FACTORS ASSOCIATED WITH EFFECTIVE HELP-SEEKING
BEHAVIOR AMONG HOMELESS PERSONS: A CROSS-SECTIONAL
STUDY OF SAN DIEGO’S STREET HOMELESS POPULATION

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by

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Factors Associated with Effective Help-Seeking Behavior Among Homeless Persons: A Cross-Sectional Study of San Diego’s Street Homeless Population

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DEDICATION

This thesis is dedicated to Grandad and to my amazing parents, Amanda and John. Thank you for selflessly offering more love, support, guidance, and patience than any one person could possibly deserve. I am so lucky!
ABSTRACT OF THE THESIS

Factors Associated with Effective Help-Seeking Behavior Among Homeless Persons: A Cross-Sectional Study of San Diego’s Street Homeless Population

by

Elizabeth B. May
Master of Science in Public Health
San Diego State University, 2011

The purpose of this study is to identify individual-level factors that are significantly associated with effective help-seeking behavior among San Diego’s street homeless population. Some persons living on the street are able to easily identify what they need and the services that might help them the most, i.e. their description of their problems/challenges matches well with the services they seek. On the other hand, some homeless persons have much more difficulty matching their problems with possible solutions. These individuals need interventions that are tailored to their understanding of themselves and their unique situations. While the issue of barriers to service access has received attention in recent years, gaps persist in the existing body of research into service utilization and help-seeking behaviors of homeless individuals. Using data from the 2009 San Diego RTFH Street Characteristics Survey, this research study aims to address this gap by identifying variables that are significantly associated with effective help-seeking behavior.

The Street Characteristic Survey was designed to capture both quantitative and qualitative data from participating homeless individuals. Questions focused instead on basic demographics, military service, living situation, marital status, reasons for living in San Diego, length and description of homelessness, employment, income sources, education, health status, drug use, self-rating of health status, HIV status, service usage, perceived reasons for being homeless, services needs, service usage and if they have been a victim of violence.

Between January 13, 2009 and February 26, 2009, trained volunteers collected 305 interviews from ‘street’ homeless persons encountered at seventeen locations located across San Diego County. In total, 302 completed surveys met all eligibility requirements for inclusion in analysis. Three surveys were excluded because the individual was not sleeping on the street the night before. An additional seventeen surveys were excluded from analysis because they were missing data necessary for analysis. A sample size of 287 surveys was included in the analysis.

The outcome of interest was a composite variable created to measure the degree of concordance survey participants exhibited between their normative service needs and their perceived service needs. The relationships between five demographic factors and the concordance outcome variable were assessed for significance. The following factors were included in the analysis: history of service accessing, chronic homelessness, gender, race category, and veteran status.
SPSS 17.0 and SAS 9.1 statistical software were used to carry out the analytic steps. After constructing the composite Concordance outcome variable, univariate and bi variate analyses were conducted. Two logit models were fitted through stepwise regression model building: one for the probability of low versus fair/high concordance between normative and perceived needs, and another for the probability of low/fair concordance versus high concordance.

The results of the ordinal logistic regression revealed that only history of service use and chronic homelessness were significantly associated (at the 5% level) with the level of concordance participants’ exhibited between normative and perceived needs. Those participants with some history of service use had 4.566 (95% CI 2.551-8.130) greater odds than those with no history of use of exhibiting high versus poor or fair concordance in their needs assessments. Chronically homeless participants had 3.496 (95% CI 2.057-5.952) greater odds than those who were not chronically homeless of exhibiting high versus poor or fair concordance in their needs assessments.

This study adds to a very small body of research on the extent to which homeless individuals display concordance between the services they seek and those they need. The findings suggest that, in general, this population does not effectively use available resources to address their needs. At its core, the ability to meet basic needs reflects how well suited a person is to deal with the challenges of daily life. It is the task of public health professionals to equip vulnerable members of society with the skills and support needed to lead healthy and productive lives. By better understanding the individual-level factors that distinguish a person who can meet his needs from one who cannot, researchers increase the capacity of the service system to intervene and alleviate problems before they escalate into homelessness.
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CHAPTER 1

INTRODUCTION

In a public address in March 2009, Barack Obama asserted “it is not acceptable for children and families to be without a roof over their heads in a country as wealthy as ours” (Moriarity, 2009). With this announcement, the President made ending homelessness in America a national priority. Despite such calls to action, the ranks of Americans who are homeless or precariously housed have swelled over the past three decades. In 2007, the U.S. Department of Housing and Urban Development’s Annual Homeless Assessment Report (AHAR) estimated that, on any given night, approximately 672,000 homeless individuals across the nation sleep in places not meant for human habitation. Even as homeless advocacy organizations heralded a 10 percent decline from the 2005 figure of 744,313 persons, predictions materialized of an upsurge in homelessness in the wake of the recent economic crisis (U.S. Department of Housing and Urban Development, 2007). The Center on Budget and Policy Priorities recently predicted that the fiscal year 2009 would end with the number of poor Americans climbing by 10.9 million. As part of the economic recovery act signed into law in February, Congress approved $1.5 billion in temporary housing assistance to be distributed to local agencies through the Homeless Prevention and Rapid Re-Housing Program (HPRP). Even with these additional resources for families that are homeless or at risk of losing their homes, data emerging from the 2009 annual homelessness count indicates increases in homelessness in over half of the regions tabulated (Sard, 2009).

AMERICA’S HOMELESS: DEMOGRAPHIC OVERVIEW

A definitive source of information on America’s current homeless population is HUD’s 2007 AHAR, prepared for the US Congress. The 2007 AHAR is based on two data sources. The first source is data provided by all Continuums of Care (CoCs) as part of their 2007 HUD application for funding. The CoC application data contain information on sheltered and unsheltered homeless persons on a single night in January 2007. The second source is data from Homeless Management Information Systems (HMIS), computerized,
web-based data collection systems that tracks the nature and scope of human service needs at individual agencies as well as across regions. The data describe the number, characteristics, and patterns of shelter use among sheltered homeless persons—or persons who used emergency and transitional housing. The 2007 AHAR uses HMIS data covering a 12-month reporting period (October 1, 2006, through September 30, 2007; U.S. Department of Housing and Urban Development, 2007).

Although stereotypes of the homeless persist, the picture that has emerged from research over the past 20 years is of an increasingly diverse population. Just as there is no one cause of, or cure for, homelessness, a single description does not capture the range of homeless Americans. Most studies show that single homeless adults are more likely to be male than female. Single adults comprise 76% of the total homeless population, and 67.5% of that single population is male (U.S. Conference of Mayors, 2007). Families with children are among the fastest growing segments of the homeless population. The U.S. Conference of Mayors, in its 2007 survey of 23 American cities, found that families with children comprised nearly a quarter of the homeless population. This same survey found that only 35% of the heads of these homeless families are male, the other 65% are single females and children. Homeless individuals are much less likely than all poor individuals to be elderly. There is, however, growing evidence that as the Baby Boomer generation ages an unprecedented proportion of homeless persons will be over the age of 50.

The U.S. Conference of Mayors estimated that 42% of the homeless population is African-American, 38% is White, 20% Hispanic, 4% Native American and 2% Asian. (U.S. Conference of Mayors, 2007). Though ethnic distribution varies geographically, minorities are overrepresented among the homeless population. In 1996, minorities represented 25% of the US general population and 59% of the homeless population. African Americans are disproportionately represented among the urban homeless population, whereas a larger proportion of the rural homeless are white; the vast majority of homeless Native Americans and migrant workers live in rural areas.

The 2007 AHAR suggests that urban areas typically contain a large share of a state’s total homeless population. The Los Angeles City and County Continuum of Care (CoC) accounts for 43% of California’s total homeless population; 80% of New York’s homeless
population is located in the New York City CoC, and the vast majority of Michigan’s homeless persons (63%) are found in the Detroit CoC.

It is estimated that nationally over 25% of homeless individuals suffer from mental illnesses such as chronic depression, bipolar disorder, schizophrenia, schizoaffective and severe personality disorders. In comparison, studies show that approximately 4% of the U.S. population suffers from serious mental illness. Therefore, the incidence of serious mental illness among the homeless was over five times that of the general population (U.S. Department of Housing and Urban Development, 2007). The prevalence of lifetime alcohol and substance abuse disorders is over 50% among homeless populations, making the burden of dual diagnosis significant. This is in contrast to an estimate that 9% of the wider U.S. population is classified as having a substance abuse disorder (U.S. Conference of Mayors, 2007).

As compared to eight percent of the general adult population, about one-third of the adult homeless population has served their country in the Armed Services (Rosenheck & Fontana, 1994). Approximately 23% of the overall homeless population, and 33% of homeless males, are veterans. The 2007 US Conference of Mayors survey estimated that, on any given night, 271,000 veterans are homeless (U.S. Conference of Mayors, 2007). Despite having a far more extensive support system than exists for non-veterans, studies indicate that veterans of the conflicts in Iraq and Afghanistan may be descending into homeless more rapidly than their Vietnam-era counterparts (Perl, 2007).

Around 150,000 to 200,000 homeless persons meet the HUD definition for chronic homelessness: an unaccompanied homeless individual with a disabling condition who has been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years (U.S. Department of Housing and Urban Development, 2007). These individuals, who often cycle between the street and hospitals, jails, or other service institutions, typically suffer from a complex medical problem, serious mental illness, and/or alcohol or drug addiction. Although chronic homelessness represents a small share of the overall homeless population (10% of all single adult homeless persons), chronically homeless people consume a disproportionately large percentage of available resources (National Alliance to End Homelessness, 2010).
SHELTERED VERSUS UNSHELTERED HOMELESS

Over the course of 2007, around 1,589,000 persons, or 60% of the total homeless population, used an emergency shelter and/or transitional housing at some point. This number translates to about 1 in every 200 persons in the U.S. utilizing a homeless residential facility at some point in 2007. The great majority of these individuals spent less than one month in a shelter (70% of men and 69% of women). The remaining 40% of homeless persons were sleeping on the streets or in other places not meant for human habitation. Shelter status has been found to vary by household type. About 72% of homeless persons in families were sheltered, and 28% were unsheltered. Sheltered homelessness is largely an urban phenomenon. (U.S. Conference of Mayors, 2007)

SAN DIEGO COUNTY

On January 31, 2008, the San Diego Regional Taskforce on the Homeless coordinated the annual Point-in-Time Count (PITC) of the County’s homeless population. In one night a regional total 7,582 homeless persons was tallied: 3,856 unsheltered persons, 3,726 in emergency shelters and transitional housing (San Diego Regional Taskforce on the Homeless, 2009). Of this total, 42% were counted in the streets of the City of San Diego, 13% in Encinitas, and 12% in Escondido. The combined areas of Solana Beach, San Marcos, Carlsbad, Del Mar, Poway, and outlying areas of the City of San Diego contributed only 195 homeless persons to the total. The number of homeless increased by nearly nine percent between 2006 and 2008, and the proportion living on the street increased from 44% to almost 51%.

Although the County’s general population is divided evenly between males and females, two out of three homeless persons were males. Nearly 80% of the unsheltered population and 64% of the sheltered population is male. The most common age was 40-49 years (39%), followed by 50-59 years old (22%), 30-39 years old (14%). The proportion of elderly homeless was comparatively small (7% reported being 60-69 years old). According to the agency census, children and teens made up about 40% of those in transitional housing. During the time of the PITC, there were 523 homeless families, a total of 1,282 persons, in the San Diego county region. Single mothers head 89% of the homeless families in the county.
Two racial groups are found in disproportionate numbers among San Diego’s homeless. African-Americans make up 5% of the local population, but 18% of the homeless population. Whites comprise 52% of the general population and nearly 60% of the homeless population. The proportion of homeless Hispanic/Latino, Asian, Native American and other races is lower than the percentages of people in these racial/ethnic groups in the County population as a whole.

Nearly 20% of San Diego’s adult homeless served in the armed services, including nearly one-third of all emergency shelter residents. When compared to the proportion of veterans among domiciled Americans (9%), this figure indicates that past military service poses a particularly high risk of homelessness.

The 2008 PITC shelter survey reveals that 24% of homeless adults in San Diego County reported mental illness as a disability. This is lower than the reported rate of mental illness among the homeless nationally (over 25%). In addition, survey results showed that among those who report a disability, 30% reported drug abuse and 37% reported alcohol abuse.

Though official data from the 2009 PITC is still lacking, the San Diego Regional Taskforce on the Homeless estimates that San Diego County currently has more than 9,600 homeless people. About 1,400 people from this group are classified as chronically homeless. Although this seems to be a very small proportion, the chronically homeless tend to be the most visible and utilize available resources in disproportionately high numbers (National Alliance to End Homelessness, 2010).

**Homelessness: A Public Health Priority**

The link between homelessness and poor health is bidirectional: physical and mental illness are both predictors and outcomes of being homeless. Identified by public health researchers as a vulnerable population, homeless individuals exhibit high prevalence rates of mental illness, alcohol and drug addiction, HIV/AIDS infection, tuberculosis, liver and renal disease, skin infections, and other health issues. Overall, the homeless population experiences mortality and morbidity in excess of the poor, domiciled population. Studies have found a significant positive association between the risk of death and length of time spent homeless (Gelberg, Andersen, & Leake, 2000).
The cost of homelessness to society is great. Homeless persons are hospitalized with greater frequency and for longer periods of time than similarly aged housed individuals. A study in New York City found that homeless hospital patients’ average length of stay exceeded the general population by 36%. Additionally, about 75% of homeless hospitalizations are for preventable conditions (Salit, Kuhn, & Hartz, 1998). The same study found that each mentally ill homeless person utilized over $40,000 annually in publicly funded shelters, hospitals, emergency rooms, prisons, jails, and outpatient health care. Much of the cost was for psychiatric hospitalization, which accounted for an average of over 57 days and nearly $13,000. Over 50% of the nation’s homeless population does not have health insurance. Undetected and untreated communicable diseases threaten the health of other homeless people, and, of particular importance to the field of public health, the American public in general. These infectious and communicable diseases have the capacity to escalate into costly and deadly public health emergencies (Lim, Andersen, & Leake, 2002). The costs, both economic and social, that result from neglecting the needs of this dispossessed and often seriously ill population continue to mount.

**STATEMENT OF THE PROBLEM**

Over 13.5 million Americans will experience "literal homelessness" at least once in their lifetime (U.S. Conference of Mayors, 2007). This persistent social problem results from systemic issues of unemployment, low wages, expensive housing, lack of health insurance and racial discrimination, as well as individual-level issues such as domestic violence, abuse of alcohol and other drugs, and serious mental and physical illnesses. Without transportation or the basic necessities of daily life, homeless individuals depend on a fragmented network of shelters, soup kitchens, and marginal jobs to meet their survival needs. Unacceptable costs result from poor access to health care.

Within the field of homelessness research, studies abound on the barriers to accessing services (Robertson & Cousineau, 1986). Additionally, numerous studies have been published describing barriers for specific subpopulations: the mentally ill, women, and veterans. Numerous recent efforts have tried to address the issue of access to services among the chronically homeless (Lim et al., 2002; Tessler & Rosenheck, 2002). Little research seems to exist, however, on persons who have not necessarily sought services, or on the
ability of these vulnerable persons to determine which of the available services are best suited to their specific needs.

The homeless population in many US cities is diverse, including both individuals and families. Those with mental illness, substance abuse, and long-term chronic health conditions co-exist on the streets with the newly and economically homeless, or victims of domestic violence. In order to serve the homeless population effectively, it is important to understand not only barriers to needed service, but also how accurately these individuals perceive their own needs, and, in doing so, identify the services most suited to their unique situation.

**PURPOSE OF THE STUDY**

The purpose of the proposed study is to identify individual-level factors that are significantly associated with effective help-seeking behavior among San Diego’s street homeless population. Homelessness has become a public health issue of increasing prevalence and societal concern over the past three decades. The individual and community-level consequences of homelessness are significant. Some persons living on the street are able to easily identify what they need and the services that might help them the most, i.e. their description of their problems/challenges matches well with the services they seek. On the other hand, some homeless persons have much more difficulty matching their problems with possible solutions. These individuals need interventions that are tailored to their understanding of themselves and their unique situations. While the issue of barriers to service access has received attention in recent years, gaps persist in the existing body of research into service utilization and help-seeking behaviors of homeless individuals. Using data from the 2009 San Diego RTFH Street Characteristics Survey, this research study aims to address this gap by identifying variables that are significantly associated with effective help-seeking behavior.

**RESEARCH QUESTIONS & HYPOTHESES**

The primary hypothesis of this study is that key individual-level variables predispose or enable a person to effectively assess their unique service needs, i.e. to demonstrate concordance between the problems they are experiencing, and the help they seek.

Question: What individual-level characteristics of homeless individuals are significantly associated with effective help-seeking behavior?
Hypothesis: It is hypothesized that male homeless individuals of color, living alone on the street, experiencing chronic homelessness, with no history of service accessing, or a history of military service may be less likely or able to correctly identify and seek out the services that best meet their needs.

Hypothesis: Conversely, it is hypothesized that individuals experiencing homelessness for the first time, particularly white females living a partner or children, with no history of military service will be better able to match their described problems with the service that will have the most impact for them. Furthermore, homeless persons with some history of service accessing will exhibit more effective service seeking behavior.

THEORETICAL BASIS: GELBERG-ANDERSEN BEHAVIORAL MODEL FOR VULNERABLE POPULATIONS

The Anderson Behavioral Model has been used in many previous studies of service accessing behavior (Andersen, 1995). The Behavioral Model was developed in the late 1960s in an attempt to explain why people use health services. More recently, researchers have relied heavily on this model for guidance when investigating the use of social services. The model suggests that use is determined by a matrix of predisposing, enabling, and need-specific factors, some internal and others external to the individual.

According to the social behavior model, certain individuals are more inclined than others to use services because of personal characteristics unrelated to need. These predisposing characteristics include demographic variables such as age and gender. Social structure characteristics such as marital status, education, occupation, ethnicity, and social networks are also included, as they are thought to determine social status within a community, coping abilities, and the resources available to the person. General beliefs or attitudes about support services might also affect service use. Enabling characteristics include income level, insurance coverage, access to transportation, and awareness of service.

BEHAVIORAL MODEL FOR VULNERABLE POPULATIONS

In 2000, homelessness researcher Lilian Gelberg introduced a modified Behavioral Model for Vulnerable Populations. Gelberg incorporated into the traditional model variables relevant to understanding the health and health-seeking behavior of vulnerable populations. Vulnerable populations include minorities, undocumented immigrants, children and
adolescents, ill and disabled persons, the elderly, and impoverished or homeless persons (Gelberg et al., 2000).

The Behavioral Model for Vulnerable Populations can be divided into two domains: traditional and vulnerable. Vulnerable domains focus on social structure and enabling resources such as residency status, abuse history, living conditions, mental illness, and substance abuse. Enabling vulnerable domain variables include personal/family resources, competing needs, and availability of information. The revised need domain introduces conditions that affect vulnerable populations: tuberculosis, sexually transmitted diseases, premature and low-birthweight infants, and acquired immunodeficiency syndrome (AIDS).

Studies examining the efficacy of both the traditional Behavioral Model and Gelberg’s revised model provide underpinnings for the proposed research. Researchers using Anderson’s model have found that the predisposing characteristics of being older, female, unmarried, and more highly educated, as well as the enabling characteristic of income, are associated with increased likelihood of service use. Although awareness of services is also strongly related to service use, even when respondents were aware of community programs, their use of programs continued to be low. Overall, perceived need was most often the best predictor of service use (Mitchell & Krout, 1998).

The significance of Gelberg’s additional vulnerable categories was tested using the UCLA Homeless Health Study subset of the 1990 RAND Course of Homelessness Study. Based on surveys of 1,548 homeless adults from the Skid Row and Westside areas of Los Angeles, researchers determined that residential history, mental health, substance abuse, victimization history, and competing needs do significantly affect the use of health services (Gelberg et al., 2000).

These findings indicate that identifying factors significantly associated with effective service seeking behavior is a meaningful precursor to designing and implementing service programs. This study attempts to determine how certain individual-level predisposing variables (namely, chronic homelessness, a history of service accessing, gender, race, and veteran status) may influence perceived service needs and, in turn, shape a homeless person’s service-seeking behavior.
RESEARCH METHODS

Beginning in January 2006, San Diego’s Regional Taskforce on the Homeless (RTFH) spearheaded the effort to enumerate San Diego’s unsheltered homeless population through annual Point-in-Time Counts (PITC). As part of this counting process, RTFH trains volunteers to conduct in-depth interviews with a sample of homeless individuals who live on the street. In 2009 the RTFH contracted with the Institute for Public Health (IPH) to aid with survey design changes, obtain human subject approval for the process, produce the consent forms, create a database, and enter the collected data (see Appendix A for informed consent documents).

SURVEY DESCRIPTION

The Street Characteristic Survey was designed to capture both quantitative and qualitative data from participating homeless individuals. The survey instrument was based on models from similar studies and contained no psychometric or standardized measures. Questions focused instead on basic demographics, living situation, length and description of homelessness, employment, income sources, education, health status, drug use, service usage, perceived reasons for being homeless, and perceived services needs (complete survey in Appendix B). All survey items were self-report and surveys were conducted in English.

The research definition of a “street homeless” individual was someone who spent the previous night in a place not meant for human habitation (such as a car, garage, public building or rural area). Only willing persons aged 18 and over that provided consent and slept on the street the previous night were interviewed. The interviews were conducted with a convenience sample of ‘street’ homeless individuals found at various service provider locations throughout San Diego. In return for participation in the study, all homeless individuals received a gift certificate for a meal at a popular fast-food chain whether or not they completed the interviews.

BASIC ASSUMPTIONS

In conducting the current research, it was assumed that participants responded honestly to survey questions and that their responses were not influenced by concerns over potential interviewer bias. Participants may have preferred to provide socially desirable responses to questions concerning socioeconomic and health status. When evaluating survey
results, it is important to bear in mind how elevated rates of mental illness and substance abuse among the study population may contribute to certain perceptions of reality. Results are generalizable to the wider population of unsheltered street homeless in San Diego County.

LIMITATIONS

As in any cross-sectional study, limitations need to be considered when interpreting results. In this study the following limitations were identified:

1. Selection Bias from Non-Random Sampling: Data were collected from a convenience sample of individuals visiting various San Diego service access points. Since the sampling procedure was non-random, research findings may not be representative of the target population (street homeless in San Diego).

2. Selection Bias from Selection Criteria: Through screening for participants (over 18, mentally competent, understands the consent process), certain types of persons are excluded from the study and therefore not represented in the findings.

3. Response Bias: Because the surveys were completed interview style, response bias may have occurred where the interviewee tries to please the interviewer instead of providing fully honest responses. The amount of response bias was not assessed although from the responses received, there was no significant evidence that interviewees were unwilling to describe undesirable behavior.

4. Selection Bias related to Language/Culture: The interview survey was only created in English and a large proportion of volunteer interviewers speak only English. In this case, interviews could only be conducted in languages spoken by the volunteer interviewers. It is not known how many ‘Spanish-Only’ or ‘other-language-only’ speakers were not interviewed because of these limitations.

5. Non-Response Bias: Bias may be introduced when persons chose not to be interviewed or when interviewers skip certain persons (due to not appearing homeless, appearing threatening, etc.). In other words, do these persons differ somehow from those who were approached and chose to be interviewed? The types of persons not interviewed are not represented in the findings. In this case, the number of refusals was not tracked, nor was the number of persons not approached for various reasons.

When interpreting results the reader should keep these in mind and realize that the information gathered from the participants interviewed may not accurately describe the entire street population in San Diego. The results definitely do not describe characteristics of homeless under the age of 18 and they probably do not accurately describe characteristics of homeless persons that are monolingual non-English speakers. Despite these limitations, it is
felt that this information is an important first step towards providing useful information about homeless persons to providers and other researchers.

**DEFINITIONS**

- AHAR - Annual Homeless Assessment Report
- ADM – Alcohol, Drug, and Mental (Disorders)
- RTFH - Regional Task Force on the Homeless
- PITC - Point in Time Count
- HSU - Health Service Utilization
- CoC - Continuum of Care
- NAEH - National Alliance to End Homelessness
- SRO - Single room occupancy
- AFDC - Aid to Families with Dependent Children
- VA - (U.S. Department of) Veterans’ Affairs
- CoC - Continuum of Care
- TANF - Temporary Assistance for Needy Families
- HHS - (U.S. Department of) Health and Human Services
- MOU - Memorandum of Understanding
- HUD - (U.S. Department of) Housing and Urban Development
- SAMHSA - Substance Abuse and Mental Health Services Administration
CHAPTER 2

LITERATURE REVIEW

Although the history of homelessness in America extends over several centuries, scholarship within the field has developed largely over the past three decades. Though the notion of homelessness can be traced to vagrancy laws enacted in sixteenth century England, the subject first caught the attention of researchers in the early 1980s (Barak, 1992). The literature review will provide a summary of the evolution of a dynamic body of research. Particular attention will be paid to the history of research focusing on service provision, service accessing and help-seeking behavior among homeless individuals. The section is organized by subpopulation, namely, the mentally ill and dually diagnosed, the chronically homeless, veterans, and women and families. The review does not aim to cover the universe of research on homelessness, but rather to provide an introduction to the field and an understanding of what is, and what is yet to be, understood regarding the help-seeking behavior of this vulnerable population.

HISTORICAL OVERVIEW: HOMELESSNESS IN AMERICA

Scholars of homelessness commonly describe the history of America’s homeless as a story in two parts: the “old vagrancy” that began with our national history and persisted until the 1980’s, and the “new homeless” that emerged post-1980. Social historians argue that despite their common marker of poverty, the socioeconomic and political forces that gave rise to the modern homeless population differ from those that spawned previous generations. Homelessness research is similarly partitioned, with recent research emphasizing the condition of homelessness, not simply describing the homeless per se, as was often the case pre-1980. This reformed approach has contributed to the demystification of homelessness. The folklore and stereotypes of wandering tramps and skid rows have given way to a deeper appreciation of the challenges facing America’s poor and underrepresented citizens.

Homelessness was scant in colonial America, if for no other reason than the fact that there simply were not many colonial Americans. Relief for the poor was disorganized,
consisting largely of a patchwork of family and community support. Settlements were fairly stable, and notions of religious duty and solidarity combined to provide adequate assistance to those in need (Barak, 1992). As the number of Americans grew, and the poor became increasingly mobile, the need outpaced the informal support system.

By the 17th Century, in growing cities like New York, churches began to rent shelters for emergency housing. The homeless were often those with no family to lean on for support, the “kinless and the homeless.” The city’s first formal almshouse was built in 1734, and with it came the first echoes of a cry still heard today: a cry of fraud, of outlaws and outcasts undeserving of charity from their wealthier neighbors. Since the 18th century the character of the homeless population has been best described as “hybrid,” a social rung where transgressors and criminals sit uncomfortably close to the desperate and the hard of luck.

In the late 19th century, against the milieu of civil war and an expanding Industrial Revolution in America, the face of homelessness began to change. A growing number of Americans experienced sustained dislocation, rendering historical perceptions of homelessness obsolete. Swelling immigration at the turn of the century fed rapid population growth that, coupled with technological advancements in transportation, shattered the identity of colonial America and ushered in a period of expansion. The peripatetic lifestyle of vagrants, frowned upon in previous centuries, became a key ingredient for national development and modernization. Entire industries became dependant on a large population of rootless and seasonal workers to lay railroad tracks, dig canals, harvest spreading crops of wheat and corn, operate canneries, and cut timber. This era gave birth to the phenomena of “tramping” and “hoboing,” to a new demographic of migratory workers that would climb to over one million during the Great Depression.

With the Great Depression came the construction of “warehouse” shelters capable of housing thousands of homeless. Aid became largely synonymous with housing, although shelter was certainly not the only service need of the heterogeneous masses seeking asylum. Two World Wars served to empty shelters and relief offices of all but the disabled, women, and the elderly. The infamous skid rows that emerged in the 1920s further solidified their reputations as a “junk heap for human beings” as all able-bodied men joined the national war effort (Barak, 1992).
Whereas the largely sequestered homeless typified by skid rows such as New York City’s Bowery were interchangeably spectacled and forgotten by the wider population, the homelessness that emerged in the 1970’s was not so easily stereotyped. The skid row residents studied during the 1950s and 1960s, despite estimates of alcohol addiction among over 30% of the population, were generally domiciled. Many of them lived in “workingmen’s hotels,” later called single-room occupancies (SROs), some in rooming houses, and a small minority in missions. Instead, the homeless of the 1980s were transforming into the more prevalent, even intrusive, population that is now part and parcel with American urban culture.

**POST-1980: CAUSES OF THE “NEW HOMELESSNESS”**

The root causes of the rapid growth in homelessness during the 1980s are a topic of debate among homelessness scholars. What is not debated, however, is that no single catalyst sparked the upsurge. Rather, it seems a constellation of social, economic, and political forces, both within the US and abroad, explain the phenomenon of the “new homelessness.”

Academic explanations of homelessness have traditionally fallen into two broad categories: individual and structural. Individual explanations place emphasis on the specific characteristics, behaviors and needs of a homeless individual. The structural theory looks beyond the addiction and personality disorders to the external social and economic factors: the condition of the housing market, increasing poverty, declining wages, and high rates of unemployment (Fitzpatrick, 2005). In the literature this dichotomy is often expressed in a conception of homelessness as a ‘housing problem’ or as a ‘social problem.’ In both cases, some weight is given to the role of the wave of deinstitutionalization of the mentally ill that occurred across the nation under Reagan-era social policy changes. In 1994, Jencks echoed the views of many fellow social scientists by concluding that housing affordability deserved less emphasis that the readily visible decline in the number of mentally ill committed to institutions (Jencks, 1994).

Other scholars share the perspective expressed by O’Flaherty, whose careful analysis of the “economics of homelessness” emphasize the changing dynamics of the low-rent housing market as the main cause of the rise of homelessness. Pointing to trends in the
destruction of SROs and to shrinking federal funding for new construction or subsidized rents for low-income units, O’Flaherty and colleagues believe that structural factors increased the number of Americans vulnerable to homelessness. Researchers from the field of medicine and psychology have also criticized such weight being placed on individual pathology in early sociological and psychological accounts of homelessness (Burt, 1991). Still, these scholars have acknowledged the role of personal attributes and suggest that these characteristics determine who among the vulnerable actually experience homelessness (O’Flaherty, 1996). Dennis Culhane, a nationally renowned expert in the field of homelessness, describes the viewpoint now shared by the majority of homelessness researchers:

[The emerging position] outlines a process in which structural factors left growing numbers of persons and households facing considerable difficulty. From this group, certain persons and households, because of individual factors… are particularly vulnerable to experiencing homelessness… (Metraux & Culhane, 1999, p. 372)

Culhane’s perspective represents a deeper understanding of the many factors that contribute to the phenomenon of homelessness. It is a dynamic perspective, gained through decades of research into the nature and causes of the homelessness. In the same way that the purported causes have evolved, the definition of homelessness has been subject to the tides of history.

**Toward a Definition of Homelessness**

Perhaps one of the greatest barriers to a robust understanding of homelessness has been the ambiguity of the condition it describes. First introduced by Victorian charity organizers in sixteenth century England, the term has, in the years since, described a broad range of human existence. There is, however, an enduring emphasis on two conditions: the absence of a domicile, and the absence of the “durable, affective and instrumental links to other individuals” (Barak, 1992). From a researcher’s perspective, how homelessness is defined has important bearing on the data obtained, especially as it determines how study subjects will be selected. A common shortcoming among early homeless research is a lack of precise guidelines for the study population. The line between homeless and other poverty-stricken individuals, the sporadically homeless or marginally housed, was blurred (Hopper, 1987).
During the early 1980’s, as awareness of the phenomenon of homeless was increasing, no single convention for describing homeless individuals existed. The 1987 Stewart B. McKinney Act, the first major legislation to create a series of targeted assistance programs for the homeless, established the first federal definition of homelessness.

The federal definition of homelessness is contained in Title 42, Chapter 119, Subchapter 1 of the United States Code.

In general, the term “homeless” or “homeless individual or homeless person” includes:

1. An individual who lacks a fixed, regular, and adequate nighttime residence; and
2. An individual who has a primary nighttime residence that is
   (i) A supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
   (ii) An institution that provides a temporary residence for individuals intended to be institutionalized;
   (iii) Or a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.
3. This definition does not include any individual imprisoned or otherwise detained under an act of Congress or a state law (US Department of Housing and Urban Development, 2007).

**Evolution of Homelessness Scholarship**

Psychological and medical perspectives have dominated homelessness research in the United States, though initial contributions came from the field of sociology (Gelberg & Linn, 1990; Snow & Anderson, 1987). In their recent comparison of homelessness research in the United States and Britain, Fitzpatrick and Christian describe a strong ‘positivist’ focus in research on homelessness in the US. They attribute this focus, in part, to the position of psychology as the disciplinary middle-road between the social and natural sciences (Fitzpatrick & Christian, 2006). Generally speaking, positivists view explanation and prediction as the goal of inquiry. As such, they hold that ‘objective’ truth underlies social realities, truth which, through the application of rigorous and systematic methods, can be revealed. This positivist tradition, reinforced by the preponderance of clinical perspectives, has encouraged high valuation of empirically-driven findings, more specifically, statistically significant correlations between predictor and outcome variables. This inclination has, in
turn, resulted in a devaluation of qualitative research. The vast majority of existing homelessness research focuses on quantitative data, collected using surveys tools, and assessed via statistical modeling.

For decades, the typical homeless person in America was regarded as a middle-aged man who is frequently unemployed, often mentally ill, handicapped, or an abuser of substances, and who exhibits few or no social linkages to society (Barak, 1992). In the late 1970s, Reich and Siegel noted the transformation of New York's Bowery to a "psychiatric dumping ground," and a literature began to develop linking the burgeoning new American homeless population with changes in policy, particularly mental health service policies (Reich & Siegel, 1978). Recent studies described a homeless population that was younger and more heterogeneous than that of the old skid rows. The new homeless include a greater proportion of single women, and minorities, particularly Blacks and Hispanics, are overrepresented. A study by the U.S. Conference of Mayors determined that families with young children are proving to be the fastest growing element of the contemporary homeless population (U.S. Conference of Mayors, 2007).

**HOMELESS SUBPOPULATIONS**

The population of homeless persons in the United States has grown increasingly diverse in recent decades (U.S. Conference of Mayors, 2007). The typical “skid row” profile of the mid-20th Century fails to capture the many demographics of Americans who now fit the definition of homelessness. As such, the US homeless population may best be considered in terms of distinct subpopulations: individuals with alcohol, drug, and mental disorders or who are dually diagnosed; homeless women and families; homeless veterans; and the chronically homeless.

**Individuals with Alcohol, Drug and Mental Disorders**

Alcohol, drug and mental disorders are important risk factors in the selection of the undomiciled from the larger population of extremely poor people. The association between alcohol use and homelessness is proven in countless studies, however, the causal relationship between homelessness and addiction is deceptively complicated: while many homeless people experience substance abuse prior to homelessness, a meaningful minority face addiction for the first time on the streets. (Hopper & Baumohl, 1996). A comprehensive
review of the literature documented high rates of mental disorders in homeless populations (Tessler & Dennis, 1992). Research conducted on homeless individuals suffering from these often co-occurring disorders over the past decade has been largely descriptive. As a result, much is known about the sociodemographic characteristics of this population, but the precise magnitude of alcohol, drug and mental disorders remains the subject of considerable debate. Furthermore, the lack of precise definitions of ADM disorders presents a real threat to the generalizability of most research findings (Rosenheck & Lam, 1997).

The variability in prevalence rates of alcohol, drug, and mental disorders reported in many studies is significant. Reported rates for mental health problems range from 2% to 90%, rates for alcohol problems from 4% to 86%, and rates for drug abuse from 1% to 70% (Fischer & Breakey, 1991). When making gender comparisons, prevalence estimates in homeless populations reflect rates reported in the general population: both alcohol and drug problems are more frequently reported in men (up to 80% and 61%, respectively, in men compared with 63% and 26%, respectively, in women), and mental health problems are of higher prevalence among women (up to 52% in men compared with 71% in women). Fischer reported that a minimum of 10% of all homeless individuals have current drug problems, and at least another 40% exhibit concurrent alcohol abuse. In general, studies report prevalence rates among homeless populations that are 6 to 7 times greater than would be expected in the general population.

Homeless sufferers of alcoholism have been found to experience an excessive number of physical health problems (Wright, 1990). Wright noted that among patients receiving health care at 19 Healthcare for the Homeless (HCH) programs, alcohol abusers tended to be much sicker than were other patients: four to seven times more likely to suffer from liver disease, twice as likely to have serious trauma, two to three times more likely to have seizure disorders or other neurological impairments, twice as likely to present with various nutritional deficiencies, and were half again as likely to have hypertension, chronic obstructive pulmonary disease, gastrointestinal disorders, and arterial disease.

From 1982 to 1986, the National Institute of Mental Health (NIMH) funded 10 studies designed to investigate various aspects of homelessness and mental illness (Roth, Bean, Lust, & Saveanu, 1985). Four of the NIMH-sponsored studies provided comparisons of the mentally ill and non-mentally ill homeless subgroups. On the basis of their review of
these studies, Tessler and Dennis concluded that homeless persons with severe mental illnesses are similar to their non-mentally ill counterparts in terms of age, sex, ethnicity, and extent of substance abuse (Tessler & Dennis, 1992). Homeless mentally ill persons were, however, homeless for longer periods of time, had less contact with family and friends, had more barriers to employment, were in poorer physical health, and had more frequent contact with the criminal justice system.

The NIMH studies consistently estimated similar prevalence rates of mental disorders: 10 to 13% were schizophrenic, 21 to 29% had affective disorders, 2 to 3% were demented, and 14 to 20% had antisocial personality disorder (Breakey, 1989).

**Dual Diagnosis**

Although the degree of overlap is difficult to discern, it is evident that a significant proportion of homeless individuals struggle with concurrent substance abuse and mental disorders. This dually diagnosed subpopulation presents a particularly complex set of challenges to service providers. Dual diagnoses range from 2 to 34%, with as many as one third having concurrent alcohol and drug problems, up to one fourth having alcohol and mental disorders, about 3% having both mental and drug disorders, and perhaps 7% suffering from alcohol, drug, and mental problems in combination. Clients with dual diagnoses generally spend significantly more days homeless, report more involvement with the criminal justice system, and a lower subjective quality of life than their non-dually diagnosed counterparts (Breakey, 1989).

**Homeless Women and Families**

Although women comprise nearly one-third of the US homeless population, research devoted to this group has, until recently, been limited. Recent statistics indicate that among homeless persons, 20% are single women, and another 15% are single women with children (Nyamathi, Leake, & Gelberg, 2000). It has been estimated that about 60% of homeless women have at least one minor child and that nearly 40% of these women have multiple children with them. Most homeless women are mothers, are under 35 years of age, are members of a minority group, have less than a high school diploma, live without the support of a spouse, and have usually experienced more than one episode of homelessness in their lifetimes.
Homeless women often have additional problems that distinguish them from homeless men and from otherwise comparable, housed women. Homeless women suffer from poorer health than do poor, domiciled women, and they have less access to appropriate health care. Studies comparing homeless men and homeless women find that homeless women report more recent injuries or acute illnesses than males. A number of studies have reported higher rates of mental illness in homeless women than in homeless men, although such gender differences have not been universally observed in samples of homeless adults (Breakey, 1989).

Women often become homeless for somewhat different reasons than men, suggesting that the needs of homeless women and men also differ (Bassuk & Rosenberg, 1988). Women, with and without children, are disproportionately represented in the situationally homeless population. Situational factors that have been found to contribute to homelessness include the feminization of poverty, scarcity of affordable housing, unemployment, teenage pregnancy, domestic violence, and family disruption. In a 24-city study by the U.S. Conference of Mayors, 50% of the cities surveyed identified domestic violence as a primary cause of homelessness (U.S. Conference of Mayors, 2007).

Despite the effort of the scholars such as UCLA’s Lilian Gelberg, a physician and pioneer in the field, data are lacking on homeless women and families. For example, minorities, especially African Americans, are disproportionately represented among homeless women (Shinn, Knickman, & Weitzman, 1991) and the role of race and ethnicity needs to be studied as a risk factor. The role of children in the lives of homeless women has been found to have a significant impact on service seeking behavior, though this phenomenon warrants further research as well.

**Homeless Veterans**

Veterans are disproportionately represented in surveys of homeless adults. In 2005 the Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) for Veterans PITC estimated that there are currently 195,254 homeless veterans on any given night, 97% of them male. Over the course of a year, approximately 500,000 veterans experience homelessness. An even larger number of veterans are
considered to be at high risk for homelessness because of poverty, lack of social supports, and inadequate living conditions (National Alliance to End Homelessness, 2006).

About 45% of homeless veterans have mental illness, and more than 70% suffer from drug or alcohol abuse (National Coalition for Homeless Veterans, n.d.). Homeless male veterans are more likely to be chronically homeless than homeless male non-veterans. Homeless veterans are, however, better educated than homeless non-veterans, less likely to have never married, and more likely to be working for pay.

Women currently comprise a growing percentage of the total veteran population, and representation of female veterans is higher among younger veteran cohorts (National Coalition for Homeless Veterans, n.d.). According to the Department of Veterans’ Affairs, female veterans now comprise nearly 10% of the total veteran population. The racial distribution of homeless veterans is similar to that of the overall homeless population. African Americans are overrepresented among both the homeless veteran and overall homeless populations.

Much of what we know about homeless veterans, particularly the causes of homelessness, is due to the work of Yale University physician and epidemiologist Dr. Robert Rosenheck. Dr. Rosenheck has studied homeless programs for the Veterans’ Administration (VA) for more than 20 years. Rosenheck and Fontana demonstrated that the two factors with the greatest effect on vets’ homelessness were support in the year after discharge from military service and social isolation (Rosenheck & Fontana, 1994). This is consistent with Rosenheck’s previous finding that homeless veterans experiencing the long episodes of homelessness are those who had behavioral risk and those lacking social bonds (Tessler & Rosenheck, 2002).

Although data are still lacking on veterans returning from Iraq and Afghanistan, initial findings indicate rates of mental health disorders in excess of those seen among Vietnam veterans. Furthermore, although many Vietnam veterans did not experience homelessness until 10-15 years after they left the service, homeless service providers are already seeing veterans of Iraq and Afghanistan (Hoge, Auchterlonie, & Milliken, 2006).
Chronically Homeless Individuals

Attempting to account for the changing faces of homelessness, a model has emerged that breaks profiles of homelessness into chronic, episodic, and transitional patterns (Breakey & Fischer, 1990; Hopper & Baumohl, 1996; Rossi, 1989). This model is based around the notion that varying patterns of homelessness can be linked to distinct personal profiles. The Interagency Council on Homelessness has adopted a working definition to identify the chronically homeless; a chronically homeless individual is an unaccompanied homeless individual with a disabling condition who has been either continually homeless for a year or has had at least four episodes of homelessness in the past three years.

The chronically homeless population consists of those persons most like the stereotypical profile of the skid-row homeless. They are likely entrenched in the shelter system, they tend to be male, older, less educated, unemployed for many years, and to suffer from chronic disabilities and substance abuse problems. Approximately 23% of the total homeless population is chronically homeless (National Alliance to End Homelessness, 2010). On any given night there are approximately 150,000 to 200,000 chronically homeless individuals nationwide. The chronically homeless account for a far smaller proportion of the population over time than the transitionally homeless, but their consumption of services is disproportionately great (Culhane & Kuhn, 1998).

Previous research suggests that a larger proportion of chronically homeless individuals suffer from behavioral issues than their non-chronically homeless counterparts, and some studies have found as many as 40% suffering from drug and alcohol disorders. A similar pattern emerges for the indicator of poor medical health, where chronically and episodically homeless are on average 1.5 times as likely to report medical problems as transitionally homeless clients.

Research has shown that persons experiencing chronic homelessness exhibit a pattern of being extremely disconnected from community life (National Alliance to End Homelessness, 2010). Many lack all traditional support systems, and, therefore, are single adults with weak family connections. A high percentage of the chronically homeless are ethnic and racial minorities. Many have past experiences with mainstream services that did not effectively address their needs or prevent them from falling into homelessness. These characteristics contribute to the long or repetitive patterns of homelessness they exhibit.
SERVICE PROVISION FOR THE HOMELESS POPULATION

In comparison to most other wealthy industrial nations, the US system of welfare provision is limited and highly fragmented (Alcock & Craig, 2001). Welfare programs fall primarily under the jurisdiction of individual states, creating a system marked by geographic and demographic disparities.

Prior to the 1980s, the vast majority of services to the homeless emerged locally, largely at the hands of individuals and churches. The first federal task force on homelessness was created in 1983 to provide information to local governments and interested parties on how to obtain surplus federal property. Between 1980-1990 the number of services available to urban homeless populations approximately tripled (Barack, 1992). In 1983 Congress appropriated $140 million in federal funds for emergency food and shelter. The aid was not, however, accompanied by any federal programs or new legislation addressing the issue. Comprehensive legislative responses to homelessness were introduced for the first time to both houses of Congress in 1986. In 1986 the Congress passed a few small parts of the Homeless Persons' Survival Act. Later that same year, emergency relief provisions for shelter, food, mobile health care, and transitional housing were introduced as the Urgent Relief for the Homeless Act.

STEWART B. MCKINNEY HOMELESS ASSISTANCE ACT

Congress enacted the first major federal legislative response to homelessness on July 22, 1987. Authorizing initially around $1 billion in federal support over a two-year period, the Stewart B. McKinney Homeless Assistance Act was the federal government’s overdue acknowledgement that homelessness represented “an immediate and unprecedented crisis” (Hopper & Baumohl, 1996). The money was allocated to fund state, local, and private nonprofit aid programs.

Between 1987 and 1994, Congress appropriated $5.1 billion to eight existing federal agencies. In addition, the legislation created a new federal agency, the Interagency Council on the Homeless. The programs provided funding across a broad range of services, among them emergency food and shelter, transitional and permanent housing, education, job training, mental health care, primary health care, substance abuse treatment, and veterans’ assistance programs.
The Department of Housing and Development, established by the U.S. Housing Act in 1937, was granted responsibility to oversee five of the programs and 70% of the budget. In 1995, HUD began to require communities to submit a single application for McKinney-Vento Homeless Assistance Grants in order to promote the development of Continuums of Care (CoCs). A Continuum of Care is a local or regional system for helping people who are homeless or at imminent risk of homelessness by providing housing and services according to the needs in the community (U.S. Department of Housing and Urban Development, 2007). The CoC approach was introduced to streamline the existing competitive funding process and to encourage communities to coordinate the planning and provision of services for homeless people.

By providing mechanisms for supportive housing, healthcare, veterans’ benefits, and family assistance, the McKinney Act was a watershed in the federal government’s understanding of social responsibility toward the nation’s poorest citizens (Foscarinis, 1991). Still, advocates are quick to point out many ways in which the system remains flawed. Implementation has been uneven across federal agencies. Enforcement litigation has repeatedly been required to force distribution of funds. Most importantly, while some of the amendments point toward longer-term relief, the Act was largely conceived as emergency assistance. In many ways, the root causes of homelessness are not addressed.

**GENERAL INCOME ASSISTANCE**

Most single individuals (those lacking dependant children) do not qualify for income assistance or housing subsidies (other than veterans, the elderly and disabled people). For many poor Americans, food stamps are the main available support program (O’Connell, 2001). The Clinton-era restructuring of federal protection for families replaced Aid to Families with Dependent Children (AFDC), in place since the 1930s, with Temporary Assistance to Needy Families (TANF). These changes introduced strict federally mandated time limits and pushed employment requirements on beneficiaries. TANF is a federal assistance subsidy awarded to individual states. State governments are, therefore, at liberty to determine benefit levels (Fitzpatrick, 2005).

First conceived of in the 1930s, the Food Stamp Program now provides a safety net to millions of Americans (James, 2009). A revised program was implemented in 1977 with a
goal of alleviating hunger and malnutrition by permitting low-income households to obtain a more nutritious diet with food-specific aid. The federal government pays one hundred percent of food stamp program benefits. Federal and State governments share administrative costs (with the federal government contributing nearly half).

Housing

The history of federal housing assistance has several salient characteristics. One ongoing trend has been to move from construction of public housing toward more flexible and intensive use of the privately built housing stock (Barak, 1992). There has been a shift at all levels of government away from direct expenditures and toward forgoing tax receipts as the preferred supply-side incentive. Another trend has been a move from subsidizing rental units and toward directly subsidizing needy tenants.

Between 1970 and 1980, about 1 million single-room units, the shelter most commonly utilized by the nation’s poor, were converted to other uses or destroyed (U.S. Department of Housing and Urban Development, 1995). From 1981 through 1989, federal housing programs for the poor were cut by more than 75% (Barancik, 1989). Federal housing programs had never met the needs of all eligible poor persons, and by 1989 waiting lists for the programs extended for two years after application.

The U.S. Housing Act was amended in 1974 to create Section 8. Through Section 8, low-income households and the disabled can receive a voucher that pays for about 70% of rent and utilities. The voucher program currently assists about 2 million American households pay for housing. Still, neither individuals nor families with dependent children are entitled to subsidized housing, and no federal mandate to secure temporary shelter for homeless households while they seek housing is in place. A subset of state and local governments has taken it upon themselves to introduce entitlement to temporary accommodation for families with children (O’Connell, 2001). Public housing is extremely limited and is heavily concentrated in deprived urban cores with tenants drawn from the very poorest groups.

In January 1990 the secretaries of the Department of Health and Human Services (HHS) and HUD signed a federal-level Memorandum of Understanding (MOU). The intent of the MOU was to encourage collaborative research and new projects to better coordinate
housing services for vulnerable poor. As one outgrowth of this effort, HUD provided $10 million in housing assistance funds. The two departments have worked closely in recent years to implement the HUD Shelter Plus Care Component of the Homeownership and Opportunity for People Everywhere (HOPE) initiative and the HHS Projects for Assistance in Transition from Homelessness (PATH) program.

Research has shown that providing supportive housing as the first step may have a greater impact on reducing homelessness than the more traditional answer of moving an individual from emergency shelter, to transitional housing and then into supervised independent living (Padgett, Gulcur, & Tsemberis, 2006). The severe problems that homeless individuals face, such as alcoholism and mental illness, can be better addressed in a permanent living environment, rather than asking someone to “get better” in an unstable situation. Evidence suggests that formerly homeless and severely mentally ill individuals can be placed in housing of various types and remain housed for extended periods of time. (Lipton, Nutt, & Sabatini, 1988).

**MEDICAL AND MENTAL HEALTH SERVICES**

The 1980’s wave of deinstitutionalization of mentally ill, without the corresponding provision of adequate community services, undoubtedly played a role in the increasing number of homeless in the 1980s. In 1970 there were 413,066 beds in state and county mental hospitals in the United States. By 1988, this number had decreased to 119,033. By 1998, the count was 63,526 beds (Barak, 1992). Over the past three decades, nearly every state has established specialized programs for the homeless mentally ill individuals. Still, the availability of an appropriate range and number of services for homeless mentally ill individuals still falls far short in relation to the need.

In 1985, nineteen demonstration projects in U.S. cities, privately funded by the Robert Wood Johnson Foundation and Pew Charitable Trusts, began providing primary medical care and case management for homeless people. The healthcare model was introduced to demonstrate a new, more integrative, way to deliver health and social services. The result was the Healthcare for the Homeless Network (HCHN), which today provides healthcare and services through over 180 projects and 500 clinics nationwide.
In 1987, the McKinney Act introduced the first direct congressional effort to assist the homeless with healthcare (Foscarinis, 1991). Section 612 of the McKinney Act authorized funding to further develop innovative services for homeless mentally ill and disabled individuals. For example, one provision of the PATH program set aside funds for homeless mentally ill. The PATH program is administered by the Center for Mental Health Services, a component of the Substance Abuse and Mental Health Services Administration (SAMHSA), one of eight Public Health Service agencies within the U.S. Department of Health and Human Services. PATH services are for people with serious mental illness, including those with co-occurring substance use disorders, who are experiencing homelessness or at risk of becoming homeless. PATH services include community-based outreach, mental health, substance abuse, case management and other support services, as well as a limited set of housing services.

A 1992 reorganization of the NIMH led to the establishment of the Center for Mental Health Services (CMHS). In turn, CMHS initiated a five-year, $17 million demonstration program called Access to Community Care of Effective Services and Supports (ACCESS) in 15 cities at 18 sites across the United States. It built on the efforts of service organizations and researchers to design service models that effectively engage and treat homeless individuals with severe mental illness.

**Veterans’ Assistance Programs**

The United States has a far more extensive system of veterans’ support than virtually any other nation. Following the First World War, Congress overhauled the national system and introduced veterans’ insurance, vocational rehabilitation, as well as disability compensation (Baumohl, 1996). Among the earliest federal agencies were the Veterans’ Bureau, the Bureau of Pensions of the Interior Department, and the National Home for Disabled Volunteer Soldiers, followed by the Veterans’ Administration (VA).

Since its establishment in 1930, the VA healthcare system has expanded from 54 hospitals to include 171 medical centers, 350 outpatient, community and outreach clinics, 126 nursing home units, and 35 domiciliaries (O’Toole, Gibbon, Hanusa, & Fine, 2003). The VA continues to be the only federal agency that provides direct hands-on assistance to homeless veterans. In 2009, the VA provided health care services to more than 100,000
homeless veterans and provided services to 70,000 veterans in its specialized homeless programs. Though limited only to veterans and their dependents, the VA's homeless programs are the most extensive and integrated network of homeless assistance programs in the country. Though statistics vary by source, as many as 55% of veterans contacted in one study reported using VA homeless services.

Income support provided to veterans generally falls into either the category of pension or of service-related disability compensation. Only 10% of all veterans are receiving one of these two benefits. Of those who file for income support benefits, only 74% receive it. Only 38% of the veterans who file for disability compensation receive assistance (U.S. Department of Housing and Urban Development, 2007).

Major housing support for homeless veterans emerged in 1992 through the HUD-VA Supportive Housing (HUD-VASH) program. The program was designed to provide permanent housing and services to homeless mentally ill veterans and those suffering from substance abuse disorders. The primary programs through which veterans receive supportive housing are the Shelter Plus Care program and the Supportive Housing Program.

All homeless veterans are eligible to participate in programs funded through the McKinney-Vento Homeless Assistance Grants. In total, HUD provides over $849 million in support for programs that directly and indirectly target veterans. Over the past several years, the percentage of total HUD projects targeting veterans (meaning they serve at least 70% veterans) has grown from 3 to 5% (U.S. Department of Housing and Urban Development, 2007).

SAN DIEGO COUNTY

The County of San Diego is the primary provider of mental health, drug, alcohol, social, and health services for the region’s homeless population. As such, the County receives the major share of funding from the federal and state governments for such programs.

In order to deliver services to the homeless, the County works in collaboration with other jurisdictions, coalitions, advisory groups, and providers. Together these parties identify gaps in services and coordinate efforts to maximize service provision. Effort is made to work closely with City of San Diego, which is home to the County’s largest percentage of urban homeless.
Nearly $70 million in public funds were allocated to homelessness in San Diego County in 2005 (San Diego Regional Taskforce on the Homeless, 2009). These funds included over $6.3 million in cash assistance and food stamps, and more than $63 million distributed through such programs as transitional housing, emergency and day shelters, health services and food. These costs do not account for law enforcement, emergency departments, paramedics and hospital expenses.

In general, local tax dollars comprise a small proportion of the funds dedicated to homelessness. The majority of projects are funded through state and federal programs such as HUD's Supportive Housing Program (SHP), Emergency Shelter Grant (ESG) program, or Community Development Block Grant (CDBG) program. Additionally, housing trust fund dollars, redevelopment agency funds, taxes from a downtown maintenance assessment district, and general city funds are currently used for homeless programs by the City of San Diego. The City of San Diego, with 51% of the county’s general population, is responsible for administering about 15% of these funds (approximately $7 million), a figure representing a contribution of $5.62 per city resident.

The City of San Diego coordinates assistance to the City's homeless community. Through contracts with nonprofit service providers, funds from the City's Community Development Block Grant, and Social Services programs, a network of funding is provided to the Winter Shelter Program, the Neil Good Day Center, the 150-bed Cortez Hill Family Center and the Seniors Transitional Housing Program. The City's Homeless Administrator represents the City on regional homeless committees, including San Diego’s RTFH, the San Diego Regional Continuum of Care Council, and the East Village Redevelopment Homeless Advisory Committee.

The Department of Housing and Community Development (HCD) supports and administers programs for the homeless through grants and loans primarily from HUD, the Emergency Shelter Grant (ESG), the Supportive Housing Program (SHP), and the Cold Weather Shelter Voucher Program. HCD assists with the funding of San Diego’s Regional Taskforce on the Homeless (RTFH). Further funding for the RTFH comes from the City and County of San Diego, the United Way of San Diego County, the San Diego Housing Commission, and other local jurisdictions. Additional support is provided by local nonprofit organizations such as the Alpha Project, which assists over 4,000 homeless or borderline
homeless individuals everyday with affordable housing, substance abuse treatment, transportation assistance, and mental health counseling (Alpha Project for the Homeless, n.d.).

A major source of healthcare and treatment for underserved residents of San Diego County, including numerous homeless children and adults, are the Family Health Centers of San Diego (Family Health Centers of San Diego, n.d.). The Family Health Centers utilize the resources of the Health Care for the Homeless Project to provide these services to homeless persons. The San Diego Health Care for the Homeless Project offers the following free services and resources for homeless patients: acute care (sick visits, physicals, medication), vision care (exam & glasses), dental care, counseling/mental health, case management, transportation, and information.

The County places special priority on assisting homeless families with children, and victims of domestic violence and special needs groups including the severely mentally ill, persons with AIDS/HIV, and those recovering from substance abuse. Despite all efforts to streamline care and make effective use of available resources, the Region has only enough facilities to meet approximately sixty percent of shelter needs of on any given night (San Diego Regional Taskforce on the Homeless, 2009). Almost all of these shelter spaces serve urban homeless individuals and families.

**FACTORS ASSOCIATED WITH HELP-SEEKING BEHAVIOR**

Research focused on the help-seeking behavior of homeless individuals is necessary in determining why, despite increases in federal and local aid to homeless service providers, these resources remain underutilized. Some researchers propose that the fragmented nature of service delivery to the homeless is to blame for low service-accessing rates (Acosta & Toro, 2000). Other scholars attribute the lack of use to discrepancies between the services desired by homeless persons and the services provided to them.

The existing body of research on the help-seeking behavior of homeless individuals is disproportionately devoted to the topic of barriers to service utilization. Apart from the issue of health services utilization (HSU), service accessing has not been well studied among the general homeless population. The topic of health service utilization was first becoming an area of active research when Andersen developed his original Behavioral Model in the late
The model suggested that service accessing is a function of a predisposition by people to use health services, factors that enable or impede such use, and people's need for care (Andersen, 1968, 1995). Indeed, despite the emergence of competing models, the existing body of research draws heavily from Andersen’s theory of predisposing, enabling, and need-related determinants (Andersen, 1968, 1995).

**Anderson’s Predisposing Variables: Race, Education, and Gender**

Since its conception, the predictors of service utilization posited by the Behavioral Model have been the topic of decades of scrutinizing research (Aday & Awe, 1997; Andersen, 1995). The resulting process of revision has been described by Andersen as consisting of three phases (Andersen, 1995). The first phase was the original model developed by Andersen. Phase 2, developed in the 1970s, included elaboration of the measures of health services use specific to particular conditions and to consumer satisfaction. A third phase of the model evolved during the last decade, and is marked by the inclusion of health status outcomes particularly important for health policy and health reform. It was not until this final phase that the notions of “effective” and “efficient” access are mentioned. Effective access, according to Andersen, occurs when studies are able to confirm that service use improves client status or consumer satisfaction with services.

While the relation of some sociodemographic factors to utilization has changed from one study to another (mental illness, income), key predisposing variables, such as race, education and gender, have continued to be strongly associated with utilization of services (Andersen, 1995).

In 1990, a seminal study by Padgett examined associations between use of services and three sets of predictor variables derived from the Social Behavioral model (Padgett, Struening, & Andrews, 1990). Researchers analyzed utilization patterns of four types of services (medical, mental health, drug, and alcohol) by residents of the New York City homeless shelter system. The results suggested that multiple of the predisposing variables posited by Andersen were significant predictors of help-seeking behavior. At the time Padgett published her findings, studies of the utilization of health and mental health services by homeless individuals were still in their infancy. Far less was known about the use of general medical services, outpatient mental health services, and drug and alcohol treatment
services, and the relationships between service use and characteristics of individuals that may affect their help-seeking behavior.

Of the various sociodemographic variables considered in this analysis, education and race emerged as significant predictors of seeking both physical and mental health services. Respondents who reported having obtained a high school diploma or GED were more inclined to access available services. Similarly, persons who were not Black showed a higher probability of service use than those self-identifying as African American. While higher education is often a correlate of health and mental health service utilization, Padgett noted that it was more difficult to explain why whites, Hispanics, Asians, and Native Americans were twice as likely to use alcohol treatment services as Blacks. A history of service seeking was also a significant predictor of use in this study. For example, persons with a previous medical hospitalization were more than twice as likely to use medical services as persons without a previous medical hospitalization. Her findings also highlighted another emerging gap in the existing research on service utilization: significant disparities between the needs assessed by trained evaluators and those assessed by the homeless individual (Padgett et al., 1990).

The role of gender in predicting service seeking behavior has been found to be significant by numerous researchers (Bonin, Fournier, & Blais, 2007; DiBlasio & Belcher, 1995). In a review of gender differences in help-seeking behavior, McMullen and Gross suggested that help-seeking behavior has been depicted as more appropriate for females than males (McMullen & Gross, 1983). Consequently, homeless women may not view help-seeking behavior as a threat to their competence or independence, leading to increased tendency to use services when compared to their male counterparts. Multivariate analysis revealed that homeless women were more likely to be slightly better educated; to have been homeless for a shorter period of time; to request services involving children, such as child care and parenting skills training; to be seeking social-service benefits; and to be less in need of alcohol and drug rehabilitation than were their male counterparts (DiBlasio & Belcher, 1995).

In their study of service utilization among a borderline homeless population in Quebec City, Bonin et al revealed that female gender, younger age, never being homeless, previous use of hospital services within 12 months, and a larger social support network were
related to greater utilization of mental health services (Bonin et al., 2007). These findings highlight a history of having accessed available services as a significant predictor of future use. Additional research has provided evidence that a history of service accessing predicts more frequent help-seeking behavior. Bonin also identified those mentally ill clients who are least likely to seek care— namely men, older people, those without a fixed address, and those with small support networks. A small social support network is one of the defining characteristics of chronic homelessness.

**HELP-SEEKING BEHAVIOR AMONG THE CHRONICALLY HOMELESS**

In their analysis of data from 738 homeless women from the National Survey of Homeless Assistance Providers and Clients, Tam found chronic homelessness to be linked to greater frequency of service use in the study (Tam, Zlotnick, & Bradley, 2008). The presence of a disability is virtually universal among the chronically homeless population (National Alliance to End Homelessness, 2010). The needs of this subpopulation are, therefore, broad: housing, health care, mental health services, substance abuse treatment, income supports and entitlements, life skills training, education, and employment. These services typically are provided by multiple agencies in different systems, leaving individuals to coordinate their own care.

Research devoted specifically to the help-seeking behavior of the chronically homeless is, at best, limited. No study was identified that assessed service use by the chronically homeless along gender, racial or other demographic lines. As a result, little is known about the various predictors of and barriers to service accessing among the chronically homeless. The role of chronicity in predicting service utilization is poorly understood: This subpopulation seems more willing to access available services, but clearly fails to address the causes of their homelessness in doing so.

**HELP-SEEKING BEHAVIOR OF HOMELESS VETERANS**

The needs of homeless veterans are substantial, especially for physical injury, psychiatric illness, alcohol abuse, and medical problems. Compared to non-veteran homeless individuals, veterans exhibit a high rate of service utilization (Wenzel, Bakhtiar, & Caskey, 1995). Use of VA services is more prevalent than non-VA service use, however a prominent
minority of veterans report using non-VA medical/surgical services. Very few veterans report use of non-VA psychiatric/substance abuse services. Sixty-two percent of surveyed veterans had at least one VA medical/surgical visit or hospitalization; 31% had such a non-VA contact. Thirty-seven percent had at least one VA psychiatric/substance abuse visit or hospitalization; 6% had such a non-VA contact.

A major factor in predicting service utilization among homeless veterans is the presence of mental illness. Wenzel and colleagues used the Andersen model to determine that inpatient service use was related to the number of lifetime psychiatric symptoms and substance use disorders during the past year (Wenzel et al., 1995). However, studies indicate that despite a need for mental health services, utilization is strikingly low: among veterans whose responses were positive for a mental disorder, only 23 to 40% sought mental health care. Furthermore, the recent experience of combat stress was related to a lower probability of receiving outpatient services. According to Rosenheck, the associations between homeless veterans’ medical problems and use of services are more appropriately considered conditional on alcohol use history: health problems were more strongly associated with service use in the absence of alcohol (Rosenheck & Fontana, 1994).

In a reversal of the trend among the general homeless population, female veterans are less likely than their male counterparts to seek services. A review of 21 studies on veterans’ help seeking behavior found that negative experiences may lead women to utilize VA services at a lower rate than male veterans (O’Toole et al., 2003). For example, a history of Military Sexual Trauma (MST) was reported at rates ranging 55 to 70%, and rates of sexual assault from 11 to 48% among women veterans. A recent survey indicated that only one in five women veterans felt comfortable using VA health care services. Research is needed to which services female veterans feel they need and to determine why they remain hesitant to seek services.

**HOMELESS PERSONS’ PERCEIVED SERVICE NEEDS**

The first studies to inquire homeless people about their own service needs targeted the mentally ill population, leading to results that were not representative of the wider homeless population (Ball & Havassy, 1984). One of the earliest instances was a 1989 study by Lin and Gelberg. When asked to rank five service needs, homeless individuals placed
good health at the top of their list, followed by steady income, a permanent job, a permanent home, and regular meals. This study failed, however, to provide participants the opportunity to identify needs separate from the list of five provided on the survey (Linn & Gelberg, 1989).

Similarly, in a survey of needs prioritized by a population of street homeless, DiBlasio and Belcher found that housing and receiving assistance in locating housing were among the top priorities, while more than half of the sample wanted help with transportation and finding employment (DiBlasio & Belcher, 1995). Other service priorities included social service benefits (42%), food (39%), medical services (34%), job training (33%), educational services (29%), service coordination (28%), budget counseling (25%), and childcare (20%). Women showed a greater need by more than ten percentage points for childcare, transportation, food, locating housing, family counseling, budget counseling, parenting skills training, job training, job finding, and individual counseling. Interestingly, a large proportion of those interviewed did not indicate a desire for very basic services. For example, 40% of the sample did not want help locating housing. Continued dialogue with the homeless population is needed to understand these discrepancies.

Of the homeless needs assessment studies conducted, most have concluded that services related to housing, employment, and food were the most immediate needs of homeless persons, with the desire for permanent homes and employment as the most pressing long-term needs (Ball & Havassy, 1984; DiBlasio & Belcher, 1995).

Few published works have examined gender or ethnic differences in preferences for community services among general populations, and only two have examined such differences among homeless people (Goering, Paduchak, & Durbin, 1990; Roth, Toomey, & First, 1992). Past researchers have suggested that homeless women have needs distinct from those of men (Hagan & Ivanoff, 1988). However, a more recent study by DiBlasio and Belcher found that differences between men and women were not so much a matter of gender as of whether subjects were accompanied by children (DiBlasio & Belcher, 1995). While women were more likely than men to request a variety of services, most of the difference was accounted for by the subgroup of women accompanied by children. Homeless men and women without children exhibited few differences in the types of services they requested, though women showed a greater need for transportation, food, affordable housing, job
The only service that men requested more often than women was alcohol and drug rehabilitation.

**Effective Help-Seeking Behavior: Concordance Between Normative and Perceived Needs**

The research outlined in the preceding section presents convincing support for the claim that factors significantly associated with service utilization can be identified. Notably absent from such studies is any indication of how effectively such services address the actual needs of the homeless client. Service providers have tended to rely more on what they intuitively believe to be the needs of the homeless population, rather than ask the population directly. This tendency contradicts prevailing definitions of “need” in the social sciences. Researchers are in agreement that any conception of the term must acknowledge its dynamic, context-dependent, and subjective nature. An assessment of client needs should, therefore, incorporate the views of both the evaluator and the client (Slade, Phelan, Thornicroft, & Parkman, 1994). In his writings on the topic, Bradshaw introduced a classification system depending on who was labeling the need. A ‘normative need’ is one that experts or scholars feel exists, an ‘expressed need’ is one the client feels exists, a ‘felt need’ is experienced but not expressed, and ‘comparative need’ is one that arises when one sees what others have (Bradshaw, 1994). In this study, the term ‘normative need’ is used to represent service needs that the researcher deems to exist. The term ‘perceived need’ is, in the context of this study, comparable to Bradshaw’s expressed need- it is a service need that the client feels exists.

Padgett’s study was among the first to note a “remarkable disparity between respondents' and interviewers' ratings of need for all types of services” (Padgett et al., 1990). This study found that interviewers ascribing more needs than the interviewees. For example, 22.5% of respondents stated a need for psychiatric services, compared with an estimate of 50.5% made by the interviewers. While medical service needs were reported by 41% of respondents, 54.6% were considered in need of medical services by the interviewers. Similar disparities were found for the ratings of need for and alcohol treatment services.

Few studies have attempted to examine the level of concordance between homeless clients’ and service providers’ assessments of individual needs. In his study comparing clients’ and providers’ perceptions of service needs at treatment centers participating in the Access to Community Care and Effective Services and Supports (ACCESS) program,
Rosenheck compared how clients and outreach workers identified clients’ needs in seven core domains: mental health, general health, substance abuse, public financial support, housing assistance and support, dental care, and employment (Rosenheck & Lam, 1997). The greatest differences between clients’ and providers’ perceptions of service needs were in dental and medical services, which were more frequently identified as needs by clients, and in substance abuse and mental health services, which were more frequently identified by providers. In conclusion, Rosenheck noted that “externally imposed solutions may be more likely rejected than solutions based on a clients preferences” and that differing needs perceptions may, ultimately, result in limited involvement in services (Rosenheck & Lam, 1997).

Research on the level of concordance between provider and client assessments of service needs has been conducted on samples of mentally ill clients using the Camberwell Assessment of Need (CAN). A study by Slade examined the association between the assessments carried out with 49 staff and patient pairs (Slade et al., 1994). The study found that staff and patients rated a similar number of needs, but not in the same areas. Researchers concluded that needs are often assessed differently by staff and patients, though the validity of patient assessments was reinforced by study findings. More specifically, the study revealed that providers and clients displayed greater concordance in the areas of their assessments that corresponded to definable service responses. Overall, the mean kappa coefficient of agreement between staff and patient ratings of needs was 0.34, indicating relative disagreement (scores between 0.4 and 0.6 indicate good agreement levels).

Padgett's group also concluded that part of the underutilization of mental health services by the homeless likely relates to the lack of a perceived need. Subjects interviewed by Padgett indicated awareness of a need for services only half as often as interviewers perceived a need. These findings point toward a need for further research to understand how accurately homeless individuals perceive their own service needs.

The variation in interviewer and interviewee assessments observed in Slade and Padgett’s studies suggest that the level of concordance between perceived and normative service needs may vary from one individual to another. Frequency of help-seeking behavior should not, therefore, presume an accurate identification of what help is truly needed to improve a homeless person’s condition. While a great deal of research has been devoted to
identifying variables that predispose a homeless person to seek services, little is known about how these same variables may impact how effectively such individuals determine their own service needs.
CHAPTER 3

METHODS

Since 1994, HUD has provided support under the Super Notice of Fund Availability (NOFA) program to assist the nation’s homeless population. To gain access to funding, eligible counties must submit a Continuum-of-Care (CoC) plan to HUD. These plans provide the rationale for community requests for funding under a variety of federal programs such as the Supportive Housing Program and the Shelter Plus Care Program. As part of the CoC funding process, HUD has required communities to assess local needs and establish estimates of the number of homeless persons. Starting in 2005, HUD began requiring CoCs to conduct a Point-in-Time Count (PITC) of sheltered and unsheltered homeless persons on a single night in January at least once every two years. Counts of unsheltered homeless persons have taken many different approaches. Most recently, San Diego’s Regional Taskforce (RTFH) on the Homeless has organized and overseen the appointment of teams of enumerators to canvass every street in the jurisdiction.

STUDY DESIGN

In conjunction with the 2009 annual PITC of San Diego’s unsheltered homeless population, researchers at the San Diego State University Institute for Public Health (IPH) partnered with the Regional Taskforce on the Homeless (RTFH) to carry out the Homeless Street Characteristics Survey at a number of locations throughout the county. The survey was administered at various service access points throughout San Diego County. Individuals were asked to participate in the survey only if they confirmed that they had slept on the street the night before, and informed consent was obtained from each survey participant. The collection of this data with the RTFH was reviewed and approved by the SDSU Institutional Review Board (IRB).

DEMOGRAPHICS

For the purpose of these interviews, the research definition of a “street homeless” individual was someone who spent the previous night in a place not meant for human
habitation (such as a car, garage, public building or rural area). The interviews were conducted with a convenience sample of street homeless individuals found at various service provider locations throughout San Diego.

All potential participants were asked several screening questions at the start of the survey to determine eligibility. Screening questions were intended to eliminate any individuals who (1) completed the interview already this year, (2) were under the age of 18, (3) did not provide consent, and (4) did not spend the night prior to the interview on the street. If the respondent did not meet these criteria the survey was not completed. Any screening question data for non-eligible candidates was destroyed. In addition, potential study subjects deemed unable to understand the consent process or mentally unable to process the information for any reason were not interviewed. In return for participation in the study, all homeless individuals received a gift certificate for a meal at a popular fast-food chain whether or not they completed the interviews.

Between January 13, 2009 and February 26, 2009, trained volunteers collected 305 interviews from ‘street’ homeless persons encountered at seventeen locations located across San Diego County (North County, North County Inland, Central San Diego, East County, South Bay). In total, 302 completed surveys met all eligibility requirements for inclusion in analysis. Three surveys were excluded because the individual was not sleeping on the street the night before. An additional 17 surveys were excluded from analysis because they were missing data necessary for analysis.

**STREET CHARACTERISTICS SURVEY DESCRIPTION**

The interview questionnaire, called the Street Characteristic Survey, was designed to capture both quantitative and qualitative data from participating homeless individuals. The survey instrument was based on models from similar studies and contained no psychometric or standardized measures. Questions focused instead on basic demographics, military service, living situation, marital status, reasons for living in San Diego, length and description of homelessness, employment, income sources, education, health status, drug use, self-rating of health status, HIV status, service usage, perceived reasons for being homeless, services needs, service usage and if they have been a victim of violence. All survey items
were self-report and surveys were conducted in English. The surveys contained no identifying information and were therefore anonymous.

The RTFH coordinated the training for and administration of the in-depth interviews. During the training, volunteer interviewers were familiarized with the survey instrument and basic guidelines for conducting interviews with the target population. Information about obtaining informed consent was provided by the IPH. Interviewers were trained not to approach persons who appear to be sleeping or impaired. After gauging the respondent’s ability to respond and checking for signs of intoxication such as slurred speech, interviewers were instructed to ask participants to read the consent portion of the form, and to explain the consent form using simple language. Signatures were collected only from those subjects who clearly understood the consent and interview process although signatures could be waived by the subject while still providing consent. Furthermore, interviewers were instructed to assure all respondents that participation was optional and could be withdrawn at any moment.

**MISSING DATA**

Any participants with data missing from one of the analyzed variables were not included in the analysis. This resulted in the exclusion of 17 completed surveys from the study population.

**DEFINING THE “CONCORDANCE” OUTCOME VARIABLE**

The outcome of interest in this study was a composite variable created to measure the degree of concordance survey participants exhibited between their Normative service needs and their perceived service needs. This “Concordance” variable was calculated using SPSS software to analyze participant responses to the Street Characteristics survey questions. Determining the Concordance variable was a three-step process requiring the creation of two sets of variables: one measuring the participants’ “Normative” service needs, the another measuring participants’ “Perceived” service needs. The relevant survey questions used in defining the population’s normative needs are provided in Table 1.

**Defining the “Normative Need” Variables**

Prior to defining the “Normative Need” variables, it was necessary to gain a sense of how this study population prioritized available services. To see which homeless services
Table 1. Definition and of the “Normative Need” Variable for Housing, Employment, Medical Services, Job Training/Educational Opportunities, and Drug Treatment/Detox

<table>
<thead>
<tr>
<th>“Normative” Need Domain</th>
<th>Definition</th>
<th>Survey Questions¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>Any potential survey takers who were not homeless were screened prior to the interview. All participants were, therefore, deemed to have a normative need for housing.</td>
<td>Screening Question B: Are you Homeless?</td>
</tr>
<tr>
<td>Employment</td>
<td>Participants’ responses to questions related to employment status and current monthly income were analyzed. Those who reported no employment OR a monthly income below the national poverty wage ($874 per month) were considered to have a normative need for employment.</td>
<td>Q20: Are you working? Q23: Current Monthly Income:²</td>
</tr>
<tr>
<td>Medical Care</td>
<td>Those participants who reported having a long-lasting medical physical condition OR being HIV positive OR receiving health care at a shelter, urgent care, emergency room (rather than a regular source of care) OR having no source of care, were deemed to have a normative need for medical services.</td>
<td>Q26a: Do you think you have, or has anyone ever diagnosed you with having a serious long-term medical/physical condition? Q27a: What is your HIV status? Q30: Where do you get healthcare?³</td>
</tr>
<tr>
<td>Job Training/Education</td>
<td>Any participants having less than GED/HS diploma OR reporting zero income OR no employment were determined to have a normative need for job training/education.</td>
<td>Q25: What is the highest level of education you have completed?⁴</td>
</tr>
<tr>
<td>Drug Treat/Detox</td>
<td>Participants citing awareness of or past diagnosis with drug or alcohol addiction OR reporting current substance use were deemed in need of drug treatment services.</td>
<td>Q26c: Do you think you have, or has anyone ever diagnosed you with having alcohol or drug abuse/addiction? Q28: Any current substance use?</td>
</tr>
</tbody>
</table>

¹ Responses were categorized: 1=Yes (has “normative” need in this domain), 0=No (does not have a “normative” need in this domain).
² This question was not Yes/No and responses were dichotomized into an Employment Normative need variable: >$874 per month (No=0), $874 per month and below (Yes=1).
³ This question was not Yes/No and responses were dichotomized a Medical Services Normative need variable: Those receiving care at a health clinic (No=0); Those receiving healthcare at a shelter, urgent care, ER, or with no source of care (Yes=1).
⁴ This question was not Yes/No and responses were dichotomized into a Job Training/Education Normative need variable: Those with a GED and any higher education (No=0); Those with less than a GED (Yes=1).
were most desired, frequency analyses were run of participants’ responses to the survey question “What would it take for you to stop being homeless?” Among the most frequently cited needs of the study population were: housing (67%), food (48%), shower facilities (48%), laundry service (42%), employment (35%), and medical services (27%) (see data in Chapter 4). For the purposes of this study, needs considered to be short-term (food, shower, restroom, etc) were excluded in favor of longer-term service needs (housing, employment, medical care). The long-term service needs frequently given by the study participants closely echoed those expressed by homeless persons in past studies on desired services: housing, employment, medical care, job training, education. These same four domains predominated in past attempts to question homeless populations about their service needs (DiBlasio & Belcher, 1995; Linn & Gelberg, 1989). In addition to these four domains, the need for “drug treatment/detox” (indicated by 23% of participants) was included in the analysis due to the high prevalence of substance abuse and dual diagnosis in this population, as well as the availability of analyzable data from the survey questions.

Once the five “Normative Need” domains were selected for analysis (housing, employment, medical services, job training/educational opportunities, and drug treatment/detox) participants’ responses to relevant survey questions were assessed to determine which of the five needs each person exhibited (see Table 1 (p. 43) for details). Each participant provided data pertaining to his housing, employment status and income, physical and mental health, level of education, and history of substance abuse. Based on this information, each individual was given a score of either “1” (yes, individual has a Normative need in this domain) or “0” (no, individual does not have a Normative need in this domain) for each of the five need domains. This process resulted in each member of the study population having a score of either 1 or 0 (except for housing, for which all participants had a Normative need and received a ‘1’) for each of the identified Normative Needs. Depending on their survey data, some persons had as many as five Normative Needs, whereas some had as few as 1 (housing).

**Defining the “Perceived Need” Variables**

The “Perceived Need” variables were based solely on each participant’s response to one survey question (Q32): What would it take for you to stop being homeless? This question
provided a long checklist of available services and participants were instructed to check any services they perceived as meeting their unique set of needs (see data in Chapter 4 for complete list). Many of the services would potentially have met each participant’s unique set of 1-5 normative service needs (affordable or transitional housing, employment services, medical services, job training/educational opportunities, and drug treatment/detox services). Again, a Perceived Need variable was determined for each of the five domains, based one which, if any, of the five services the participants checked off on his survey. A score of ‘1’ was given to those members of the population who checked ‘Yes’ to services that would meet one of the five Normative Need domains; A score of ‘0’ was given to those members of the population who checked ‘No’ or gave no response to these services. At the end of this step each member of the population now had a score of either ‘1’ (individual perceived needing services in this domain) or ‘0’ (individual does not perceive needing services in this domain) for each of the five need domains being analyzed. An individual who did not indicate a need for services related to housing, employment, medical care, education/job training, or drug treatment would have five zeroes for their Perceived Need Variables. Conversely, an individual who indicated a need for services to all five need domains would have a score of “1” for each of the five Perceived Need variables.

**Defining the Outcome Variable: “Concordance” between Normative and Perceived Needs**

Finally, a dichotomous “Concordance” variable determined if the client exhibited agreement between the Normative and Perceived Need variables. For example, a participant who did not report any past drug/alcohol addiction or current substance abuse in survey question 26c or 28 (Normative Need = ‘No’), and also did not indicate a need for detox services in response to question 32 (Perceived need= ‘No’), displayed concordance and would receive a score of “1” for Concordance in the Substance Abuse need domain. Alternatively, an individual who reported past diagnosis with a serious long-term physical condition or no source of healthcare (Normative need= ‘Yes’), but did not indicate a need for Medical Services in his response to question 32 (Perceived need= ‘No’) would receive a score of “0” for Concordance in the Medical Services need domain. Each client received a score from 0 to 5 based on the number of domains in which he displayed concordance between the Normative and Perceived Need variables.
The outcome variable was initially scaled zero to five (for each of the five needs examined). However, due to data constraints, the Concordance variable was collapsed into three categories: low (concordance in 0-1 Normative and Perceived needs), fair (concordance in 2-3 Normative and Perceived needs), and high (concordance in 4-5 Normative and Perceived needs).

Table 2 outlines the process of defining the Normative Need, Perceived Need, and Concordance variables for a single participant. The data presented in the table is based on hypothetical survey responses.

The relationships between five demographic factors and the Concordance outcome variable were assessed for significance. These factors were selected because they have been identified as having some effect on service accessing behavior based on research findings outlined in Chapter 2, as well as the availability of analyzable survey data. The following factors (Table 3) were included in the analysis: history of service accessing, chronic homelessness, gender, race category, and veteran status.

**Statistical Analysis**

Completed surveys were delivered to the IPH for data entry into an Access database created by IPH staff. SPSS 17.0 statistical software was used to carry out the initial analytic steps. The first step in the data analysis was the computation of the Concordance outcome variable. The research question was first assessed thorough descriptive univariate analyses to gain a better picture of the study population. Bivariate analyses were carried out to determine if any significant associations could be identified between the outcome variable and the factors in the model.

For the second stage of analysis, SAS 9.1 software was used to perform ordinal logit analysis. Two logit models were fitted through stepwise regression model building: one for the probability of low versus fair/high concordance between Normative and perceived needs, and another for the probability of low/fair concordance versus high concordance. All main effect terms, as well as those interaction terms deemed applicable based on findings in literature review, were tested in arriving at the most parsimonious model. The significance of each new term was assessed using GLH tests. Terms found to be significant at the 95% confidence level remained in the model, while all others were removed. The significance of
Table 2. Defining the Normative Need, Perceived Need, and Concordance Variables Based on a Hypothetical Set of Street Characteristics Survey Data Fixed Factors and Covariates

<table>
<thead>
<tr>
<th>Need Domain</th>
<th>“Normative Need” Variable</th>
<th>Score</th>
<th>“Perceived Need” Variable</th>
<th>Score</th>
<th>Concordance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Survey Question</strong></td>
<td><strong>Response</strong></td>
<td><strong>Score</strong></td>
<td><strong>Survey Question:</strong></td>
<td><strong>Response</strong></td>
<td><strong>Concordance Score</strong></td>
</tr>
<tr>
<td>Housing</td>
<td>Screening Question B Yes</td>
<td>1</td>
<td>Affordable Housing</td>
<td>Checked ‘Yes’</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Q20: Are you working?</td>
<td></td>
<td></td>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Q23: Current Monthly</td>
<td></td>
<td></td>
<td>Income:</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment</td>
<td>Q26a: Serious long-term</td>
<td></td>
<td>Medical Services</td>
<td>Checked ‘Yes’</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>medical condition? Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Q27a: HIV status?</td>
<td></td>
<td></td>
<td>Negative</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Q30: Source of healthcare</td>
<td>ER</td>
<td>Job training/ Ed.</td>
<td>Checked ‘No’</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Opportunities</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Q25: Highest level of</td>
<td>0</td>
<td>Drug Treatment</td>
<td>No Response</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>education completed?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Some College</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Q26c: Suspected/diagnosed</td>
<td></td>
<td></td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>alcohol or drug abuse?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Q28: Any current</td>
<td></td>
<td></td>
<td>Yes</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>substance use?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Concordance Score 3
Concordance Category Fair
Table 3. Name and Description of Outcome Variables and Factors Used in Analysis

<table>
<thead>
<tr>
<th>Variable Type</th>
<th>Variable Name</th>
<th>Description</th>
</tr>
</thead>
</table>
| Outcome         | Concordance         | Concordance Variable Score  
|                 |                     | 0-1 assessed: “low”  
|                 |                     | 2-3 assessed: “fair”  
|                 |                     | 4-5 assessed: “high”  |
| Factor          | History Service Access | Does this individual show a history of service accessing behavior? |
|                 | Chronic Homeless    | Chronic Homelessness:  
|                 |                     | >1 yr or >4 periods in 3 past years  
|                 |                     | Not living as couple/married  
|                 |                     | Not living with child <18 yrs  
|                 |                     | Long-term disabling condition  |
| Factor          | Gender              | Male, Female  |
| Factor          | Race                | Race Category (dichotomized)  |
| Factor          | Veteran Status      | Is this person a war veteran?  |

The resulting parsimonious model was determined by comparing -2 Log Likelihood values for the null versus final model to determine the test statistic and p value. The point estimates from the final model regression statistics were applied to the logit models to obtain odds ratios addressing the research question.
CHAPTER 4

RESULTS

Between January 13, 2009 and February 26, 2009, trained volunteers collected 305 interviews from ‘street’ homeless persons encountered in various locations. In total, 302 completed surveys met all the screening requirements. An additional 17 surveys were excluded from analysis due to missing data, leaving a study population of 287 individuals.

Univariate analysis revealed a study population that is predominantly male (78%) and White (67%) (Table 4). The majority of the participants fall between the ages of 25 and 50 years (58%). Roughly one in five participants (21%) is a veteran. A sizeable minority of the population is considered chronically homeless (29%). The most frequently reported racial minority is African American (17%), followed by Mixed/Multi-Racial (6%). The majority (64%) of participants reported some history of service accessing.

Data for the Perceived needs variable were collected from survey question 32, which asked the participants to indicate, from a list of available resources, which services they would require to stop being homeless. Participants were told to mark “Yes” or “No” and were encouraged to check as many services as they deemed necessary. The most frequently indicated Perceived needs of the population were affordable housing (67%), transitional housing (37%), and employment (35%) (Table 5). Many of the most commonly stated services needs were considered immediate, short-term needs such as food (48%), shower facilities (48%), laundry services (42%), public toilets (40%). Short-term needs were not considered in this study because they tend to be symptoms of homelessness, rather than the root cause of an individuals’ homelessness or his most significant barrier to becoming housed. In addition to housing and employment, other recurring long-term service needs were: medical services (27%), job training (40%), transportation (41%), and educational opportunities (34%). Included in Table 5 is a univariate analysis of Perceived service needs among the subset of chronically homeless individuals in the study population. Although chronically homeless persons indicated, on the whole, more service needs when compared to the larger study population, they prioritized their needs much like their non-chronically
Table 4. Demographic Characteristics of Street Survey Participants (n = 287)

<table>
<thead>
<tr>
<th>Demographic Characteristic</th>
<th>Category</th>
<th>Number</th>
<th>Percent of Responders</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>225</td>
<td>78%</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>62</td>
<td>22%</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td>White/Caucasian</td>
<td>191</td>
<td>67%</td>
</tr>
<tr>
<td></td>
<td>African American</td>
<td>48</td>
<td>17%</td>
</tr>
<tr>
<td></td>
<td>Mixed/Multi-Race</td>
<td>17</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>American Indian</td>
<td>13</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>Asian Pacific Islander</td>
<td>9</td>
<td>3%</td>
</tr>
<tr>
<td></td>
<td>Other ^2</td>
<td>9</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Age Group</strong></td>
<td>Young Adults (18-24)</td>
<td>45</td>
<td>16%</td>
</tr>
<tr>
<td></td>
<td>Adults (25-50)</td>
<td>161</td>
<td>58%</td>
</tr>
<tr>
<td></td>
<td>Older Adults (51-61)</td>
<td>67</td>
<td>24%</td>
</tr>
<tr>
<td></td>
<td>Seniors (62+)</td>
<td>5</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Veteran</strong></td>
<td>Yes</td>
<td>61</td>
<td>21%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>226</td>
<td>79%</td>
</tr>
<tr>
<td><strong>Self-Reported History of Service of Accessing</strong></td>
<td>Yes</td>
<td>185</td>
<td>64%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>102</td>
<td>36%</td>
</tr>
<tr>
<td><strong>Chronically Homeless ^2</strong></td>
<td>Yes</td>
<td>84</td>
<td>29%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>203</td>
<td>71%</td>
</tr>
</tbody>
</table>

^1 Other includes (verbatim): non specified (8 persons), Indian (1 person).

^2 According to the HUD Definition
Table 5. Univariate Analysis of Participants’ Perceived Service Needs: Responses to Survey Question “What Would It Take for You to Stop Being Homeless?” Street Characteristic Survey, 2009 (n=302)

<table>
<thead>
<tr>
<th>Response Categories</th>
<th>Frequency 'Yes'</th>
<th>Percent 'Yes'</th>
<th>Chronically Homeless (n=84)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordable Housing</td>
<td>191</td>
<td>67%</td>
<td>59 (70%)</td>
</tr>
<tr>
<td>Food</td>
<td>137</td>
<td>48%</td>
<td>56 (67%)</td>
</tr>
<tr>
<td>Shower Facilities</td>
<td>136</td>
<td>48%</td>
<td>51 (61%)</td>
</tr>
<tr>
<td>Laundry Services</td>
<td>120</td>
<td>42%</td>
<td>47 (56%)</td>
</tr>
<tr>
<td>Transportation</td>
<td>118</td>
<td>41%</td>
<td>46 (55%)</td>
</tr>
<tr>
<td>Public Toilets</td>
<td>114</td>
<td>40%</td>
<td>46 (55%)</td>
</tr>
<tr>
<td>Job Training</td>
<td>115</td>
<td>40%</td>
<td>40 (48%)</td>
</tr>
<tr>
<td>Transitional Housing</td>
<td>106</td>
<td>37%</td>
<td>45 (54%)</td>
</tr>
<tr>
<td>Employment/Job</td>
<td>100</td>
<td>35%</td>
<td>34 (41%)</td>
</tr>
<tr>
<td>Mail Services</td>
<td>97</td>
<td>34%</td>
<td>41 (49%)</td>
</tr>
<tr>
<td>Educational Opportunities</td>
<td>98</td>
<td>34%</td>
<td>37 (44%)</td>
</tr>
<tr>
<td>Help Applying for AID (General Relief, SSI, etc.)</td>
<td>86</td>
<td>30%</td>
<td>40 (48%)</td>
</tr>
<tr>
<td>Medical Services</td>
<td>77</td>
<td>27%</td>
<td>39 (46%)</td>
</tr>
<tr>
<td>Dental Services</td>
<td>78</td>
<td>27%</td>
<td>29 (35%)</td>
</tr>
<tr>
<td>Referrals/Info.</td>
<td>75</td>
<td>26%</td>
<td>36 (43%)</td>
</tr>
<tr>
<td>Case Management</td>
<td>74</td>
<td>26%</td>
<td>31 (37%)</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>54</td>
<td>19%</td>
<td>25 (30%)</td>
</tr>
<tr>
<td>Legal Services</td>
<td>48</td>
<td>17%</td>
<td>28 (33%)</td>
</tr>
<tr>
<td>Relocation Services</td>
<td>41</td>
<td>14%</td>
<td>21 (25%)</td>
</tr>
<tr>
<td>Drug Treatment/Detox</td>
<td>41</td>
<td>14%</td>
<td>19 (23%)</td>
</tr>
<tr>
<td>Childcare/Family Services</td>
<td>19</td>
<td>7%</td>
<td>4 (5%)</td>
</tr>
<tr>
<td>HIV Services</td>
<td>17</td>
<td>6%</td>
<td>8 (10%)</td>
</tr>
<tr>
<td>Domestic Violence Services</td>
<td>15</td>
<td>5%</td>
<td>5 (6%)</td>
</tr>
<tr>
<td>Ex-Offender Services</td>
<td>13</td>
<td>5%</td>
<td>8 (10%)</td>
</tr>
<tr>
<td>Foster Care</td>
<td>4</td>
<td>1%</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>Other^2</td>
<td>5</td>
<td>1%</td>
<td>4 (5%)</td>
</tr>
</tbody>
</table>

1 Nonresponses were considered to be a “No” response. Percents are valid percents.
2 Other includes: homeless by choice, renew truckers license, a truck, place to hang out during day, used any in lakeside area, declined.
homeless counterparts. Chronically homeless participants’ responses differed most significantly from the rest of the population with regard to medical services (46% of chronically homeless versus 27% of entire study population), referrals (43% of chronically homeless versus 26% of entire study population), and legal services (33% of chronically homeless versus 17% of entire study population).

The calculation of the Normative service needs variable is outlined in detail in Chapter 3 (Table 1, p. 43). Using findings from past studies on service accessing behavior of homeless populations, as well as data from relevant survey questions, five Normative Need domains were selected for analysis. Univariate analysis of the frequency with which members of this study population exhibited each of these normative needs is provided in Table 6.

Table 6. Univariate Analysis of Participants’ Normative Service Needs, StreetCharacteristic Survey, 2009 (n=287)

<table>
<thead>
<tr>
<th>Normative Service Needs</th>
<th>Sample Size: No. Responding</th>
<th>Percent 'Yes'</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>287</td>
<td>100%</td>
</tr>
<tr>
<td>Employment</td>
<td>264</td>
<td>93%</td>
</tr>
<tr>
<td>Medical Services</td>
<td>149</td>
<td>52%</td>
</tr>
<tr>
<td>Drug Treatment/Detox</td>
<td>149</td>
<td>52%</td>
</tr>
<tr>
<td>Job Training/Educational Opportu</td>
<td>96</td>
<td>35%</td>
</tr>
</tbody>
</table>

All participants were screened prior to completion of the survey to ensure that they were, in fact, homeless. It follows that 100% (n=287) of this study sample would be considered to have a normative need for housing services. Based on participants’ responses to survey questions pertaining to their employment status and monthly income (Appendix for complete survey), 93% (n=264) of the population had a normative need for employment services. Data on serious, long-term medical conditions, as well as source of medical care, were used to conclude that 52% (n=149) of the population had a normative need for medical services. Participants’ responses to survey questions related to past or current substance abuse and addiction indicated that 52% (n=149) of the sample population exhibited a normative need for drug treatment/detox services. Finally, data collected from participants about their level of educational attainment suggested that 35% (n=96) of the population had a normative need for job training or educational opportunities.
Table 7 breaks down the need domains in terms of the most concordance participants’ demonstrated between normative and perceived needs. Housing has the highest percent concordance (65%), whereas only 17% of participants were able to match their normative and perceived need for drug treatment services.

Table 7. Univariate Analysis of Participants’ Normative Service Needs by Percent Concordance, Street Characteristic Survey, 2009 (n=287)

<table>
<thead>
<tr>
<th>Normative Service Needs</th>
<th>Percent Normative Need</th>
<th>Percent Perceived Need</th>
<th>Percent Concordant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>100%</td>
<td>67%</td>
<td>65%</td>
</tr>
<tr>
<td>Job Training/Educational Opportunities</td>
<td>35%</td>
<td>51%</td>
<td>42%</td>
</tr>
<tr>
<td>Employment</td>
<td>93%</td>
<td>35%</td>
<td>30%</td>
</tr>
<tr>
<td>Medical Services</td>
<td>52%</td>
<td>27%</td>
<td>51%</td>
</tr>
<tr>
<td>Drug Treatment/Detox</td>
<td>52%</td>
<td>14%</td>
<td>18%</td>
</tr>
</tbody>
</table>

Bivariate analysis confirmed that, within the study population, most survey participants displayed low concordance between their Normative and perceived service needs (60%) (Table 8). Only a small proportion of the population was able to display high concordance between normative and perceived service needs (7%). Among the individual-level factors considered in the analysis, only history of service accessing and chronic homelessness were significantly associated with the concordance variable. Both factors, being chronically homeless and having a history of service accessing, proved to be associated with demonstrating higher concordance between normative and perceived service needs. Variability in low, fair, or high concordance category was not significantly associated with gender, race, or veteran status.

The logistic regression analysis reveals that, adjusting for gender, veteran status, and race, there is a significant association between history of service accessing and chronic homelessness and the level of concordance a participant displays between normative and perceived service needs (Table 9). Those individuals with some history of service seeking are 4.519 (95% CI 2.524-8.089) times more likely than those with no history to exhibit a high level of concordance (versus low or fair level) in their needs assessment. Similarly, chronically homeless individuals are 3.952 (95% CI 2.276-6.864) times more likely than to exhibit a high level of concordance (versus low or fair level) in their needs assessment those
Table 8. Bivariate Analysis of the Relationship between Demographic Factors and Concordance between Normative and Perceived Service Needs, Street Characteristic Survey Participants (n =287)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Category</th>
<th>Concordance</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Low n (%)</td>
<td>Fair n (%)</td>
<td>High n (%)</td>
<td></td>
<td>P value</td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
<td>133 (59%)</td>
<td>76 (34%)</td>
<td>16 (7%)</td>
<td></td>
<td>0.6335</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>33 (53%)</td>
<td>25 (40%)</td>
<td>4 (7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>White/Caucasian</td>
<td>113 (59%)</td>
<td>65 (34%)</td>
<td>13 (7%)</td>
<td></td>
<td>0.8135</td>
</tr>
<tr>
<td></td>
<td>Other 2</td>
<td>53 (55%)</td>
<td>36 (38%)</td>
<td>7 (7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veteran</td>
<td>Yes</td>
<td>38 (62%)</td>
<td>20 (33%)</td>
<td>3 (5%)</td>
<td></td>
<td>0.6503</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>128 (57%)</td>
<td>81 (36%)</td>
<td>17 (8%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Reported History of Service of Accessing</td>
<td>Yes</td>
<td>83 (45%)</td>
<td>87 (47%)</td>
<td>15 (8%)</td>
<td></td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>83 (81%)</td>
<td>14 (14%)</td>
<td>5 (5%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronically Homeless</td>
<td>Yes</td>
<td>31 (37%)</td>
<td>38 (45%)</td>
<td>15 (18%)</td>
<td></td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>135 (67%)</td>
<td>63 (31%)</td>
<td>5 (3%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>166 (60%)</td>
<td>101 (33%)</td>
<td>20 (7%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 Concordance outcome variable categories collapsed for ease of analysis (Low=0-1 needs assessed; Fair=2-3 needs assessed; High=4-5 needs assessed).

* Significant at the p<0.01 level.
Table 9. Logistic Regression of Demographic Factors Associated with a High Level of Concordance between Participants’ Normative and Perceived Service Needs (n =287)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Category</th>
<th>Odds Ratio</th>
<th>95% CI of Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Male</td>
<td>1.0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>0.703</td>
<td>0.382-1.295</td>
</tr>
<tr>
<td>Race</td>
<td>White</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>0.972</td>
<td>0.567-1.665</td>
</tr>
<tr>
<td>Veteran</td>
<td>No</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>1.604</td>
<td>0.843- 3.053</td>
</tr>
<tr>
<td>Self-Reported History of Service Accessing</td>
<td>No</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>4.519</td>
<td>2.524-8.089*</td>
</tr>
<tr>
<td>Chronically Homeless</td>
<td>No</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>0.3952</td>
<td>2.276-6.864*</td>
</tr>
</tbody>
</table>

1 Indicates reference category for categorical variables.
* Significant at the p<0.01 level.

A series of multinomial ordinal logit models were fitted to assess the relationship between the polychotomous concordance variable and a set of factors (Table 10). All main effect and interaction variables relevant to the research question were entered, stepwise, into the model. Statistically insignificant variables were removed until the most parsimonious model was reached. The inclusion of potentially confounding interaction terms in the model did not noticeably alter regression coefficient values for significant main effect variables. Since the model parameters for significant main effect variables remained stable from one model to the next, the presence of confounding variables was unlikely and the insignificant interaction terms were removed from the model.

The results of the ordinal logistic regression revealed that only history of service use and chronic homelessness were significantly associated (at the 5% level) with the level of concordance participants’ exhibited between normative and perceived needs. Those participants with some history of service use had 4.566 (95% CI 2.551-8.130) greater odds than those with no history of use of exhibiting high versus poor or fair concordance in their
Table 10. Ordinal Regression of Demographic Factors Associated with a High Level of Concordance between Participants’ Normative and Perceived Needs (n = 287)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Category</th>
<th>Odds Ratio</th>
<th>Odds Ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Service Use</td>
<td>No</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>4.566</td>
<td>2.551-8.130</td>
</tr>
<tr>
<td>Chronically Homeless</td>
<td>No</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>3.496</td>
<td>2.057-5.952</td>
</tr>
</tbody>
</table>

needs assessments. Chronically homeless participants had 3.496 (95% CI 2.057-5.952) greater odds than those who were not chronically homeless of exhibiting high versus poor or fair concordance in their needs assessments. None of the interaction terms associated with these variables were significant.
CHAPTER 5

DISCUSSION

The purpose of this study was to identify variables significantly associated with effective help-seeking behavior among San Diego’s street homeless population. Heightened interest in homelessness research in recent decades has expanded our understanding of the causes and nature of this persistent social crisis. Though the scope of needed services and barriers to service use have been examined, conclusions were drawn almost exclusively from the perspective of service providers. Among those studies attempting to determine service needs according to homeless individuals themselves, little effort has been made to determine how effectively homeless individuals identify their own service needs. Improving intervention outcomes requires not only expanding the body of available services, but also ensuring that services be utilized by the appropriate target population.

This study used data from the 2009 San Diego RTFH Street Characteristics Survey to identify individual-level factors that are significantly associated with a homeless persons’ ability to display concordance between normative and perceived service needs. Gaining insight into the determinants of effective help-seeking behavior allows providers to tailor outreach efforts to better suit the diverse needs of the homeless population.

Data from 287 surveys were analyzed to address the research question (see Appendix for complete Street Characteristics survey). Participants’ responses to survey questions were used to establish five service need domains: housing, employment, education, health, and drug treatment/detox. A composite ‘Concordance’ outcome variable was computed to assess the degree of concordance participants displayed in matching their normative service needs with a list of available resources. In order to receive a high concordance score, participants’ needed to demonstrate agreement between their normative service needs and the services they desired.

Univariate analyses revealed a study population dominated by White males between the age of 25 and 50, with a relatively high proportion of veterans and chronically homeless persons. Demographically, this study population falls into the same pitfall as most homeless
research: a paucity of female and racial minority participants. Although women comprise nearly a third of the national (and over a third of San Diego County’s) homeless population, only 62 (22%) of the study participants were female. The predominance of males in the study population is most likely due to the sampling locations selected for survey distribution. The surveys were administered at service locations such as soup kitchens and community resource centers, locations generally dominated by males, so a disproportionately small number of women were recruited. Past research demonstrated that, when asked about their service needs, women’s responses tend to differ from those of their male counterparts (Hagan & Ivanoff, 1988). More recent findings suggest that these discrepancies may be contingent on the presence of dependent children and not solely gender (DiBlasio & Belcher, 1995). The findings from this study are likely biased toward those services preferentially indicated by men (such as drug treatment, emergency shelters), and fail to accurately represent the service needs of homeless women (such as domestic violence services, foster care, and family services). Employing a non-random, stratified sampling technique for future studies would eliminate this bias.

This study’s racial distribution (67% White, 18% African American) was an accurate reflection of San Diego County’s homeless population (60% White, 18% African American). A greater proportion of the study sample fit the description of chronically homeless than is seen in the homeless population nationally (29% in this study versus approximately 20% of the US homeless population). Over 20% of the study population was veterans, compared to 33% of homeless males nationwide, and just eight percent of the domiciled US population. Overall, only 20 participants (7%) exhibited a high level of concordance between normative and perceived service needs, and over half (60%) exhibited low concordance between normative and perceived service needs.

Bivariate analyses were carried out to determine significant associations between the outcome variable and five variables: gender, race, veteran status, chronic homelessness, and history of service accessing. Among the set of variables, only history of service accessing and chronic homelessness were significantly associated with the level concordance between participants’ normative and perceived service needs. Finally, two logit models were fitted through stepwise regression model building to simultaneously assess the relationship between the Concordance variable and five factors: one modeling the probability of low
versus fair/high concordance, and another modeling the probability of a low/fair concordance versus high concordance.

The results of the final regression model reveal that only history of service use and chronic homelessness were significantly associated with the level of concordance participants’ exhibited between normative and perceived needs. Those participants with some history of service use had $4.566$ (95% CI 2.551-8.130) greater odds than those with no history of use of exhibiting high versus poor or fair concordance in their needs assessments. Chronically homeless participants had $3.496$ (95% CI 2.057-5.952) greater odds of than those who were not chronically homeless of exhibiting high versus poor or fair concordance in their needs assessments.

Previous studies have demonstrated that persons with a history of service accessing are more likely to seek help again (Bonin et al., 2007; Padgett et al., 1990). This study expands upon these findings by suggesting that individuals with a past history of service use identify their service needs more effectively than those with no history of service use. Service accessing does not, therefore, appear to be a random act. Rather, there may be an identifiable “type” of person who views service accessing as meaningful and worth the effort, and selectively accesses those services that benefit them most. Perhaps the most important implication of this finding is that the opposite phenomenon may also be at work: those homeless individuals who are least likely to access the service system may be the least capable of helping themselves and the most in need of assistance. Although these findings provide evidence of a significant correlation between history of service accessing and a high level of concordance between normative and perceived needs, it does not give any indication of the direction of this relationship. It is equally possible that those persons who are able to accurately identify their service needs are the most likely to have sought out these services in the past.

Findings from the literature review indicate that the role of chronicity in shaping help-seeking behavior among homeless individuals is not well understood. Chronically homeless persons, by definition, experience cyclical bouts of homelessness, rely heavily on the service system, suffer disproportionately from mental and physical ailments, and to have a high burden of substance abuse (National Alliance to End Homelessness, 2010). The results of this study suggest that some segment of this population is able to perceive their service
needs with relative accuracy. That these persons should exhibit a higher level of concordance between their normative and perceived service needs, yet fail to adequately address the cause of their homelessness, may be explained by several factors.

- Many chronically homeless individuals may have had sufficient previous exposure to the service system to understand what services are available in their area. Given their longer period of homelessness, these individuals may be more adept in obtaining assistance; they are likely to have more experience negotiating life on the street and navigating between locations.

- Past encounters with case managers over the course of their homelessness may have provided them with insight into their service needs. Due to the constellation of physical, mental, and substance abuse issues that plague this population, the barrier to progress may be an inability to follow through with recovery plans rather than an inability to identify which services to access in the first place.

- Many chronically homeless individuals suffer from long-term physical conditions that require vigilant health maintenance. Rather than treating their symptoms chronically, this population tends to persistently address acute pain by accessing emergency rooms and urgent care with great frequency (Salit et al., 1998). In the case of acute pain, the need for medical services is concrete and the appropriate service channel is easily identifiable and accessible (ER, urgent care). Accurately indicating a need for medical services, was, in the case of many chronically homeless persons, a given.

- Compared to non-chronically homeless, the needs of the chronically homeless tend to be broad and rather glaring. The service needs of a healthy, capable, educated individual who is situationally homeless may be less readily apparent than a chronically homeless person who lacks education and job training, suffers from poor mental or physical health, or has been diagnosed with substance abuse. The chronically homeless person is likely to have a broader spectrum of normative service needs and discerning between normative and perceived service needs is, therefore, more straightforward.

The chronically homeless are often portrayed negatively for being financially burdensome, living off the service system, and disproportionately sapping limited resources. While this may be true, unlike those homeless individuals who do not voluntarily access services or are unable to discern which services they need the most, chronically homeless persons access the system (Tam et al., 2008) and, per this study’s findings, are more likely than other homeless persons to access through channels that meet normative service needs. The potential for effective interventions to result in normative progress for this subpopulation is significant.

One clear conclusion of this research is that the onus for intervention lies not only on the homeless client, but also on the service provider. The participants in this study generally
displayed a low level of concordance between normative and perceived needs, suggesting that many are not well suited to be the architects of their own recovery from homelessness.

Additionally, homelessness persists even among those who exhibited higher concordance in assessing their needs. What, then, can be said about the efficacy of our current approach to service provision?

**Implications for Policy**

Two decades of increased interest from the fields of social science and public health has given rise to a number of perspectives on how best to prevent homelessness and effectively intervene once it occurs. The findings from this study lend support to a few of these approaches, while drawing other current strategies into question. In particular, those strategies espousing a “no door is the wrong door” approach to service delivery, in contrast to centralized specialty services or fragmented disparate services, appear promising. There is also a clear need for outreach and case management interventions that aim to draw homeless persons into the services system and monitor their progress. Fragmented, stepwise systems of delivery, such as those embodied by many regional HUD-designated Continuums of Care (CoC), warrant reconsideration.

Despite the efforts of public and private organizations to streamline CoC service delivery, recent evaluations of 25 CoCs revealed that many communities have not succeeded in improving access or coordination of programs (The Urban Institute, 2002). In particular, CoCs have struggled to reach many of the most vulnerable subpopulations: chronically homeless persons with mental illness, homeless families, or those with substance abuse problems continue to fall through gaps. Though the CoC process has stimulated increased communication and information-sharing among providers, findings also indicated that much of the focus was shifted from year-round community planning to a few months of concentrated effort leading up to completion of the HUD funding applications. The findings from this study indicate that the majority of homeless individuals, when provided with a list of available resources, fail to identify the services that best meet their specific needs. Increased integration of service delivery in regional CoCs would ensure that a homeless person entering the system through any channel would be guided toward those services that best suit his unique set of needs. For the vast majority of CoCs service delivery continues to
be discontinuous and piece-wise, and, for many regions, attaining a significantly higher level of integration appears unlikely in the foreseeable future.

**“NO WRONG DOOR” SERVICE MODEL**

Within the “no wrong door” service delivery system, homeless persons who engage through any channel are connected with or exposed to additional services (Clark, Samnaliev, & McGovern, 2007). Systematic linkages steer clients into the optimal programs within the first visit and program staff offer informed guidance toward other available resources. For those individuals who have trouble identifying their own needs, this approach is advantageous because it removes the need to discern which services are best suited to their individual needs.

Perhaps the truest embodiment of the ‘no wrong door’ approach can be found in Los Angeles’ PATHMall (Center for Civil Society, UCLA School of Public Affairs, 2006). Developed in 2002 by the non-profit organization People Assisting the Homeless (PATH), PATHMall is a three-story, 40,000 square foot Regional Homeless Center (RHC) housing dozens of services and a transition housing program under one roof. By consolidating the scope of services into a “one stop” mall, the PATHMall facilitates service coordination and client tracking through computerized databases. The center is also more cost effective for individual agencies, since overhead costs are shared. The PATH organization also operates “street outreach teams” who travel in vans through underserved areas of Los Angeles, building relationships with the homeless population, and encouraging the use of available services. The PATHMall, together with two other PATH-operated housing facilities, serves over 10,000 homeless individuals annually, placing 1,000 in full-time jobs.

Development of a San Diego PATHMall prototype called ‘Connections Housing’ is slated to begin in Fall 2011 (Roberts, 2010). The facility, located in the downtown World Trade Center building, will be the city’s first permanent shelter. Management of Connections Housing will be shared between PATH, Affirmed Housing Group, and Family Health Centers of San Diego. Together these organizations hope to offer a similar package of services as PATHMall: individual assessments, a one-stop service center, a primary care health clinic, transitional housing, and permanent supportive housing.
COMMUNITY OUTREACH & CASE MANAGEMENT

Previous studies have found homeless individuals to be capable of identifying their own needs with some accuracy (Slade et al., 1994). However, these studies took place within an institutional setting and, though clients and providers did not differ on the number of needs defined, there was considerable disagreement about the types of needs and also how they should by prioritized. In this study, only 7% of the homeless respondents demonstrated a high level of concordance when aligning normative and perceived service needs, and 60% of the population displayed low concordance. This finding suggests a need for case managers and support teams to guide homeless persons down the road to recovery and into stable housing.

Furthermore, when asked what services they needed to “stop being homeless” (survey question 32), many participants indicated short-term needs such as food, public toilets, laundry, and shower facilities (Table 5, p. 51). Given the complexity of any case of homelessness, it is unlikely that meeting such immediate service needs would result in becoming housed. This inability to differentiate between short-term and long-term service needs- a trait that likely played a role in many of the participants’ descent into homelessness- provides further evidence of a need for professional assistance in navigating the network of available services. A service system should provide professional guidance and outreach, not only to enroll those homeless persons who do not actively seek support, but also to ensure that services are being utilized effectively. Case managers, who typically function by providing their clients with needs assessments, systematic linkages, monitoring, and advocacy, should play a key role.

The Assertive Community Treatment (ACT) strategy has consistently generated better outcomes than other approaches to case management (Nieves, 2002). ACT relies upon multidisciplinary teams trained in substance abuse treatment, mental health assessment, employability development, medical care, case management, and life skills training. These teams engage in outreach with the street and sheltered homeless community “in vivo” to encourage them to enter more permanent housing. Housing is separate from other supportive services in ACT, meaning that placement in permanent housing is not contingent on receiving other treatment. This ‘housing first’ strategy has proven favorable to clients, and does not result in poorer treatment outcomes than more conditional housing arrangements in
case-control studies. ACT has the most extensive body of supportive research, particularly in assisting clients suffering from mental illness to maintain stable housing and contact with case managers (Morse, Calsyn, Klinkenberg, Trusty, & Gerber, 1992). Studies have shown ACT to produce more client contacts, higher utilization of needed resources, higher client satisfaction, and less homelessness than less proactive case management models.

**AVENUES FOR FUTURE RESEARCH**

Limitations posed by the methodology, size, and scope of this study present ample opportunities to future research. Like the majority of homelessness research, the study sample demographics provide a misleading snapshot of the true underlying population. In particular, the unique needs of minorities and females were difficult to assess given their limited presence in the study population. More focused research on the ability of these subpopulations to assess their own service needs would likely lead to different outcomes for several reasons. As was previously stated, women comprise a larger proportion of the situationally homeless, meaning that their condition often stems from financial or domestic issues that resulted in the loss of housing (U.S. Conference of Mayors, 2007). They have also demonstrated a more sophisticated and family-oriented approach to service seeking than their male counterparts (DiBlasio & Belcher, 1995). Ethnic minorities show lower prevalence rates of substance abuse and mental illness while living on the street. Though the correlation between substance abuse, mental health disorders, and effectiveness help seeking behavior warrants further research, previous studies suggest that help seeking behavior is best considered conditional on these factors (Rosenheck & Leda, 1991).

Among the predisposing demographic characteristics proposed by Anderson’s Social Behavior model, education has consistently been significantly correlated with help-seeking (Andersen, 1995). Data limitations precluded the investigation of education in this study, since all available data on education was used in computing the concordance outcome variable. Further research is needed to understand if socioeconomic variables such as education are associated with the ability to demonstrate higher concordance between normative and perceived needs.

The results of this study provide further evidence of the complexity of chronic homelessness. The role of chronicity in shaping an individual’s perceptions of the service
delivery system, or their approach to help-seeking, is not well understood. Efforts to
determine how discerning members of this population are in their service use are complicated
by the sheer breadth of their needs. Though the increasing prevalence of “housing first”
programs represents a step in the right direction, more research is needed to determine how
the multiple and interrelated needs of this population are best addressed. Do structured
housing programs, with curfews and sobriety requirements have better long term outcomes
from programs with fewer rules but still modeled on the ACT approach? What is to be done
to assist chronically homeless persons with little interest in seeking assistance, or those who
perceive their service needs to be different than they normatively are? What are the most
effective strategies for dealing with substance use and mental illness in permanent supportive
housing?

This study adds to a very small body of research on the extent to which homeless
individuals display concordance between the services they seek and those they need. The
findings suggest that, in general, this population does not effectively use available resources
to address their needs. For many of these individuals, this trait is likely one of the root causes
of homelessness. At its core, the ability to meet basic needs reflects how well suited a person
is to deal with the challenges of daily life. It is the task of public health professionals to equip
vulnerable members of society with the skills and support needed to lead healthy and
productive lives. By better understanding the individual-level factors that distinguish a
person who can meet his needs from one who cannot, researchers increase the capacity of the
service system to intervene and alleviate problems before they escalate into homelessness.
REFERENCES


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Center for Civil Society, UCLA School of Public Affairs. (2006). *Good practices profile: If you build it, they will come.* Retrieved from http://www.spa.ucla.edu/ccs


Nieves, E. J. (2002). The effectiveness of the assertive community treatment model. *Administration and Policy in Mental Health, 29*(6), 461-480


APPENDIX A

2009 STREET CHARACTERISTICS SURVEY
CONSENT INSTRUCTIONS & COVER PAGE
**Informed Consent Instructions:**

**Interviewer Instructions:** Please let the potential participant read this entire consent document, and then go over each section of the document with the participant. Ask the questions in bold to be sure the participant understands.

If you think a person is too cognitively impaired to consent voluntarily do not continue with the interview.

If a person does not wish to sign the consent form they may waive the signing as per the last paragraph but you still need to review each part to obtain informed consent.

---

**2009 Unsheltered Street Characteristic Survey**

**Interview Collection Cover Sheet**

Name of Interviewer: __________________________________________

Please fill in one row for each date and place of survey:

<table>
<thead>
<tr>
<th>Date</th>
<th>Place of Survey</th>
<th>Number of Interviews Conducted A [A=B+C]</th>
<th>Number of Signed Consents B</th>
<th>Number of Waived Consents C</th>
<th>Number of Persons Declining (Approach, Screening Questions or Interview)</th>
<th>Number of Persons not interviewed due to Cognitive Impairment</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Please turn your surveys into Kiefer Rich; his number is 858-292-7352 extension 16.
Keep consent forms and surveys SEPARATE at all times.
You must keep the surveys and consent forms in a locked file cabinet or with you at all times.
Lock your car if you are gathering more surveys.
Place completed surveys and completed consent forms in the envelopes provided.

Thank you for your support, your help makes this possible!!!
APPENDIX B

STREET CHARACTERISTICS SURVEY, 2009
## Screen Questions: Start Here

**Do not interview client and destroy these responses if ANY in column B are marked:**

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you interested in taking a survey?</td>
<td>Yes</td>
<td>No</td>
<td>Stop</td>
</tr>
<tr>
<td>Are you homeless?</td>
<td>Yes</td>
<td>No</td>
<td>Stop</td>
</tr>
<tr>
<td>Did you sleep on the street last night?</td>
<td>Yes</td>
<td>No</td>
<td>Stop</td>
</tr>
<tr>
<td>Surveys were explained and understood &amp; obtained?</td>
<td>Yes</td>
<td>No</td>
<td>Waived</td>
</tr>
<tr>
<td>Participants: Have you completed this survey in the recent past?</td>
<td>Interviewed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Main Survey (All columns A)

**Surveyor Fill-in**

- **Surveyor Name:**
- **Interviewer Name:**
- **Today's Date:** __/__/____
- **Location of interview:**
- **(City and suburb):**
- **Time:** AM/PM

### Personal Details (for refusal in any section across question)

1. Were you born in the USA? | Yes | No
2. What is your date of birth & age? | / | / | Age:
3. What is your gender? (Mark one)
   - Male
   - Transgender: Male to Female
   - Female
   - Transgender: Female to Male
4. Did you serve in the military? | Yes | No
   - If yes, did you serve during:
     - W W II
     - Desert Storm
     - Korean War
     - Current Gulf
     - Vietnam
     - Other:
5a. Which of the following categories best describes your racial background? (Check all that apply)
   - White
   - Black or African American
   - Asian or Pacific Islander
   - American Indian or Alaskan Native
   - Some other race:
6. Are you of Hispanic origin? | Yes | No

### Living Situation

6a. Where did you sleep last night? (Choose one)
   - Abandoned Building
   - Building Under Construction
   - Storm System
   - Car
   - Garage
   - Industry Building
   - Outside (Street, Park, or Other Open Space)
   - Public Building (Bus, Library, Bar, etc)
   - Rural Area

6b. Surveyor: describe location (include landmarks if possible)

6c. How long did you stay there?
   - 1 day - 7 days
   - 8 days - 4 weeks
   - 5-12 months
   - More than 1 year

6d. If you spent the night in a different location on date of count date, please describe where:

7. Why didn’t you stay in an emergency shelter, safe house, or transitional shelter last night? (Choose one)
   - Turned away - full
   - Turned away - inappropriate
   - Didn’t know about them
   - Didn’t want to (specify):

---

8. Where do you usually sleep? (Choose one)
   - Abandoned Building
   - Outside (Street, Park, or Other Open Space)
   - Car
   - Own House / Apartment
   - Drop-in Center
   - Public Building (Bus, Library, Bar, etc)
   - Friends
   - Other (specify):
   - Relative Home
   - Other:

9. How many nights, if any, in the past year have you spent in jail or prison?

10. Have you been homeless for a year or longer this time? | Yes | No
11. Have you been homeless four or more times in the past three years? | Yes | No
12. What is the longest single time period you have ever been homeless? | 1 day - 4 weeks | 4 weeks - 1 month | 1-6 months | More than 6 months
13. Why do you live in the San Diego area?
   - Community
   - Free Food/Distributed
   - Friends/Family
   - Jobs
   - Recycling Access
   - Safety
   - School
   - Service Access
   - Weather & Comfort
   - Other:

14. About how long have you lived in the San Diego area? | Years | Months | Unsure
15. Were you homeless when you moved here? | Yes | No
16. Where did you live before San Diego? | Not in USA | In USA, City | and State

### Marital Information

17. What is your marital status?
   - Never Married
   - Married
   - Separated
   - Widowed
   - Divorced

18. Are you currently living on the street as a single person or part of a couple?
   - Single (could be ‘not married’, separated, divorced, widowed)
   - Couple or Married

19. Do you have any children under 18 that stayed with you last night? | Yes | No
   - If Yes, What are their ages?

### Employment / Education / Health

20. Are you working? | Yes | No
   - If Yes, Average number of hours work per week:

21. Are you a farm worker or day laborer? | Yes | No
22. What were your sources of income for the last 6 months?
   - Alimony
   - Child Support
   - Paid Work / Job
   - TANF
   - Education Based / School Related
   - Family/Friends
   - General Relief
   - Social Security Benefits (SSA)
   - Social Security Disability Income (SSDI)
   - Other:

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2 OVER
Start Here (Second Side)

Supplemental Security Income (SSI) □ Yes □ No
Unemployment □ Yes □ No
CalWorks □ Yes □ No
Recycling □ Yes □ No
Veterans' Disabilities Benefits □ Yes □ No
Workers' Comp. □ Yes □ No
□ None listed
□ Other (specify):

23. Current monthly income $ (estimate ok)

24. Do you receive food stamps or other food vouchers? □ Yes □ No

Education and Health:

25. What is the highest level of education you have completed? (choose ONE)
□ Less than high school (could be some HS -no diploma)
□ Finished high school or GED
□ Some college or a 2-year Degree
□ Finished 4-year Degree
□ Advanced Degree
□ Other (specify):

26. Do you think you have, or has anyone diagnosed you as having:
□ A serious long-lasting medical or physical condition  □ Yes □ No
□ A serious mental illness  □ Yes □ No
□ Alcohol or drug abuse/addiction  □ Yes □ No
□ A developmental disability  □ Yes □ No
□ Other Disability  □ Yes □ No

27a. What is your HIV status? (choose ONE)
□ Positive
□ Negative
□ Unknown
□ Decline

27b. When was your last HIV test? (choose ONE)
□ Within the last six months
□ Within the last year
□ Within the last 6 years
□ Unknown (I've had one, I just don't remember when)

28. Any current substance use? □ Yes □ No

If yes,
□ Street Drug □ Yes □ No [□] times per week
□ Alcohol □ Yes □ No [□] times per week
□ Prescription Drugs (non medical need) □ Yes □ No [□] times per week
□ Other □ Yes □ No [□] times per week

Services:

29. What services have you accessed in the last 6 months?
□ AA / NA □ Yes □ No
□ Case Management □ Yes □ No
□ Drug Treatment / Detox Services □ Yes □ No
□ Domestic Violence Services □ Yes □ No
□ Education □ Yes □ No
□ Employment □ Yes □ No
□ Ex-Offender Services □ Yes □ No
□ Food □ Yes □ No
□ Foster Care □ Yes □ No
□ HIV Services □ Yes □ No
□ Medical Services □ Yes □ No
□ Mental Health Counseling □ Yes □ No
□ Psychiatrist □ Yes □ No
□ Referrals / Info □ Yes □ No
□ Transitional Housing □ Yes □ No
□ Childcare / Fam. Serv. □ Yes □ No

Dental Services □ Yes □ No 3

□ Emergency Shelter □ Yes □ No
□ Job Training □ Yes □ No
□ Legal Services □ Yes □ No
□ Relocation Services □ Yes □ No
□ Transportation □ Yes □ No
□ Other (specify):

30. Where do you get Healthcare?
□ Shelter □ Yes □ No
□ Health Clinic □ Yes □ No
□ Urgent Care □ Yes □ No
□ Emergency Room or Hospital □ Yes □ No
□ Don’t Receive Any Health Care □ None
□ Other (specify):

31. How many times in the past 12 months have you used the Emergency Room for any treatment?

32. What would it take to stop?

33. What services do you need most right now?
□ Yes □ No
□ Affordable Housing □ Yes □ No
□ Emergency Shelter □ Yes □ No
□ (housing any type)
□ Education opportunities □ Yes □ No
□ Employment / Job □ Yes □ No
□ Job Training □ Yes □ No
□ Childcare / Family Services □ Yes □ No
□ Foster Care □ Yes □ No
□ Drug Treatment/Detox □ Yes □ No
□ Medical Services □ Yes □ No
□ HIV Services □ Yes □ No
□ Dental Services □ Yes □ No
□ Mental Health Services □ Yes □ No
□ Domestic Violence Services □ Yes □ No
□ Ex-Offender Services □ Yes □ No
□ Legal Services □ Yes □ No
□ Relocation Services □ Yes □ No
□ Case Management □ Yes □ No
□ Referrals / Info □ Yes □ No
□ Help applying for aid (general relief, SSI, etc.) □ Yes □ No
□ Food □ Yes □ No
□ Transportation □ Yes □ No
□ Shower facilities □ Yes □ No
□ Public toilets □ Yes □ No
□ Mail services □ Yes □ No
□ Laundry services □ Yes □ No
□ Anything else? (specify):

34. If you haven’t used some of these services, why not?

Other (SD=San Diego)

35. Did you become homeless as a result of domestic violence? □ Yes □ No

36. Since becoming homeless in SD, have you been a victim of:
□ Assault □ Yes □ No
□ Kidnapping □ Yes □ No
□ Police harassment □ Yes □ No
□ Sexual assault □ Yes □ No
□ Rape □ Yes □ No
□ Robbery □ Yes □ No
□ Arson □ Yes □ No
□ Domestic violence or partner abuse □ Yes □ No

Surveyor Comments: