as many as 90 percent of homeless people might be suffering from mental illnesses—including many with severe illnesses such as schizophrenia and other psychoses (Bassuk, Rubin & Lauriat, 1984). Many critics quickly identified the deinstitutionalization of people with mental illness from state hospitals as a major "cause" of homelessness in the 1980s (Koegel, Burnam & Baumohl, 1996). Others pointed out that both sampling and diagnostic tools used in early studies of mental illness among homeless people were seriously inadequate, and that the timing of deinstitutionalization could not directly implicate it as a direct cause of homelessness.

In the mid-1980s the National Institutes of Mental Health funded a series of rigorous epidemiological studies based on systematic sampling strategies and state-of-the-art assessment methods. These studies demonstrated that 20-25 percent of homeless single adults had lifetime histories of serious mental illness; about half had histories of alcohol abuse or dependence; and about one-third had histories of drug abuse or dependence (Susser, Struening, & Conover, 1989; Breakey et al., 1989; Koegel, Burnam & Farr, 1989). While these rates of lifetime mental illness were 3-5 times greater than rates in the general population, these studies demonstrated that most homeless people did not have serious mental illnesses, and that less than 15 percent had suffered from schizophrenia (Koegel, Burnam & Baumohl,

1996; Tessler & Dennis, 1989). Although far more modest than rates reported in previous studies, these data clearly showed that severely mentally ill people were at much higher risk for homelessness than others and that they endured homelessness for greater periods of time. Because the public believed that the needs of people with serious mental illness had not been adequately addressed by the community mental health movement, and because it was more widely accepted that people with serious mental illness "can't help themselves," the public has been willing to support outreach programs to facilitate the entry of distrustful homeless people with mental illness into programs.

Alcoholism has long been identified as a central feature of the lives of homeless people and an explanation for their homelessness (Bahr & Caplow, 1973; Wiseman, 1973). However, among the homeless people who became visible during the 1980s, alcohol addiction was often found in younger members of minority groups (Koegel & Burnam, 1987) and among people with concomitant mental illness. About half of those with serious mental illness also had substance abuse disorders—the so-called dually diagnosed (Drake, Osher & Wallach, 1991). Alcohol abuse and dependence were often combined with the use of illicit drugs, especially crack cocaine (Jencks, 1994). Because crack cocaine was much cheaper than other drugs and other forms of cocaine, it was widely used by low income people during the years after1984.

The high level of addictiveness of crack cocaine resulted in sustained, widespread use; one survey found 66 percent of anonymous urines collected in a New York City homeless shelter were positive for crack cocaine (Jencks, 1994). While the path from alcoholism to homelessness was not a new one, the path from crack cocaine to homelessness was new, and was markedly facilitated by the low cost of the drug. Here, too, it affected the poor, infirm, and disadvantaged with special harshness.

In addition to the high rates of alcohol, drug, and mental disorders, homeless people also suffer from serious medical infirmities and experience mortality rates as much as twice a great as those of poor, domiciled people with mental illness (Kasprow and Rosenheck, 1998). The rate of HIV infection is especially high among homeless people. One study conducted in a New York City men's shelter found that 19 percent of homeless mentally ill men were HIV positive (Susser, Valencia & Conover, 1993) while another found 62 percent of homeless men were HIV positive and 18 percent had active tuberculosis (Torres et al., 1990). Another large study of New York City shelter users found that use of drugs, alcohol, and the presence of psychiatric disorder are all associated with poorer physical health, even distinct from specific illnesses such as HIV, and that the physical health status of homeless men is well below that of community samples (Streuning & Padgett, 1990).

Homelessness is thus both an effect and a cause of serious mental and physical health care problems. On the one hand, survey data strongly suggest that people with physical and mental infirmities are far more likely to become homeless than others. On the other hand, the exposure to the elements, poor nutrition, and lack of basic comforts experienced by homeless people worsens their already compromised health status. There is little question that homeless people need health services well beyond those they receive through conventional channels. The mentally ill among homeless people are often the most demoralized and hopeless, and least convinced that they can improve their situation. Supportive case management within a sustained healing relationship is an especially important component of services for this segment of the population.

Homeless People with Special Status in Society

Homeless Veterans

For as long as there have been armed forces, veterans have been honored and received considerable public attention and concern. Since the development of citizen armies in the 19th century, in recognition of their service and sacrifice, their power as a political force, and the potential threat they pose to social order, veterans have had a unique status in society (Severo & Milford, 1989). Surveys conducted during the 1980s indicated that as many as half of homeless veterans served during the Vietnam era compared to only one-third of veterans in the general population. These estimates led many to suggest that homelessness among veterans might be yet another consequence of military service during the Vietnam War and, more specifically, of combat-related posttraumatic stress disorder (PTSD) (Robertson, M, 1987). Although studies have clearly shown that some Vietnam veterans have suffered prolonged psychological problems related to their military service, the assumption that homelessness among veterans is primarily related to Vietnam service is not supported by available evidence.

A systematic synthesis of survey data indicated that 40 percent of homeless men report past military service, as compared to 34 percent in the general adult male population (Rosenheck et al., 1994), a modest increase in risk. Further studies using numerous, diverse data sets show that homeless veterans are not more likely to have served during wartime or in combat than age-matched peers who were not homeless, and were no more likely to have war-related posttraumatic stress disorder than non-homeless low income veterans (Rosenheck et al., 1996). A causal model of the genesis of homelessness among veterans also found that while mental illnesses other than PTSD, substance abuse, and social isolation were significantly related to homelessness, combat exposure and PTSD were not major predictors (Rosenheck & Fontana, 1984). In fact, the subgroup of veterans at greatest risk of homelessness as compared to their non-veteran peers are those who served after the Vietnam war, during the initial period of the All Volunteer Army, when the military was unpopular, paid low salaries, and was forced to admit many poorly adjusted recruits (Rosenheck, Frisman & Chung, 1984).

Studies conducted during the 1980s consistently reported that homeless veterans were older and are more likely to be white than other homeless men (Roth et al., 1992; Schutt et al., 1986; Streuning & Rosenblatt, 1987; Robertson, 1987). Some of these studies also reported that homeless veterans had more often been in jail than homeless non-veterans, were more likely to have problems related to alcohol use, or are more likely to have been hospitalized for a psychiatric or a substance abuse problem. A re-analysis of data from three surveys conducted during the late 1980s found that homeless veterans were older than non-veterans; more likely to be white; better educated; and more often previously or currently married, but were not different on indicators of residential instability, current social functioning, physical health, mental illness or substance abuse (Rosenheck & Koegel, 1993). Thus, it appears that the personal risk of homelessness among veterans was due primarily to the same factors as homelessness among other Americans—poverty, joblessness, mental illness and substance abuse.

However, homeless veterans have received considerable special attention and some degree of incremental service funding because of their past service to society. A headline in *USA Today*, for example, hailed "a shattered army: 500,000 homeless veterans most of whom served in Vietnam," a degree of sympathetic attention not granted to other subgroups of the homeless. Secretary of Veterans Affairs Jesse Brown told the Congress that homelessness among veterans "is an American tragedy.…The way a society treats its veterans is an indication of who we are as a nation." It is unlikely that any other cabinet officer has spoken as feelingly or as convincingly about a particular subgroup of the homeless.

Criminal Justice System Users

In dramatic contrast to the public's view of veterans are the feelings about the large numbers of homeless persons who have past histories of involvement in the criminal justice system (Fisher, 1992; Gelberg, Linn & Leake, 1988). An estimated 20 percent to 66 percent of homeless people have been arrested or incarcerated in the past as compared to only 22 percent of men and 6 percent of women in the general population (Fisher, 1992). These high rates may reflect one of four distinct personal configurations: (i) long-term deviant life styles (people who are deeply involved in crime and antisocial behavior as a way of life, including drug abuse); (ii) subsistence (the need to commit crimes for material sustenance); (iii) adaptation (criminal behavior as a necessary part of adjusting to life on the street), or (iv) diminished capacity (crime resulting from the inability to tell right from wrong due to mental illness). Reliable estimates of the relative importance of these four patterns among homeless people are not available, although they have different implications for social policy. Long term deviant life styles, for example, might suggest the need for increased incarceration while the diminished capacity explanation suggests targeting additional treatment resources to the homeless.

One author points out that the rise in homelessness during the 1980s corresponds closely to the increase in numbers of prison inmates (O' Flaherty, 1996). Between 1974 and 1984, for example, the prison population of New York State increased 2.3 times—from 12,532 to 28,992. In this view, personal characteristics are less central that social policy in explaining the large numbers of criminal justice system users among the homeless. By incarcerating a growing proportion of poor, often drug abusing, largely minority, citizens, criminal justice policy cut these vulnerable citizens off from the communities from which they came, unintentionally reducing the likelihood that they would ever be able to reestablish themselves after their release from jail or prison. Homelessness among former inmates may reflect an unanticipated negative consequence of a failed solution to a misunderstood social problem.

From another perspective, however, it has been observed that the criminal histories of many homeless people primarily reflect arrests that occurred after they became homeless—arrests for stealing or disturbing the peace that are an intrinsic part of life in public spaces (Fisher, 1992; Snow et al., 1989). Here, too, we have little information on the relative importance of each of these processes, but it is important to note the dramatic contrast between interpretations that view homeless people with past histories of involvement in the criminal justice system as victims of societal mistreatment, as contrasted with interpretations that emphasize behavioral deviance as determined at the individual level (Benda, 1987; Martell & Elliott, 1992; Martell, Rosner & Harmon, 1995).

Considerable emphasis has been placed in the literature on the possibility that people with serious mental illness are being referred with increasing frequency to the criminal justice system because of the inadequacies of the mental health system (Torrey et al., 1992). Advocates have suggested expanding jail diversion programs to appropriately channel people with mental illness to the mental health, rather than criminal justice system (Steadman, Barbera & Dennis, 1994).There is a considerable need for further research on the interrelationship of homelessness, mental illness, minority status and involvement in the criminal justice system.

Illegal Immigrants

We conclude this section by describing a subgroup of homeless people whom virtually nothing has been written: illegal immigrants. While this population has been growing rapidly and has provoked a harsh backlash reflected in the passage of Proposition 187 in California in 1994 (Suro, 1998), we know of only clinical anecdotes revealing the presence of such people among the homeless. Little is known about this population for the following reasons: (i) they may not be very numerous, (ii) they may be unwilling to identify themselves for fear of being deported, and (iii) they receive little attention because they have the least claim on our sympathies (a point deeply underscored by the passage of Proposition 187). To better serve this group, additional information about their needs is necessary.

Summary: Heroes, Deviants, and the Invisible

In this brief survey of homelessness among veterans, users of the criminal justice system, and illegal immigrants we have described three subgroups that cross social status levels: from some of the most idealized members of society, to some of the most despised, to the largely ignored. And yet survey data suggest that the boundaries among these groups may be much clearer in the public imagination than in reality. In a sample of over 10,000 homeless mentally ill veterans seen in a national Congressionally funded VA program, one-third of whom had served the nation in combat, over 50 percent of the sample had significant criminal justice histories (Rosenheck et al., 1989); in fact, they differed little from other homeless men in this or any other respect. The parable of the good Samaritan urges us to care for strangers just as we would care for our closest relatives. In our reflection on homelessness among these three subgroups we confront most dramatically the tension between attending to each subgroup in order to better understand and respond to their needs—or to differentiate among them to best decide who are deserving of public provision and who are not.

Discussion

In this presentation we have reviewed research on the diverse needs of various subgroups of homeless people. While we have discussed the distinct needs of each subgroup, we have also provided evidence indicating that the most effective way of preventing homelessness is to directly provide residential services and adequate income support. Although many homeless subgroups, especially the young and the mentally ill need personal support and remoralization to take full advantage of expanded opportunities, the late 1970s and early 1980s was not a time of epidemic demoralization, but of structural change in our society.

Why then have we focused on subgroup characteristics? To answer this question, we must briefly review American attitudes and public policy towards social support for the disadvantaged. Between the 1880s and 1920s the major industrial nations outside of the United States guaranteed protection for all citizens against insufficient income due to old age, disability, illness, or unemployment (Weir, Orloff & Skocpol, 1988a; Skocpol,1992; Wilensky & Lebeaux, 1965; Rimlinger, 1971). Programs for workman's compensation, old age pensions and insurance, health insurance, unemployment insurance, and mother's insurance were instituted not just to attack poverty, but to generate a form of

social citizenship that guaranteed basic rights and expressed the solidarity of national community (Heclo, 1995). For various cultural (Rimlinger, 1971) and political reasons (Weir, Orloff & Skocpol, 1988a; Skocpol, 1992) a broad commitment to social welfare never developed in the United States.

For example, in the mid-1980s in five European nations, Australia, and Canada, 23 percent of the population would have lived in poverty without welfare benefits. However, only 5 percent were poor as a result of government benefits, a reduction of 18 percent which was attributable to public provision. In contrast, in the United States, 20 percent of the population would have lived in poverty without welfare benefits; 13 percent remained in poverty even after consideration of benefits, a drop of only 7 percent (Mischel & Bernstein, 1993). While European nations spent an aggregate of 20 percent of GDP on social welfare programs in the mid-1980s, the US spent only 16 percent (Weir, Orloff & Skocpol, 1988a).

These statistics reflect deeply held American attitudes. While other industrial nations have maintained a broad commitment to social provision for their citizens—even as they have reduced the generosity of benefits in recent years—the United States has long questioned the motives and deservingness of its poor (Katz, 1989). In fact, Americans have reduced their national commitment through various welfare reform measures and retrenchments (Mishel & Bernstein, 1993). The American approach to public assistance has traditionally been based on a critical evaluation of deservingness, rather than on a broad commitment to assisting the economically disadvantaged. The current withdrawal of public support has occurred in the face of compelling evidence that the distribution of income has become increasingly inequitable since the mid 1970s, and that earning opportunities for unskilled workers continue to diminish even in a booming economy (Passell, 1998).

It is not surprising that within this context the differential composition of the homeless population in America receives so much attention. While in other wealthy industrial countries, the mere fact of homelessness justifies a public response, the traditions of social provision in this country demand further justification of the claim for public sympathy and support for each specific subgroup of homeless people. In a broad empirical review of the performance of the U.S. Government, former President of Harvard University, Derek Bok, concluded that while our country excels above all others in its productivity and high standard of living, and that our government is both effective and efficient, it does less well than other countries at protecting its citizens and assuring their personal security (Bok, 1997, p. 63-64).

Convincing others that people are deserving of assistance requires that researchers specializing in the problems of each subgroup advocate for the legitimacy of their needs. This also may explain why so much scholarly attention is directed at subgroups of the homeless who are regarded as "deserving": families, children, the severely mentally ill, and veterans. Little emphasis is placed on other subgroup characteristics such as extreme poverty, minority status, or being an illegal immigrant.

We do not mean to underplay the importance of addressing the pressing needs of subgroups of the homeless. Children must be educated, single mothers must have child care and job training, the mentally ill need treatment for their illnesses, and veterans deserve honor and recognition for their past sacrifices. All the disadvantaged need encouragement and support (Bardach, 1997). But the studies we have reviewed suggest that as important as these specialized services are, they are not the most effective way out of homelessness. That data strongly indicate that all services must be targeted to the specific needs of individual clients, and that emphasizing subgroup characteristics and needs should in no way imply a *de facto* acceptance of homelessness itself as irremediable and therefore, as acceptable. Since we as a people are not committing the funds to provide subsistence resources for the poor, we understand that there will continue to be hundreds of thousands of homeless persons on any given night, and we are resigned to providing for their educational, health care and job training needs within that context. To do so is certainly preferable to neglecting those needs. However, it is imperative that policy makers understand that such a response may reflect capitulation to an outcome that is not inevitable. If the political will were present, homelessness could be eradicated or at the very least, very markedly reduced.

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