

HOMELESSNESS IN SPAIN: PSYCHOSOCIAL ASPECTS

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Homelessness in Spain: psychosocial aspects. This paper analyses the phenomenon of homelessness in Spain from a psychosocial perspective. First, both Spanish and international definitions are reviewed and figures are provided in relation to those affected. Subsequently, results of studies on causal and sustaining factors of homelessness are presented, especially those referring jointly to economic and psychosocial aspects. Available data on the mental and physical health of this population group are also reviewed. Finally, we reflect on the social response: social welfare and specific services and their effectiveness.

En el presente trabajo se analiza la situación de las Personas Sin Hogar en España, desde una perspectiva psicosocial. En primer lugar se revisan las definiciones españolas e internacionales del término y las principales cifras relativas a las personas que sufren esta situación. Seguidamente se presentan los resultados de diversos trabajos que se han ocupado del estudio de los factores causales y mantenedores de la situación Sin Hogar especialmente aquellos que han abordado aspectos económicos y psicosociales conjuntamente. Igualmente se pasa revista a los datos disponibles relativos a la Salud Física y Mental de este grupo de población. Posteriormente se ofrece una reflexión sobre la respuesta social española: factores de protección, servicios específicos y eficacia de los mismos.

1. WHAT DOES THE TERM “HOMELESS PERSON” (HP) MEAN?

In contrast to the situation in other European countries, there is no official definition of the HP in Spain, be it from central, regional or municipal authorities. Nor are there any definitions of terms that could be considered synonymous or close in meaning. This fact has, up to now, had serious social implications for the homeless, most importantly in relation to the legal vacuum that affects people in this situation. Nevertheless, in spite of this lack of an official definition, a homeless population obviously exists, and with characteristics similar to those of other European countries. The above-described situation has led to the fact that, over recent decades, different types of definition have been used by different authors and by the different social sectors involved in the problem. Below we present the main types of definition and briefly discuss their current applications.

First, we should mention some of the terms used in the Spanish language that over the years have attempted to

represent, in one way or another, the group of people that today could be defined as HPs. That is, they are not definitions of the term HP, but rather words with content that is very close to the reality of the HP as we understand it today. Using as a guide the *Diccionario de la Real Academia Española* (Dictionary of the Spanish Royal Academy) (1977), the terms most worthy of note are *mendigo* (**beggar**) (person who begs); *vagabundo* (**vagabond, tramp, bum**) (person who moves from one place to another without any fixed direction); *carrilano* (**traveller**) (person who lives “on the road”); *vago* (**tramp, bum**) (person without trade or profession). All of these words refer to different sectors of the population whose definition may coincide to a greater or lesser extent with the term HP. At the same time, they all have markedly negative connotations in everyday language, and moreover, none of them includes all of the characteristics of this population. Today, all of these terms are used in some measure by the general population, but no specialist or official body would use them –indeed, there are campaigns against the use of this type of disparaging and humiliating term in this context (for an excellent review of the terminological aspect, see Salinas, 1994).

From another perspective, we can consider attempts at definition emerging from the earliest studies in the area or from the providers of public or private services. The basic idea is always the same: the HP is that person who

The original Spanish version of this paper has been previously published in *Intervención Psicosocial*, 1998, Vol. 7 No 1, 7-26

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uses the services designed for this population. The definition may vary according to the type of service involved. While these types of definition helped to clarify the initial work context and facilitate early research, they are less viable now, since they include people who are not HPs and exclude authentic HPs that do not use services.

Cáritas España (a Spanish registered charity) (Salinas, 1994; Nerín, 1996) has preferred to use the term *transeúnte* (a term roughly equivalent to “vagrant”, but without the negative connotations) in this context. For this author, *transeúntes* are poor and marginalised people that use services (mainly hostels); “*sin techo*” (“roofless”), on the other hand, refers to *transeúntes* who literally live in the street (they do not use hostels).

International definitions: Poverty and social exclusion

In recent years various European research groups, coordinated around the **European Federation of Services for Homeless Persons** (FEANTSA) (Avramov, 1995), have noted the need for a common definition for all EU member countries. Indeed, demands for such a definition have been filed with all the governments concerned (Daly, 1993), but have up to now gone unattended.

Initial efforts to produce a common definition have taken their cue from those used in the United States, including that of the **McKinney Homeless Assistant Act** (1987) and, especially, that of the United States Alcohol, Drugs Abuse and Mental Health Administration (1983), which defines the HP as “any person that lacks adequate accommodation, resources or links with the community”. Thus, this definition covers the criteria of **poverty** and **social isolation**.

The **Council of Europe** (1992) has defined the homeless as “persons or families that are socially excluded from permanently occupying a personal and adequate home. Persons or families that:

- have no roof over their head and are condemned to live in the street as vagrants;
- are temporarily housed in hostels or centres for the homeless, especially created by public authorities or the private sector;
- are temporarily housed in the private sector, in bed and breakfasts, cheap hotels or private hostels, or with friends or relatives with whom they may be obliged to live;
- occupy, legally or illegally, unsafe housing, shacks, abandoned houses, etc.
- live in institutions, children’s homes, hospitals, prisons or psychiatric units, and have no home to go to when they leave;
- live in a dwelling that cannot be considered adequate or socially acceptable, thus converting them into poorly-housed persons or families.”

FEANTSA and the **European Observatory of the Homeless** (Daly, 1994; Avramov, 1995) reach a similar conclusion: “The HP is that person who is incapable of accessing to and maintaining an adequate personal dwelling through his/her own means, or incapable of maintaining a dwelling with the aid of Social Services.”

In these definitions two relevant criteria are unified: economic poverty that impedes access to housing in the market context, and social exclusion, which, apart from the personal marginalisation implied, impedes access to housing through community assistance channels (social services). Also considered as HPs are those persons who currently live in institutions (hospitals, prisons, etc.) and have no personal home to go to on leaving, and those living in sub-standard housing or in conditions of overcrowding.

To sum up, the current situation in Spain indicates the pressing need for an official government definition of the term HP, agreed with the other EU member govern-

TABLE 1
Number of homeless persons in Spain,
according to different estimations

SOURCE	Persons using hostels per year	Persons with urgent housing needs	Homeless persons (FEANTSA definition)
Salinas (1989-1993)	40 - 45.000	--	--
Avramov, 1995 (estimated)	11.000	100.000	160.000
Salinas (1995) Combining data on hostel use and from the FOESSA Report (Extreme poverty + sub-standard housing)	30.000	--	225-250.000

ments. The statistical, political and social service implications of such a definition are obvious. In the meantime it would be advisable to employ the definition offered by the Council of Europe and later delimited by FEANTSA and the European Observatory of the Homeless.

2. HOW MANY HOMELESS PEOPLE ARE THERE IN SPAIN?

In Spain there are no official statistics, either global or regional, on the homeless. Therefore, the only data available comes from estimations based on different parameters and using different definitions (Cabrera, 1997; Vázquez, Muñoz and Rodríguez, 1998). Table 1 shows some of the main data on estimated numbers of homeless persons in Spain.

As can be seen in Table 1, the most realistic estimations with regard to the phenomenon were not made until 1995. In that year the European Observatory of the Homeless (Avramov, 1995) put the number of HPs in Spain at around 160,000. In order to arrive at this figure, Avramov took the number of persons per day sleeping in hostels (approximately 8,000), the mean duration

of stay (2 months) and the percentage of those returning to the hostel (38.5%), producing a figure of some 11,000 people using hostels. He then combined this figure with those provided by Cáritas (Salinas, 1990; 1991; 1992; 1993) on vagrants (between 40 and 45,000 per year) and with those on people with urgent housing needs (around 100,000).

Also in 1995, Salinas amended the figures on the Spanish situation, including a wider definition than that of *transeúnte*, which had been used up until then. Employing the definition of HP developed by FEANTSA (Avramov, 1995), and using the data from the Observatory reports of previous years and the Report of the FOESSA Foundation (1994), Salinas arrived at a figure for HPs of between 225,000 and 250,000, if we include those living in sub-standard housing conditions. This figure would give Spain a rate of 7 HPs per 1,000 inhabitants, very close to the 7.5/1,000 estimated for the EU as a whole (Daly, 1993; Drake, 1994). As it can be seen, there are marked differences in the HP figures depending on the definition used: the highest estimations appear when the inadequate housing criteria are included and those of social exclusion are not. The lowest estimations correspond to the single criterion of sleeping literally "in the street", while the intermediate ones, around 45,000 to 50,000 persons, are found on considering those that sleep in the street plus those that have serious problems gaining access to housing and suffer extreme social exclusion. Using this latter, wider definition the figures come much closer to those of the rest of the EU countries than they had with previous definitions.

3. CURRENT DEMOGRAPHIC ASPECTS AND CHANGES OVER TIME

Spanish census figures do not include valid references with regard to HPs. Thus, any comments relating to the demographic characteristics of the homeless population cannot be anything more than estimations based on the main research carried out. Table 2 shows the data considered most relevant for defining the sociodemographic profile of HPs in Spain. All of the data comes from *research* related to the health and/or needs of HPs, rather than from surveys with strictly sociodemographic objectives, and a variety of definitions of HP are used¹.

According to the data, and with the necessary precaution, it can be stated that HPs in Spain:

- Are predominantly male, although designs using more sophisticated sampling strategies find up to 21% females.

TABLE 2
Demographic characteristics of homeless persons in Spain (percentages).

	Madrid ¹	Aranjuez ²	Barcelona ³	Gijón ⁴
N	262	524	99	170
Percentage males	79	95.2	85.9	87
Age				
18-30	24	N.A.	24.2	24.5*
31-45	38	N.A.	41*	38.9*
46-60	28	N.A.	32*	26.4*
>60	10	N.A.	1	7.5*
Mean (SD)	41.9	40	39.2	39.9
Years of education (mean)	7.7	8*	10*	8*
Marital status				
Married	7	7	12.1	3
Widowed	5	4	5.1	4
Separated or divorced	24	19	37.4	35
Never married	64	70	45.5	57
Total not married	93	93	87.9	97
Previous psychiatric hospitalisation	25	18	N.A.	22.2
Previous imprisonment	28	24	24.2	N.A.
Currently employed	97	88	68.7	75
Duration of homelessness (years)				
Less than 1 year	20	N.A.	54.5	38
1-5 yrs	39	N.A.	31.24	32
5-10 yrs	16	N.A.	N.A.	13
>10 yrs	25	N.A.	N.A.	17

¹ Muñoz, M., Vázquez, C. and Cruzado, J.A. (1995).

² Rico, P., Vega, L.S. and Aranguren, L. (1994).

³ Lucas, R. et al. (1995).

⁴ Vega, L.S. (1996).

* Estimated from indirect data provided by the author.

N/A: Data not available.

- Have an average age of around 40, the most numerous group being aged 31 to 45.
- Have a low educational level, equivalent to the primary level that is obligatory in Spain.
- Live alone, in the vast majority of cases.
- Have undergone experiences of institutionalisation in prison and/or psychiatric hospitals (a significant proportion as high as 30% if data are combined).
- Have a high level of unemployment
- Having reached a situation of homelessness, tend to remain in that situation for many years, or even for the rest of their life. 80% of the current homeless population have been so for more than a year, and between 30 and 40% for more than five years.

In Table 3 it can be seen how changes from 1975 to 1995 in some sociodemographic variables only reflect significant alterations in the category of divorces (divorce was not legal in Spain until 1981). As mentioned earlier, the expected modifications in this profile (e.g., more women and more young people), though stressed by

social observers, are not reflected in empirical studies, though this may be due to their lack of reliability.

All of the above indicates the need to carry out studies that estimate and define the sociodemographics of HPs in Spain, that are guided by the new European definitions of HP, and that use the most up-to-date sampling methods developed for this type of population (Burt, 1992; Marpsat and Firdion, 1996). In this line, as part of the National Plan I+D, the present authors are carrying out a study on psychosocial factors related to the situation of the homeless. This study includes a sampling system stratified by services, random and weighted as a function of the probability of being selected in the sample and of frequency of use of services; it also includes a control group of persons that use HP services but have their own home. There is a 12-month follow-up study for each group.

4. CAUSES OF THE HOMELESS SITUATION

The situation of the homeless is obviously the result of complex interactive factors (Morse, 1992). Although it is clear that large-scale socioeconomic factors (housing policy, unemployment, social welfare policy, immigration, etc.) are important bases of the problem, they are *not* the only causes. As Rossi (1989) states, although general structural factors may help to explain how many people are at any one time without a home, "...personal characteristics may explain who might find themselves in such a situation" (p.144). Thus, it is fundamental to gain better knowledge of the factors of *personal vulnerability* (life events, support networks, critical situations, illness, etc.) that may make some individuals more susceptible than others. This double causal perspective (*macroeconomic* and *psychosocial*) is essential for analysing the different factors that, in each country, may produce a situation of homelessness. For example, poverty is important but not determinant. As Rossi (1989) once again points out, extremely poor people appear to have a similar level of economic resources as the homeless, but, obviously, only a small proportion of the really poor become homeless². According to Spanish data on poverty approximately 6.5 per 1,000 in extreme poverty become homeless.

In previous works (Muñoz, Vázquez and Cruzado, 1995; Muñoz, Vázquez, Bermejo and Vázquez, in press) we have studied the factors that cause and maintain the homeless situation. We have categorised life events following the classification by Daly (1994), who, in a report summarising the situation of homeless persons in Europe, considered the commonest causes of homelessness to fall into four groups:

TABLE 3
Changes in some demographic characteristics in the last 20 years

	1975 ¹	1984 ²	1991 ³	1995 ⁴
Age				
18-39	48	40	56	43
40-59	43	42	36	42
>60	9	17	7	8
Mean (SD)	41.9	40	39.2	40
Years of education (Mean)	N.A.	N.A.	8	8
Marital status				
Married	18	16	7	5
Widow/er	6	10	8	4
Separated or divorced	3	10	23	30
Never married	73	53	57	60
Total non-married	82	84	93	95

¹ Cáritas (1975).

² CEDIA Report (Spain).

³ Adicso-Incis Report (unpublished).

⁴ Averaged data from Muñoz *et al.* (1995); Rico *et al.* (1994); Lucas *et al.* (1995);

and Vega (1996).

N/A: Data not available.

¹ The study carried out in Aranjuez (Rico, Vega and Aranguren, 1994) uses as an inclusive criterion the use of services provided by a hostel; that of Barcelona (Lucas *et al.*, 1995) includes persons using hostels and those that sleep in the street; that of Gijón (Vega, 1996) uses data on persons selected at random from those using any HP service offered in the city; finally, that of Madrid (Muñoz, Vázquez and Cruzado, 1995) considers a random sample from the hostels, social services, canteens and streets of the city.

² This is an extremely relevant matter for Spain and possibly other Mediterranean countries, since levels of poverty and poor housing are relatively higher than those of other countries, but these levels do not correspond to proportional levels of literal homelessness (Avramov, 1995).

Material: grouping economic variables, essentially related to poverty.

Affective: including mainly variables related to loss of social support and breakdown of social networks.

Personal: this category includes physical and mental illness, addictions and loneliness.

Institutional: includes relations of homeless persons with any type of institution.

Summarising the main results, the first point to note from our data is that, as in other studies carried out in Spain (Vielva, 1992; Vega, 1996) and elsewhere (Wright and Weber, 1987; Banyard, 1993; Padgett, Struening, Andrews and Pittman, 1995; D'Ercole and Struening, 1990; Ingram, Corning and Schmidt, 1996; Fischer, 1992; Goodman, Dutton and Harris, 1995; Stein and Gelberg, 1995; Alexander, 1996), HPs have undergone an extraordinary number of stressful events in the course of their life –around 9 important ones on average. Such a great quantity of stressful events may not only affect physical and mental health, but also weaken social networks, and all of these are aspects closely related to the HP situation. Moreover, a high incidence of stressful situations may have an even more negative impact on HPs with mental disorders, such as schizophrenia (Lieberman, 1988; Calsyn and Morse, 1992).

On asking people to situate these events in time with regard to the first episode of homelessness, the majority of the events (a mean of eight) appear as having occurred **before** or **during** their transition to that episode (Muñoz *et al.*, 1995). This data seems to coincide with that of North and Smith (1992) on the timing of the appearance of Post-Traumatic Stress Disorder. Their study shows that three out of four persons suffering from this disorder begin to do so before their first situation of homelessness.

A number of results that merit special attention can be derived from the results of their work. First, the distribution of the events that is observed confirms the need to consider the HP phenomenon as a **multicausal** one. It is far from being the case that solely economic factors are responsible, from the subjective point of view, for the appearance and maintenance of this problem. From the perspective of those affected, in addition to economic factors (personal economic crises, unemployment) an influential role is played by personal factors, especially those related to serious mental disorders, drug and alcohol abuse and feelings of loneliness and neglect at key points in life. Equally important are affective factors related to difficulties in social relations, which lead to the appearance of interpersonal conflicts, matrimonial separations, and so on.

Secondly, HPs tend to situate the occurrence of stressful life events in the period **before** and in the **transition to** the first situation of homelessness, with far fewer of them being situated after becoming homeless. Thus, as far as stressful life events are concerned, our study suggests that they fulfil one of the main requirements for a variable to be considered as causal, the prior occurrence in time (Haynes, 1992).

Thirdly, HPs attribute high causal value to the majority of events included in the study, especially those related to economic problems, the break-up of affective and social relationships and mental illness. Although these aspects, like those described previously, should be submitted to further research (through longitudinal studies with both subjective and objective measures that allow the comparison of data), this finding allows us to state that there is some degree of hierarchy (at least from the subjective perspective) in the causality of the HP situation.

5. HEALTH OF HOMELESS PERSONS

Studies on the state of health of HPs have constituted an important focus of research in recent years. In Spain the data are not as comprehensive as they could be, but it is nevertheless this aspect on which there is more information than any other related to the homeless. Below is a summary of the principal results relating to the physical and mental health of this sector of the population.

5.1 Physical health

Two studies, in two different cities, Madrid (Muñoz, Vázquez and Cruzado, 1995) and Gijón (Vega, 1996) have dealt with this problem directly. In the case of Madrid data was collected –following the scheme of the Washington DC NIDA Study (Thornberry, Ardini and

TABLE 4
Physical disorders in homeless persons in Spain (percentages)

Disorder	Madrid ¹ N=250	Gijón ² N=250
	Medical diagnoses reported	Medical diagnoses confirmed
Tuberculosis	1.6	2.9
AIDS	2.4	4.5
Respiratory	56.3	8.0
Circulatory	24.8	2.4
Locomotor	26.8	2.7
Digestive	27.2	7.2
Nervous system (non-mental)	14.2	2.7
Others	15.2	3.0

¹Muñoz, M, Vázquez, c. and Cruzado, J.A. (1995)

²Vega, L.S. (1996)

Dennis, 1991)– by means of *self-report* on medical diagnoses the subject had received. The Gijón study also used self-report, but subjects were asked to provide some documentary proof of the reported diagnoses (medical reports, prescriptions, etc.). The main results are presented in Table 4.

As it can be seen, there are marked discrepancies between the results for the majority of disorders, quite possibly due to the differential data-collection strategies. In any case, some significant and alarming facts should be highlighted. First, in the Madrid study practically the entire sample presents some kind of health disorder, whilst in the case of Gijón the indices are lower (though it should be remembered that in this study the interviewees had to provide empirical data demonstrating the diagnoses). In both studies the indices of AIDS and tuberculosis are very high, both compared to the normal Spanish population and the homeless population in other countries (Vázquez, Muñoz and Sanz, 1997).

5.2 Mental health

Table 5 shows the main results obtained by studies carried out in different cities. It should be pointed out that the sampling locations and procedures are different, as are the diagnostic instruments used. This fact may explain some of the discrepancies reflected in the table. When the same instruments are employed and the samples are representative (Muñoz et al., 1995, 1996; Vega, 1996), the results become much closer.

As it can be observed, there are high indices of schi-

zophrenia (between 4.2 and 28.3%). The incidence of severe depression, when the CIDI (Composite Diagnostic International Interview) is used, is situated between 15 and 20%, which is high, but not alarming if we consider that we are talking about lifetime prevalence and people suffering from extreme poverty, homelessness and lack of social networks. Also high is the index of Cerebral Organic Syndrome, approximately between 1% and 6%, the difference possibly being due to the difficulty of diagnosis of this disorder. In general terms it can be seen that when the same instrument (CIDI) is used, the results tend to be similar.

Although these indices of lifetime prevalence are very high if we compare them with the non-homeless population, they are not as high as some observers had previously suggested –some had gone as far as to state that 90% of HPs were mentally ill, and that the majority had come out of psychiatric institutions. If we consider the fact that only around 18% of HPs had been previously admitted to psychiatric hospitals, the hypothesis of psychiatric disinstitutionalisation can be ruled out, or at least seriously called into question, as an important global cause of the homeless situation.

However, the most prominent finding is that referring to the prevalence of consumption (abuse and dependence) of alcohol and other drugs. According to the different studies, and taking into account the double diagnosis, disorders associated with the consumption of drugs of one type or another affect almost 50% of the homeless population (Muñoz, Koegel, Vázquez, Sanz & Burnam, in press).

TABLE 5
Lifetime prevalence of DSM-III disorders based on diagnostic interviews

Authors	City	Location	Instruments	N	Males %	Schizophrenia	Severe depression	Dysthymia	Current serious cognitive deterioration	Alcohol abuse or dependence	Drug abuse or dependence
Rico, Vega and Aranguren (1994)	Aranjuez	Hostel	Clinical interview	524	95	5	2	0.6	0.8	29	5
Lucas and cols. (1995)	Barcelona	Hostel Street	PERI and MOR	99	86	28*	N.A.	N.A.	N.A.	48	30
Muñoz, Vázquez and Cruzado (1995)	Madrid	Hostels Canteens Social Services Street	CIDI	262	79	4	20	17	6	44	13
Vega (1996)	Gijón	Information centres for the homeless	CIDI	170	91	12	15*	N.A.	2	24	20

Notes: * Any psychotic disorder
 † Any affective disorder
 CIDI Composite International Diagnostic Interview (Spanish version 1.1)
 N/A: Data not available

It is clear that there are important discrepancies between the studies (Muñoz, Vázquez, Koegel, Sanz & Burnam, in press); at present it is not so clear whether these discrepancies are attributable exclusively to the research design or to different patterns of homelessness. Once again it is necessary to carry out rigorous research on all aspects of the phenomenon.

6. SOCIAL RESPONSE

6.1. Social welfare factors

Although Spain's figures of relative poverty and, above all, unemployment, are high, indicators of social exclusion, including the homeless, do not suggest a high incidence³. Studies from different autonomous regions of Spain suggest that the percentage of socially excluded is around 4% of families and 3% of people in the country as a whole (Laparra, Gaviria and Aguilar, 1994). It would therefore appear that Spanish society, by comparison with Europe in general, is relatively well integrated. There are a series of differential factors that may help to explain why poverty in Spain is not reflected in high indices of marginalisation and, in particular, of homelessness.

Family structure. The first cohesive factor is the family. For example, two out of three unemployed persons live in families in which another person is working, the highest proportion in the EU (Laparra, Gaviria and Aguilar, 1994). Another integrating aspect is that very few people –by comparison with the rest of Europe– live alone. According to official data (1991), in Spain as a whole, only 10% of homes are single-occupant (and in only 3.6% of single-occupant homes is there an adult under 65). These figures are much lower than those of the rest of OECD countries. For example, France has approximately 25% of single-occupant homes, Sweden 33%, Canada 20%, Ireland and Italy 18%, and the USA 23% (Roussel, 1986; de Miguel, 1993)⁴.

Family contact level is very high⁵, which undoubtedly constitutes an important coping resource. Moreover, the Spanish family tradition favours children staying at

home, with their parents, until an advanced age –a phenomenon that is even growing due to the economic crisis: according to official data from 1991 88% of Spaniards under 20 still live with one or both parents (Valenzuela, 1995). This clearly represents an important element of natural social protection against potential homelessness.

Social welfare expenditure. There has been a great increase in welfare expenditure in Spain over the last decade⁶. According to 1991 data, EU social expenditure accounted for 26% of GDP⁷, whilst in Spain it accounted for 22%. Nevertheless, welfare expenditure in Spain differs markedly from that of the EU in two aspects: *retirement* and *unemployment* benefits. While expenditure on pensions is lower in Spain (6.5% of GDP) than in the EU as a whole (9.3% of GDP)⁸, unemployment spending (3.9% of GDP) is, in relative terms, more than double the EU mean (1.7%). This is a factor that undoubtedly *cushions* the effects of Spain's alarming unemployment figures (Eurostat, 1992). Unfortunately, however, the coverage of unemployment benefits is not universal⁹. Although great efforts were made to go from 34.1% coverage in 1989 to 67% in 1993 (a figure similar to the European mean), the fact is that currently, 1 out of 3 unemployed persons receives *no type of economic benefit* whatsoever.

Another important aspect of the social welfare system is constituted by *non-contributory pensions* –that is, pensions for strongly disadvantaged groups which, having failed to subscribe to the social security system in the past, would not be entitled to any benefit. This system was introduced in Spain in 1990. Although it currently accounts for only 3% of pensions, it is nevertheless a factor that also contributes to offsetting social marginalisation.

Health services. Health service coverage is another important element of social cohesion in most European countries. In Spain, the health system has been universal since 1989. That is, *all* citizens, without exception (including persons without any economic resources), are entitled to use the services of the National Health System¹⁰, unless they voluntarily decide to subscribe to a private health scheme¹¹. This universalisation of health services is also a very important element in reducing or attenuating the effects of exclusion in marginal and very low income groups.

Housing. Housing, education and employment are the most important factors of social integration/exclusion (Gaviria, Laparra, and Aguilar, 1995). One of the peculiarities of Spain is that it is the European country with

³ The European conception of social exclusion refers to those individuals that, for any reason, *do not have access* to the social welfare system (salaried employment, unemployment benefits, pensions, housing, etc.).

⁴ Whilst in Paris and New York the percentage of single-occupant homes is 35%, in Madrid it is 16%. Similarly, the index of persons that are homeless, living in the street or in hostels, per 1000 inhabitants, is 20-30 in Paris, 100-120 in New York and only 6-8 in Madrid (US Census Bureau, 1992; INSEE, 1993).

the highest rate of property *ownership*¹². Rented housing accounts for only 20% of the total, while in the EU as a whole it represents 40-60%. This very high proportion of owned property may constitute an important differentiating factor of the Spanish situation with regard to other countries, since the ownership of type of residence is a very important “anchoring” factor that cushions the effects of poverty and precarious economic situations. Nevertheless, over the last 15 years the situation has markedly worsened. On the one hand, the construction of new housing has decreased significantly, especially that of subsidised low-price dwellings¹³; on the other, the price of buying/renting a house has increased greatly¹⁴, which may constitute a serious factor in a future increa-

⁵ Two out of three Spaniards have contact with members of their family with whom they do not live at least once a week (specifically, 30% have daily contact, and 34% weekly contact).

⁶ Social welfare expenditure includes economic benefits (e.g., contributory and non-contributory pensions), health services, social services and unemployment benefits. From 1985 to 1993 this expenditure doubled, and by 1994 was more than 2,000 million pesetas (12m Euros) (Economic and Social Council, 1994).

⁷ The extreme cases were Holland, with 32% and Portugal, with 19%.

⁸ Among EU countries only Portugal and Ireland spend less on pensions.

⁹ Mean duration of benefits was 12.4 months in 1992. This is the mean period available to the jobless person for finding work before assistance is withdrawn. On average, the unemployed person uses up some 8 months of the period corresponding to him/her, although, due to the serious crisis of 1991-93, this figure has grown (Economic and Social Council, 1994).

¹⁰ In many cases central government has transferred responsibility for the management of resources to the Regional Authorities

¹¹ Only 7% of the population (Economic and Social Council, 1994) voluntarily subscribe to private health schemes.

¹² According to data from 1993, 76% of Spaniards live in dwellings they own, and this tendency even appears to be on the increase (Valenzuela, 1994, p. 1576).

¹³ In 1975 some 370,000 dwellings were built, whilst the 1994 figure was only 220,000. The construction of subsidised housing decreased even more: it went from 200,000 in 1975 to 50,000 in 1994 (El Mundo, 1996, p. 323).

¹⁴ In the period 1980-1990 the mean purchase price of housing rose by 234%, whilst by comparison with Europe the stock of rented housing is low; moreover, after 1985, due to a set of new liberalising laws, prices increased sharply. Moreover, the proportion of subsidised or protected rented properties is the lowest in Europe (only 8% of dwellings fall into this category); the countries with the largest proportions of subsidised rented housing are the United Kingdom (78%) and Holland (66%) (Netherlands Ministry of Housing, 1992). Only 20% of Spain's construction activity, as against a European mean of 32% (Salinas and León, 1995).

¹⁵ Rehousing accounts for only 20% of Spain's construction activity, as against a European mean of 32% (Salinas and León, 1995).

se in risks for the homeless, especially young persons, for whom access to housing is difficult (Salinas and León, 1995).

Although the population of literally homeless is comparatively low in Spain, there is a high proportion of poor-quality housing. As we showed in Table 1, studies with a common methodology, carried out by the FOES-SA Foundation, permit us to estimate that, apart from the 30,000 homeless people (living in hostels or sleeping in the street) –Salinas, 1995– there are approximately 250,000 poor people living in poor or sub-standard housing (shanty towns, caves, or dwellings without clean water or lighting), or in conditions of serious overcrowding (two or more families in the same dwelling) Salinas and León, 1995. This situation is exacerbated by the fact that *rehousing programmes* (either public or private) are relatively scarce in Spain¹⁵.

6.2. Services for the homeless

The social welfare system in Spain (i.e., Social Security, Health, Education, Unemployment, Housing, and Social Services) has made enormous advances in the last 15 years (Morena and Pérez, 1992; Rodríguez Cabrero, 1994), even with regard to traditionally excluded sectors (García and Ramirez, 1992). Current legislation obliges all municipalities with more than 20,000 inhabitants to have social services for HPs, a fact that has favoured the disposition of new resources in the last few years. All of this has contributed also to an improvement in attention to the homeless and the marginalised and in models of intervention.

Unfortunately, this legislation has not been more fully developed: only the large cities have introduced social services aimed specifically at the homeless population. Meanwhile, private initiatives continue to depend almost exclusively on religious organisations. The role of lay non-governmental organisations, though on the increase in recent years, is still a minor one.

Information on existing services is partial and fragmentary, as there are no comprehensive or reliable figures on attention to the homeless. Nevertheless, using the available information, Table 6 summarises the main types of service available in 1990 (Spanish Institute of Public Opinion Studies, 1990).

As it can be seen, there are 129 hostels with 5,224 places, which is clearly insufficient for a population that oscillates between 11,000 and 45,000. Moreover, there are only 386 places for occupational or employment rehabilitation. The categories with most services are those of Information Centres, canteens and clothing ser-

vices. The first of these three are normally provided by local councils, which offer this service as the only type of assistance to the homeless; the case of canteens and clothing services is different: they are usually run by parish and religious groups or lay NGOs. In fact, the number of these services quoted in the table may be a considerable underestimation, as they are found in many small parishes, etc., that are difficult for surveys to cover.

The lack of official figures on services or a unified network of resources makes it impossible to be much more specific at present as far as the country as a whole is concerned. In order to give a detailed account it is necessary to concentrate on the major cities, in which there exists an incipient network of HP services. In our case we take the city of Madrid as a reference.

As it can be seen in Table 7, Madrid has 10 hostels with around 1,100 places (2 public and 8 private/religious), which accommodate a total of 1,100 persons per day – a figure close to estimations of the city’s needs. There are two information centres that attend to 55 persons per day. Especially relevant is the *public information service*, which provides an emergency telephone (SITADE) and Social Emergency Mobile Units, in the form of cars that patrol the city and attend to all types of social (not health) emergency, including all cases of people sleeping in the street. Employment services continue to be quite scarce, and reach no more than 200 persons per day, a figure far below the estimated needs. There are two night centres, attending to around 120 persons per day, and where HPs can go and spend the night, receive medical or psychological help, have a hot drink or simply stay there even if there are no beds available (since it is not a hostel). Night centres are especially useful for drug-dependent HPs. Equally scarce are centres

with an authentic case-management approach, though worthy of note in this context is the publicly-funded *Realidades* centre, which attends to some 100 people in a comprehensive way, helping them to find housing, work, organise pensions, and so on.

As in the rest of the country, clothing services and canteens are widely found, with small-scale services of this type all over the city (parishes, union centres, etc.), though no complete figures exist (the table includes the most important ones, reflecting only partially the reality of the situation).

As far as specific services for the homeless population are concerned, it should first be borne in mind that all health and social services are available to *the entire Spanish population*, without exclusion. Nevertheless, as we have seen, there do exist specific services for HPs. These can be summarised using as a reference those included in the hostels, which function as centralising nuclei of resources.

As Table 8 shows, all hostels include at least accommodation, canteens and washrooms, while 84% also include legal and/or social advice services. A majority (68%) include psychological help and/or psychosocial rehabilitation programmes for the chronically mentally ill. Roughly half of the hostels offer medical services (always with first aid and facilities for transfer to the state system) and clothes. An important aspect is that 32% of the hostels have access to protected flats, which

SERVICES	Number of centres	Places available	Persons/day
Hostels	129	5.224	N.A.
Work and/or occupational	50	386	630
Information	209	N.A.	N.A.
Canteens	135	N.A.	8.000
Clothing services	96	--	1.524
TOTAL	619	5.610	--

N/A: Data not available.

SERVICES	Public		Private	
	Number	Persons/day	Number	Persons/day
Hostels	2	350	8	750
Information services	1	15	1	40
Occupational centres	1	38	3	150
Night centres	--	--	2	120
Washrooms	3	300	--	--
Clothing services	--	--	14 ¹	140
Canteens	--	--	20 ¹	2.000
Individual assistance centres	1	100	--	--
TOTAL	7	803	48	3.200

¹ Estimation. Many churches offer sporadic services of this kind.

serve as initial rehousing facilities. Finally, only in one are resources available for the education of children staying in the hostel.

As it can be deduced from the data presented, the attention given and the services and programmes offered to homeless persons are far from ideal, and by no means sufficiently flexible and individualised to be able to offer personalised support and services for the rehabilitation and social reintegration of this population.

7. EFFECTIVENESS OF THE SERVICES

Considerable efforts have been made in recent years by various organisations to tackle the problem of homelessness, with the result that useful programmes have been undertaken (Cáritas, Rauxa, Realidades, Albergue de San Juan de Dios, etc.). Among the most noteworthy, not least because of its complexity, is that coordinated by the Madrid Municipal and Regional Authorities for the social integration of the chronically mentally ill homeless. However, there is still no specific assessment scheme for the effectiveness of this type of service for HPs, though a detailed observation of them should enable us to draw some conclusions:

1. There is an *uneven distribution* of resources across cities or regions, which in some cases leads to homeless persons moving from one city to another, with the negative effects that such a situation generates.
2. The existing services do not function in a coordinated and complementary way, which is a basic condition for comprehensive intervention. Despite the efforts of some cities (e.g., Madrid or Barcelona) to develop a coordinated and integrated network of services, there is still a long road ahead. One of the main determining factors of this situation of fragmentation and lack of coordination, is the absence of appropriate integrated plans for the prevention of homelessness and attention to and social reintegration of HPs.

TABLE 8
Types of services offered in hostels in Madrid

SERVICES	Percentages
Lodging	100%
Food	100%
Washroom and health services	100%
Legal or social assistance	84%
Psychological assistance	68%
Psychosocial rehabilitation	68%
Medical assistance	50%
Clothing services	50%
Subsidised flats	32%
Schools/kindergartens	16%

3. In spite of the advances made with regard to the public system of social services, the weight of responsibility for attention and services for the homeless continues to fall on the mainly *religious social initiatives* that in the majority of cases operate with scarce resources and support. It is therefore necessary to move toward greater interrelation and coordination between the official and unofficial sectors, between public and private social initiatives, which implies better funding and a better distribution of responsibilities.
4. There have undoubtedly been advances in the last 20 years in terms of attention to this community, with the repressive and/or charity-based model being replaced by more dignified forms of attention and attempts at rehabilitation and social reintegration (Rodríguez Diaz, 1987). However, the general model continues to be centred on *assistance*: the majority of resources are devoted to covering basic needs (accommodation, food and clothing). In fact, as we explained, most of the existing resources are constituted by hostels and attention centres, canteens and clothing services. Although ever greater efforts are being made by hostels and attention centres to offer psychosocial services and rehabilitation programmes, an additional impulse in this direction is required in order to be able to respond to the causal multidimensionality of the problem (Renes, 1994; Gaviria et al., 1995). Furthermore, in many cases services for homeless persons become converted into a last resort, a catch-all that serves to deal with everything the other social services have passed over due to their rigidity or inadequacy. Thus, these services become *overloaded* with problems that have gone unattended by others. For example, the inadequacy and unsuitability of community social attention to the elderly, handicapped, mentally ill, etc., is forcing many hostels and attention centres to take in these populations because the resources and care provided by the community are insufficient.
5. It is imperative to make advances in the introduction of a wider range of *services and programmes*: day centres, psychosocial rehabilitation programmes, community housing resources (supervised flats, residences, small-scale residences, help with access to and maintenance of housing, etc.), employment advice and rehabilitation programmes, job creation schemes, follow-up and social support teams, and so on. Such measures, taken together, would help

the homeless to make progress in terms of their own individual rehabilitation and social reintegration itineraries.

6. *Prevention* should be the next great priority, both as regards primary and secondary prevention and early intervention. There are insufficient social policies measures in the areas of housing, social services, health services, etc. that allow the detection of people in situations of personal and social precariousness, and therefore *at risk* of falling into processes of marginalisation and homelessness (Castel, 1992). Unfortunately, once people begin to be affected by such problems, there are scarcely any agile and flexible responses that permit the provision of appropriate early intervention to avoid their marginal situation becoming consolidated and chronic. This is a vital necessity since, as we pointed out with regard to stressful life events, homeless persons, before and during the process of becoming homeless, are subject to a great number of such events.
7. It is of fundamental importance to develop *integrated plans* based on collaboration between public and private organisations, on comprehensive action from all types of social welfare services and on a consideration of all action levels: prevention, attention, rehabilitation and social reintegration. Intervention should be global, coordinated and comprehensive, going beyond the mere covering of basic needs, to promote active processes of personal and social rehabilitation and offer effective opportunities for participation and integration in the community.

Both community social services and specific services for the homeless (hostels and attention centres) recognise that intervention, in general, occurs when the problem is already established and attention is provided in response to the user's *demand*. Up to now the predominant approach has been one of *assistance*, with an attentional style based on waiting, which is insufficient and poorly adjusted to the specificity and nature of the problems of the homeless. Many HPs neither use services regularly, nor find the norms and logic of the way they work to be suitable for their needs. It is necessary to promote orientation and intervention styles that are *active* and flexible, with a searching approach; services that, rather than waiting for the homeless to come to them, become involved in their needs, in the identification of persons with difficulties, in community support that favours the participation and involvement of those affected in both the proper use of available services and the development of

their individual itineraries of social reintegration. Despite the existence of isolated initiatives in this direction (e.g., Madrid council's Social Emergency Mobile Units), it is necessary to make further progress in the consolidation of this more community-based model of intervention with a more active, dynamic style, more focused on prevention and on the promotion of and flexible support for rehabilitation and social reintegration. If such approaches are not adopted, it will become ever more difficult to offer adequate attention to the homeless, and more of them will remain excluded even from the services designed to help them.

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