

HEALING HANDS



Vol. 4, No. 4 ■ August 2000

Women's Health Care: Show Me the Way to Go Home

Fleeing from an abusive partner, dulling the pain with addictive substances — more often than not, this is the subtext of homeless women's lives that clinicians may fail to read or simply avoid addressing. Research has demonstrated significantly higher rates of substance abuse/dependence, major depression and posttraumatic stress disorder among homeless than low-income housed women. Homeless women are also more likely to be victims of physical or sexual abuse and to trade sex for commodities. Consequently, they are at increased risk for contracting sexually transmitted diseases including HIV/AIDs and the human papilloma virus, which is associated with cervical cancer and compromised immune function.¹

Unfortunately, homeless women also face special barriers to health care that could decrease these risks. They are less likely to have a regular provider or source of care, and may have difficulty obtaining addictions treatment, mental health services, screening for STDs, and HIV counseling, testing or treatment.¹ Although homeless women

with children may have greater access to health care than single women, like housed mothers they tend to subordinate their own health needs to those of their children.¹ For all of these reasons, women's health care should be of special concern to clinicians serving homeless populations, even if a majority of their clients are male.

In 1998, women comprised 38% of Health Care for the Homeless service recipients.² A national survey conducted in 1996 found that over 30% of all homeless service users were female — of whom approximately 20% were single women unaccompanied by children, and nearly 10% were mothers living with at least one child. Among homeless clients in families, 84% were women; among single homeless clients, 23% were women.³ In this issue of *Healing Hands*, a formerly homeless woman and several clinicians experienced in homeless health care tell how it is possible to help these traumatized, ostracized women begin the healing process and find their way home. ■

Reality Check: A Client's Perspective

Homelessness isn't for sissies. It takes guts and perseverance merely to find the next meal and a safe place to stay when you are homeless, let alone seek help for health problems, says **Vera M.**, consumer representative on the Board of the Family Health Center (FHC) in Kalamazoo, Michigan. "It's like the Survivor Show out there. When people do something for you, they usually want something in return." Vera is a refugee from domestic violence and a recovering alcoholic

who worked for 14 years in radio broadcasting before becoming homeless. "After making \$100,000 as a popular disk jockey in Chicago, I found myself panhandling on the streets of Denver for \$1.75, just to get a bottle," she recalls.

It's been a long and arduous journey back to her roots in Michigan and back to full-time work in radio, this time in commercials and sales. Thanks to experienced homeless service

providers and to her own persistence, she is homeless no more. Nevertheless, this gutsy, articulate woman hasn't forgotten what it was like to fight fear, addiction and homelessness simultaneously. So she spends part of every Saturday working at a halfway house where she once stayed, helping to cheer up women with similar histories who are still struggling.

As an FHC Board member, she helps homeless service providers understand the human

realities of homelessness, and how they can reduce the barriers to healing that homeless women face. She also shares her insights in a videotape under production by the National Health Care for the Homeless Council that will be used as a training tool for new HCH staff. Here readers find a preview of her experience and advice.

BARRIERS TO HEALING Homeless women without children have *difficulty finding programs to meet their health needs*, observes Vera. Substance abuse treatment is especially hard to come by. Many addicts can't get shelter without abstinence and can't maintain abstinence without therapy — but often can't find a substance abuse treatment program that will accept them. *Lack of insurance* is a major barrier. Most single women don't qualify for Medicaid, and those who do may lose it once they get a job. Even state programs for indigent persons may be limited to the unemployed.

Women who are both “under the influence” and uninsured are often turned away by mainstream health care providers or treated with contempt. “Homeless women already feel lower than low,” she says. “They don't need to cope with *negative attitudes of service providers*, which can be devastating.”

“When you're out there and homeless, sometimes it's easier to find a drink or a drug than a well-balanced meal.”

Vera M.

Women who are recently homeless or new to an area *may not know where to go for non-emergent health care*. Their first priority is physical safety. “You're thinking about where to get your next meal, where to sleep when shelters won't take you if you have been drinking or using drugs, how to get a job when you have no presentable clothes.” It took Vera a long time to find out about HCH services. “We need more pamphlets and flyers at hospitals to inform uninsured people how to obtain primary care,” she says.

Transportation is another issue. “If you're not physically fit in the first place, having to walk ten miles to a clinic is really hard.” Bus service may not be available when you need it or at all, especially in rural areas. What's more, homeless women may be *afraid to visit clinics* that are located in neighborhoods where drug addicts hang out. Even if they find the courage to run the gauntlet of homeless males clustered outside, they may have to wait for hours or all day before seeing a provider — especially in larger cities where HCH clinics are overwhelmed with patients.

“Clinics that are open only during working hours are especially hard to manage when you're just starting a job,” says Vera. (In response to consumer input, FHC is now open on Wednesday evenings and Saturdays.)

An outreach worker finally hooked Vera up with the Family Health Center, where she received a complete physical work-up including cancer screening. Like many other states, Michigan has a Breast Cancer & Cervical Cancer Program (BCCCP) that provides free Pap smears and mammography for uninsured women. Social Services Director **Jihad Ford, RSW**, helped her obtain coverage for treatment under the state insurance program. After a couple of abnormal Pap smears, she was referred for a colposcopy that revealed a pre-cancerous condition, which resolved following treatment.

Vera remembers her experience at the hospital as somewhat intimidating. She was frightened of the radiological procedure, even though a doctor took time to talk with her beforehand. “He was very compassionate, had a sense of humor, and asked me if there were other issues going on,” she remembers. “But women hold back. They are more likely to tell about winning the Boston Marathon than a history of alcoholism or abuse.” No one asked her if she had experienced domestic violence, and she didn't volunteer the information. Women who have experienced physical or sexual abuse are often *mistrustful of men*, even male clinicians, explains Vera. “Even if the physical scars are gone, the emotional scars remain.” But it's often *hard to find mental health professionals* who can help the nightmares subside.

HOW CLINICIANS CAN HELP As a single homeless woman, Vera M. saw the good, the bad and the ugly in American health care delivery systems. Although she found more understanding and acceptance from Health Care for the Homeless providers than elsewhere, some were more helpful than others. To accommodate services to homeless women's needs, here is what she recommends to all clinicians:

TIPS FROM A CONSUMER

- **Use common courtesy and respect for human dignity** to help motivate clients to begin **taking care of themselves**.
- **Express genuine concern**. Be observant; ask about changes in your clients' appearance or behavior.
- **Extend clinic hours** to evenings and weekends.
- **Do general health screening**, not just gyn screening. When clients come in sick, use the opportunity to offer preventive care.
- **Use questionnaires** to help clients remember all their concerns, not just what is hurting them at the moment.
- **Address mental health and substance abuse issues** as well as physical illnesses and injuries. Ask specifically about physical and sexual abuse.
- **Teach clients about diet**. Help them figure out how to eat healthy foods.
- **Listen to your clients**. Ask *them* how to create more user-friendly services.

Vera eventually obtained substance abuse treatment through a 12-step recovery program at The Next Door, a shelter for single women sponsored by the Kalamazoo Youth Ministry. “The shelter provided food, safety and time to work on myself,” she says. “After staying there for a year, I finally realized that homelessness is not Vera — it's just a circumstance, and not what I'm about.” ■

says. One patient with a high probability of cancer was asked to leave care by a provider in the county system because of an anxiety disorder. Only limited proactive case management and patient follow-up are provided through the county system. HCH clinicians are still trying to find out if the woman ever got the surgery she needed.

Other systems barriers to care for homeless women in California include excessive documentation requirements and the fact that coverage is authorized only three months at a time for specific kinds of care. County clinics require phone numbers and mailing addresses to authorize treatment. Homeless clients who don't receive their communications are accused of noncompliance. Those who try to call these clinics encounter a tedious, automated answering system. "People give up," says Roseland. "There are lots of missed appointments and a general lack of communication." The HCH is the lead agency in a county homeless coalition that is advocating for *decreased fragmentation, increased access and continuity of care* for homeless people.

"Most of my patients could qualify for Medicaid/SSI on PTSD alone, but clinicians don't know how to document their disability appropriately, or patients fearful of upscale psychiatrists to whom Medicaid typically refers them for confirmation of the diagnosis may miss appointments," says Dr. Means. "The system breaks down for these women." She encourages patients to get an independent evaluation from a mental health professional they trust, and tries to facilitate linkages with clinicians who are sensitive to homeless women's needs

and aware of documentation requirements. [For information about documenting disabilities for Medicaid/SSI eligibility, see O'Connell, 1997.⁶]

FACILITATING PREVENTIVE CARE Roseanna Means advocates a wellness perspective, and reports strong patient adherence to health screening. The key to preventive care is convincing your patients that you genuinely *care about* them, she contends. Women with traumatic histories or addiction problems are just as fearful of female clinicians as they are of males, she says. "Put your stethoscope away, put your hands in your pockets, open your ears and just listen," she advises students. "It's better to wait a year to do a Pap smear than to scare women off by trying to do one before they are ready." If preventive care must be delayed, Means follows the patient closely in frequent, short visits to address acute medical problems, reinforce trust and establish the habit of seeing a doctor regularly. She finds that most homeless clients are very responsive to this approach. "Even those with severe mental illness return for care."

Tom Roseland and his staff frequently spend time during lunch walking around at a local soup kitchen, giving special attention to homeless women. They encourage regular breast and cervical cancer screening and share information about free screening programs. "Most of these women are interested in obtaining health care, but no one has offered it to them before in a respectful, caring manner," he says. His advice to other clinicians is, "just get out there, be seen and build trust." If you build it, they will come. ■

RECOMMENDED PREVENTIVE HEALTH SCREENING & INTERVENTIONS FOR HOMELESS WOMEN

- **Hypertension:** blood pressure measurement at least once every 2 years if last systolic/diastolic readings were below 140/85 mm Hg; annually if last diastolic reading was 85-89 mm Hg.
- **Obesity:** periodic height and weight measurements for all patients; appropriate counseling to promote physical activity and a healthy diet. BMI commonly used as measure of severity and risk for co-morbidities.
- **Coronary Heart Disease:** periodic measurement of total blood cholesterol for all women ages 45-65; most important in perimenopausal women and persons who have gained weight.
- **Cervical cancer:** annual Pap smear and pelvic exam in all women beginning age 18 who have been sexually active (ACOG, AAFP); or every 2 years for high-risk women ages 20-65 (ACP); "Women who are HIV positive require more frequent screening." (USPS)
- **Breast cancer:** annual mammogram + clinical breast exam (CBE) every 1-2 years beginning age 40, annual mammogram + CBE beginning age 50, routine teaching of breast self-exam (ACS, ACOG); or annual mammogram ± CBE ages 50-69 (USPS); or CBE every 1-3 years ages 30-39 and annually thereafter, with annual mammogram age 50+ (AAFP) or mammography every 2 years ages 50-74 (ACP). [Barini-Garcia recommends ACOG guidelines.] Educate about signs of cancer.
- **Colorectal cancer:** beginning at age 40: annual digital rectal exam; beginning at age 50: annual fecal occult blood test (FOBT), sigmoidoscopy every 3-5 years (ACOG, ACS). Educate about signs of cancer.
- **Substance abuse:** history of alcohol or drug use/abuse; standardized questionnaire recommended for alcohol use only (CAGE is most popular). Establish a trusting relationship; discuss in non-judgmental manner.
- **Domestic violence:** Use screening tool developed by The Better Homes Fund in collaboration with HCH Clinicians' Network, February 2000.⁵
- **Sexually Transmitted Diseases:** Screen for gonorrhea, HIV, chlamydia, trichomonas in women with multiple sex partners or if woman/partner is using drugs or exchanging sex for commodities.
- **HIV:** Screen sexually active women in high prevalence areas with multiple partners and injection or street drug users. Educate about risk reduction.
- **TB:** tuberculin skin test (PPD) for women at increased risk for tuberculosis - those infected with HIV, in close contact with TB-infected person, immigrants, alcoholics, injection drug users or shelter residents.
- **Immunizations:** tetanus-diphtheria, rubella (or serology, vaccination history) in women of childbearing age, influenza, pneumococcal in certain chronic illnesses, hepatitis A & B in women with high-risk sexual behavior or injecting/street drug users.

adapted from the Report of the U.S. Preventive Services (USPS) Task Force, Second Edition, 1996⁷ and conversations with Magda Barini-Garcia, MD, Chief Medical Officer, Division of Training & Technical Assistance, HIV/AIDS Bureau, and Karen Holman, MPH

Relational Care: Clinicians' Imperative

What are the most serious health issues non-pregnant homeless women face? What prevents them from obtaining the care they need, and what can be done to address individual and systems failures that impede their healing? How can clinicians integrate preventive care with treatment for acute and chronic conditions in this highly mobile, crisis-driven population? Several clinicians serving homeless women respond to these questions, suggesting ways to overcome obstacles to care, reduce health risks and begin to resolve conditions that gave rise to homelessness.

CRITICAL HEALTH ISSUES “Depression, anxiety disorders and domestic violence are high on the list of clinical problems homeless women experience,” says **Tom Roseland, FNP-C**, clinical director and homeless health project coordinator at Golden Valley Health Centers in Modesto, California. Among his female clients, 85% have experienced domestic violence, in comparison with 22–25% in a normal family practice. They are typically behind on complete physicals and Pap smears, he says, primarily because of the lack of clinical environments in which they feel welcome and secure.

“We also see a large number of female heroin addicts,” adds head nurse **Teresa Olson, RN, PHN, MSN**. “They use drugs primarily to relieve emotional pain — from physical or sexual abuse, the loss of a child, a broken marriage or other tragedies.” Mental illness and *substance abuse* are frequently intertwined. A great deal of compassion and understanding is required in treating these clients, who can be very frustrated and angry, she says.

Substance abuse, *cervical and breast cancer*, and *HIV* are among the most serious women’s health problems seen at Family Health Center’s HCH program in Kalamazoo, Michigan, reports **Jihad Ford, RSW**. “Homeless mothers who are HIV-positive often delay care in deference to their children’s needs.”

Internist **Roseanna H. Means, MD**, President, Women of Means, Inc., Wellesley, Massachusetts, says 100% of her homeless female clients report being raped or abused, and many suffer from *posttraumatic stress disorder*. Social isolation compounds their emotional devastation. Survival sex and lack of condom availability increase their risk for *STDs*. The HIV positivity rate among homeless people in her area is 20%.⁴ She also sees lots of *foot and vascular problems* associated with diabetes and obesity, particularly in postmenopausal women, which are exacerbated by the high-fat/carbohydrate diet in shelters.

“Homeless women are getting abused by themselves, by their partners, and by the system; they feel they’re at the end of the line.”

**Teresa Olson, RN, PHN, MSN,
Golden Valley Health Centers HCH**

OVERCOMING OBSTACLES TO CARE Clinical environments that are inhospitable to homeless women pose a serious barrier to their health care, says **Tom Roseland**. Many clinicians don’t take the time to explain things or do a good history. Homeless women often avoid mainstream medicine because they are concerned about revealing substance abuse or an active sexual history, and clients with personal-

ity disorders are discouraged from returning to mainstream clinics. “Active, conscious attention to building trust with homeless women is not a key component of most mainstream health systems,” he observes. “Because HCH staff actively try to build trust, it is not accidental that homeless women feel more at home there.”

BARRIERS TO CARING FOR PERSONS WHO ARE HOMELESS⁴ SOURCES:

- **Society** – lack of affordable housing, low wages, insufficient day care, inadequate welfare-to-work programs, domestic violence, few mental health and substance abuse resources.
- **Patients** – transience, high-risk behaviors, mistrust of caregivers; cultural, linguistic, literacy and education issues.
- **Clinicians** – ignorance of underserved populations, insufficient education about homelessness, inattention to community problems beyond their institution or discipline, ignorance of Medicaid rules.
- **Homeless networks** – lack of inter/intra-agency communication, turf wars, ignorance of managed care, under-documentation.
- **Managed care** – ignorance of complexities in treating homeless populations, cost-containment priorities at the expense of quality, unrealistic rules and restrictions.

Roseanna Means H., MD, Women of Means, Inc.

Continuity of care and a reputation for being compassionate and trustworthy are crucial elements of a therapeutic relationship that can defuse a client’s fear of clinicians, says Roseland. *Relational care should be integral to medical care*. “We start with the front-office staff, who welcome clients and invite them to come back.” To build trust, he spends 35–40 minutes during the client’s first visit, carefully listening to her concerns, then repeating them back to her. All individuals over age 12 are asked about domestic violence, which he treats “as a normal part of life rather than as something shocking or shameful.” The Better Homes Fund’s domestic violence screening tool, which the HCH helped to field test, is used as an opportunity for client education.⁵

Dr. Roseanna Means uses a podiatry kit to break down communication barriers with clients. She offers to cut clients’ toenails and shave their calluses. “Holding their feet in your lap and making small talk has a calming effect on women who have been traumatized. People will tell me more things under those circumstances than they will while I’m taking their blood pressure — which may be too close for comfort. This non-threatening bodily contact stimulates a physical remembrance of other nurturing relationships clients have had.” She sees gyn patients with their clothes on first, carefully explains the

genital exam, and never leaves them alone in stirrups.

Means is doing what she can to change the negative stereotype of mainstream health care. Formerly a medical director of Boston HCH and head of the McGinnis House respite care facility, she now directs her own homeless program, Women of Means. “Many homeless women avoid HCH clinics because they are fearful of the environment and male clients,” she says. Means delivers care at two area shelters, accompanied by clinician volunteers and students from medical and nursing schools. She is also a consultant for Massachusetts Medicaid and serves on the state’s Homeless Task Force. Through her clinical work and statewide advocacy, she hopes to *involve more mainstream clinicians in caring for currently underserved homeless women*. “As homeless health care providers, let’s be the experts; let’s craft the policy for mainstream doctors, not just provide an alternative health care delivery system,” she urges.



Photo by Rey Banogon

Dr. Roseanna Means and client say “ahhhh!”

MAKING SERVICES USER-FRIENDLY FOR HOMELESS WOMEN⁴

- **Build trust.** Create an atmosphere of safety. Be patient. Listen well and talk first, examine second, invade third. Tell the truth and be predictable; don’t make promises you can’t keep.
- **Understand the paradigm of traumatic experience.** Respect physical and psychological space; ask permission to touch, to perform each exam.
- **Set realistic goals and interventions together.** Prioritize; employ small steps in weekly meetings. Tailor care to client’s stage of homelessness. Keep regimens simple.
- **Praise patients for accomplishments.** Thank them for showing up, even if late, and for complying with treatment. Don’t scold.
- **Build communication networks with other providers.** Give clients the tools they need to access services. Track high-risk patients following referrals. Educate colleagues about homelessness.
- **Keep expectations realistic but as high as clients can manage.** Identify inappropriate, maladaptive behavior together.
- **Be flexible.** Encourage appointments but allow walk-ins. Use creative thinking to reach clients. Keep your sense of humor.

Roseanna Means H., MD, Women of Means, Inc.

Clinicians in Colorado and California find that mandatory reporting of domestic violence in their states can interfere with health care and client safety. “If a client states that she has been battered, we must report her to the police,” says **Liz DelaTorres, BSW**, community health care coordinator at the Pueblo Community Health Center HCH in Pueblo, Colorado. If enough evidence of abuse is found to pursue the case, the district attorney presses charges against the batterer. DelaTorres thinks women avoid the clinic because they are afraid of the consequences if batterers find out they have been reported. “How can you inspire trust and provide appropriate care for abused women when you are legally required to report them?”

“Unfortunately, premature reporting of domestic violence may compromise the trust relationship between clinician and client,” agrees **Tom Roseland**. “It may also exacerbate violence if the client is not ready to leave her batterer,” adds **Teresa Olson**. To minimize the damage, Roseland explains his legal responsibility to the client and his concern for her safety. If she reports a history of domestic violence but there is no visible evidence of injury, he offers to call the police, gives the client information about a women’s center where she can receive counseling and respite, and offers the clinic as a source of help. Women hiding from batterers are immediately placed in a private room instead of the waiting room. If there is evidence of physical abuse, California law requires him to call a police officer. Emotional abuse alone, though often worse than physical injury, doesn’t require reporting. [Reporting requirements vary from state to state. For more information, see Melnick and Bassuk, 1999.⁵]

“What we really need is a *collaborative relationship with law enforcement and mental health services*,” says Roseland, who is trying to replicate Merced County’s emergency response team — a police officer, a women’s center representative and a mental health provider. The team is on 24-hour call, responding simultaneously to clients’ legal, medical and emotional needs. “Clinicians should also *pay attention to the male partners of homeless women*,” he suggests. Many of them also bear the emotional scars of abuse experienced or observed in childhood. “Domestic violence can be related to a difficult child, an illness or depression, which often manifests itself in rage. Problem-solving should involve the whole family.” Roseland gets to know the woman first, then may end up seeing her partner as a patient.

Obtaining specialty care is particularly difficult for homeless women without children because of fragmented services imposed by discrete sources of public funding, according to Olson. In California, indigent adults may receive primary care through the HCH, cancer/STD screening and some medical treatment through the state, and surgery or inpatient care financed and administered by the county. High-risk patients can get lost in the shuffle from one system to another, she

SOURCES AND RESOURCES:

1. Bassuk; Smith; Weinreb; Wood; Fisher; Parker – as cited in John Y. Song, MD, *HIV & Homelessness: Recommendations for Clinical Practice and Public Policy*, HCH Clinicians' Network, November 1999: www.nhchc.org/HIV.html.
2. Bureau of Primary Health Care/HRSA/DHHS. UDS report, 1998.
3. Urban Institute. *Summary Report of the National Survey of Homeless Assistance Providers and Clients*, December 1999: www.urban.org/housing/homeless/homeless.html.
4. Roseanna H. Means, MD. Caring for the Homeless and Marginally Housed: Are Your Patients At Risk? *Continuing medical education* 5(1), Fallon HealthCare System, 2000: 1-16; curriculum on homelessness.
5. Sharon M. Melnick, PhD, and Ellen L. Bassuk, MD, The Better Homes Fund. *Identifying and Responding to Violence in Poor and Homeless Women*, February 2000: www.nhchc.org/domviolence.html.
6. James J. O'Connell, MD, Boston HCH. *Determining Disability: Simple Strategies for Clinicians*. National Health Care for the Homeless Council, December 1997: www.nhchc.org/disability.html.
7. Office of Disease Prevention and Health Promotion, DHHS. *Guide to Clinical Preventive Services*, Second Edition, 1996: <http://odphp.osophs.dhhs.gov/pubs/guidecps>.
8. American College of Obstetrics & Gynecology (ACOG). Routine Cancer Screening, *Committee Opinion No. 185*, Sept.1997: 225-227.
9. Office of Minority and Women's Health, Bureau of Primary Health Care: 301/594-4490; www.bphc.hrsa.gov/omwh/omwh.htm; The National Women's Health Information Center, DHHS: www.4woman.gov.
10. Iniciativa Nacional Hispana Contra El Cancer [National Hispanic Leadership Initiative on Cancer], sponsored by the National Cancer Institute: <http://enaccion.bcm.tmc.edu>.

excerpts from **The Homeless Women's Prayer** by "Storm"

...We are the mothers, we are the sisters...
We need opened eyes; we need help
To stay from the arms of harm's clutches....

...We are your wives, ... your sisters, ... your mothers....
We dodge guns,... knives, and much worse, rape.
We do not want to live in crime-filled streets.
Please, God, get us out.

A blanket — well, that's nice of you;
A jacket — that's kind of you;
But at night we lie naked under your skies.
We are among drunken men, with little choice.
We are scared. God, please give us a home.

A sandwich — that helps
Some change — that's nice;
But still no shelter is to be found.
Lord, we could use a safe place to wash the smell
From filthy, bourbon-stained streets where the winos meet,
Away from the drugs we despise and do not choose to use...

God, no one else has given a damn,
Maybe you can help them to understand....

from *Friendship Quilt*, a publication of the Women's Enhancement and Equality League, Seattle, Washington

Communications Committee

Adele O'Sullivan, MD (Chair); Lisa Cunningham Roberts, MA, NCC; Liz DelaTorres, BSW; James Dixon, BSW; Jan Harris, LCSW-C;
Karen Holman, MD, MPH; Scott Orman; Linda Ruble, PA-C, ARNP; Pat Post, MPA (Editor)

Healing Hands is a publication of Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council.
P.O. Box 60427, Nashville, Tennessee 37206-0427 ~ For membership information, call (615) 226-2292 or visit www.nhchc.org.



HCH Clinicians' Network
P.O. Box 60427
Nashville, TN 37206-0427