

**Homeless Men in New York City's Public Shelters:  
A Life Course Perspective**

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## ABSTRACT

### Homeless Men in New York City's Public Shelters: A Life Course Perspective

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Many questions surround the nature of the relationship between homeless individuals' personal attributes, histories and problems and their recent experiences with homelessness, their current level of social and psychological functioning and their need for services. Using data collected in a major needs assessment survey of municipal shelter users in New York City, the study explores the continuities and discontinuities between different phases in the life histories of homeless men aged 28 to 50. Employing factor analysis and multiple regression methods, the study examines associations between a range of disparate variables describing experiences of childhood and adulthood as well as several current status measures. The relationship between these variables and homeless individuals' self-rated service needs is also investigated.

The emerging view of the contemporary homeless population as defined by considerable heterogeneity was supported. Four broad life course dimensions (mental illness/substance abuse, childhood deprivation/family disruption, positive adjustment/achievement, delinquency/deviant behavior) were identified and described. Childhood runaway behavior, delinquency and separation from

the family were found to be significantly associated with a number of specific adult outcomes and current status measures. Homeless persons' self-ratings of their need for services was found to comprise a coherent factor structure and to be associated with selected life course variables. Policy and practice implications and recommendations for future research are discussed.

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This work is dedicated to the memory of my father

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## CHAPTER ONE

### INTRODUCTION

Homelessness is one of the most pressing social problems now confronting our city and our nation. Homeless people have become ubiquitous fixtures in parks, in subways and on the streets. A huge shelter and homeless services industry, universally criticized as inadequate to meet the need, has emerged as a growing component of the social service system. Public expenditures related to the homeless continue to rise while debate on the problem continues to generate great public interest and considerable controversy.

The conflict surrounding the nature of homelessness--its causes, scope and potential solutions--starkly demonstrates the central importance of social definition in our understanding of social problems. Competing definitions of the homelessness problem abound. Many analyses stress the contributing role played by disabilities on the part of homeless individuals, as demonstrated by the unusually high prevalence of untreated mental illness and substance abuse among the homeless population. Others emphasize the widespread structural problems of poverty, unemployment and a shortage of affordable housing. Each of these paradigms leads to a different primary solution to the problem. Given a focus on macro-level explanations, the indicated interventions are rather straightforward; build more housing and create more jobs. In the personal disability paradigm,

the emphasis is on providing psychiatric treatment or other rehabilitative approaches (in some cases on a compulsory basis) aimed at the homeless themselves.

In fact, both perspectives have a good deal of merit. It is undeniable that the societal factors noted above have powerfully contributed to the explosion of homelessness during the past decade. Numerous studies have documented the demise of much of the low-cost housing supply in many urban areas (Hartman, 1986; McChesney, 1990; Wright and Lam, 1987). Demographic changes and labor market shifts resulting in the loss of relatively well-paid manufacturing and public sector jobs have diminished the employment prospects for many young adults, particularly in urban and minority areas (Easterlin, 1987; Freeman and Holzer, 1986; Hopper and Hamberg, 1984; Hopper, Susser and Conover, 1985). There has also been considerable erosion in the capacity of income maintenance programs to prevent poverty among the non-aged as the benefit levels provide by AFDC and general assistance programs have failed to keep pace with inflation (Rossi, 1989).

At the same time, the accumulated evidence suggests that, when compared with the general population, an unusually large proportion of homeless individuals are in fact afflicted by serious personal problems, particularly mental illness and substance abuse (Tessler and Dennis, 1989). These types of problems are rendered that much more socially disabling by virtue of the well-documented

shortcomings in the system of care for the seriously mentally ill and the inadequate supply and questionable effectiveness of many drug and alcoholism treatment programs.

In sociological terms, the process of defining homelessness reflects the tensions between viewing the problem through the lens of social dysfunction versus social deviance (Merton, 1971). The social deviance model, perhaps influenced by the common stereotype of the skid row homeless of an earlier generation, is well represented by views of the homeless population as comprising primarily released mental patients, substance abusers, and others whose marginality can be largely attributed to incapacity or shiftlessness. Accepting this paradigm suggests that ameliorative efforts ought to consist primarily of treatment and rehabilitation of the ill and addicted coupled with policies intended to direct the able-bodied toward self-sufficiency. Within this formulation, there is considerable room to debate the degree to which coercion (i.e. in the involuntary hospitalization of the mentally ill) should play a central role.

Those subscribing to the social dysfunction approach view contemporary homelessness as a symptom of a malfunctioning society which is unable to provide sufficient opportunities for meeting the most basic subsistence needs of its less advantaged members. In this analysis, focusing on the personal characteristics of those who are homeless

merely deflects attention from the structural conditions of poverty, unemployment and the shortage of low-cost housing which are ultimately responsible for the problem. To take this argument a step further, the personal disabilities which burden many homeless people may be seen as, in large measure, brought on by the stresses endemic in being without permanent shelter. This formulation, which reflects the position of the major homelessness advocacy groups, logically leads to an emphasis on the need to expand the supply of affordable housing, create better paying employment opportunities for the poor and unskilled, and provide a higher floor of income support for those not in the labor force.

There is no doubt considerable validity to both of these problem definitions. However, it is equally clear that neither alone can fully explain the dynamics of homelessness or offer a guide for policy makers and program planners faced with the task of developing appropriate services for homeless people. All those who are poor, disadvantaged or disabled are not homeless. Among those who have experienced residential dislocation, there is considerable variation in individual responses and outcomes. For some, homelessness is an isolated, transitory condition, while for others, homelessness forms part of a constellation of multiple problems and chronic dependency. It is a fair supposition that an individual's personal attributes and life history will affect, and in turn be affected by, his

experience with homelessness. Of particular relevance here is C. Wright Mills' (1959) admonition of the need to examine both public issues and personal troubles, history and biography to develop a fully informed analysis of a social problem.

The heterogeneity of the homeless population is by now a well-documented fact. A number of recent studies (examined in some detail in Chapter 2) have demonstrated that among the homeless population may be found a wide range of people and problems: men, women and children; the able-bodied and those with personal disabilities such as substance abuse and mental illness; the chronically unemployed and those with significant work histories; those whose experience with homelessness is long-term and those whose homelessness is more episodic. Nevertheless, with a few recent exceptions (most notably with respect to the mentally ill homeless), the service delivery system remains largely undifferentiated, responding as if the homeless population were much more homogeneous than it is now known to be.

Little work has been done which attempts to uncover the continuities and discontinuities between different phases in the life histories of homeless people and their potential implications for range of possible interventions. Such a life course perspective endeavors to understand the relationships (if any exist) between a wide range of disparate variables associated with childhood, adulthood and

current status measures. Specifically, there is a need to explore the ways in which homeless individuals' personal attributes, characteristics and life history variables are relevant to understanding their recent experiences with homelessness, their current level of social and psychological functioning as well as their need for social services.

The main question to be answered is as follows: What is the relationship between homeless persons' childhood experiences, personal attributes and earlier life experiences and their more recent experiences, their present level of functioning, and their need for services? Subsidiary questions are: to what extent can particular types of experiences or self-ratings among the homeless be better understood as general domains or factors, and are these domains useful in understanding the possible relationships noted above?

These question will be investigated utilizing data on a representative sample of 1400 homeless shelter users collected in the Housing Needs Assessment of the Homeless Survey (HNAS) completed in 1985 under the direction of Dr. Elmer Struening of New York State Psychiatric Institute. This survey provides one of the richest and most carefully collected data sets on the homeless to be developed to date. As such it allows for complex manipulations of data from across a broader domain of variables than has generally been performed in the recent research on homelessness.



The study is exploratory in its attempt to identify a range of salient life course variables and determine how these variables may be understood in some ordered fashion and ultimately related to a set of subsequent outcomes. It is hoped that the study will contribute to the homelessness literature by beginning to identify explanatory models of homeless persons' life experiences which can be explored in future research.

In addition to augmenting the knowledge base on homelessness by focusing on how the interplay between personal experiences and societal conditions contributes to the development of a critical social problem, the study's findings will hopefully have significant implications for policy and program interventions. The findings may suggest possible approaches to prevention of dependency by identifying predictors of long-term homelessness and other negative outcomes while shedding light on the differing service needs of various types of homeless shelter users.

## CHAPTER TWO

### RELATED LITERATURE AND THEORETICAL CONSIDERATIONS

Homelessness is a subject which has generated a huge volume of literature produced by social scientists, social workers, missionaries, physicians, journalists and others concerned about the plight of the neediest and most troubled among us. As such, the literature spans an especially wide range of topics, methodological approaches and theoretical emphases. Among the broad categories of literature on the homeless are the following: historical accounts; journalistic and personal observations; spiritual and religious analyses; ethnographic studies; sociological studies (including "deviance" studies); policy analyses and planning documents; survey research and epidemiological studies; and various studies of specific subgroups of homeless persons such as youth, alcoholics, and the mentally ill. Although contributions to the literature have come from many countries, the great majority of important studies come from Great Britain and the United States. It is clearly beyond the scope of this thesis to discuss the enormous number of works on homelessness and homeless persons from among the full range of these categories. Instead I will attempt to cull from each of these areas, works which have the most relevance to the experience of today's urban, homeless individuals. Where indicated I will also review relevant studies which fall outside of the

homelessness literature, in particular several works dealing with housing policy and social networks. Citations are drawn from books, journal articles, government documents, masters and doctoral theses as well as unpublished reports.

The literature review is divided into the following areas: Policy Analyses and Planning Documents; Demographic and Epidemiological Studies; Program Descriptions and Evaluations; and Ethnographic Studies. For the sake of organization, several of these areas are further divided into sub-areas.

#### Policy Analysis and Planning Documents

As noted above, the problem of homelessness has recently come to the fore as one of the most important policy issues in the social welfare field. Consequently, a good number of recent policy analysis and planning documents have been generated by a range of governmental and non-governmental sources. My review of these documents focus primarily on work which details the recent re-emergence of homelessness and frames the current views of the problem. It is organized into the following categories: U.S. Government Reports; State and Local Reports; and Non-Governmental Reports.

#### U.S. Government Reports

Acting at the request of Representative Ted Weiss, Chairman of the House Subcommittee on Intergovernmental

Relations and Human Resources of the Committee on Government Operations, the U.S. General Accounting Office (1985) reviewed the problem of homelessness and assessed the efforts which federal agencies have made in responding to it. To accomplish the task, an exhaustive review of existing studies from across the country was undertaken. In measuring the scope of the problem, the GAO found that there is agreement that "homelessness has been increasing over the last several years, although there are no reliable data to identify how much it is increasing" (p. 4). The report describes the technical difficulties which are encountered in efforts to count the number of homeless people in the nation and in particular localities. Factors cited as contributing to individuals becoming homeless include the following: increased unemployment; deinstitutionalization and lack of community-based services; increases in personal crises; cuts in public assistance programs; decline in the supply of low-income housing and; alcohol/drug abuse problems. The GAO found that, although no single federal agency or program is responsible for providing services to homeless people, "federal agencies have expanded their role to help states and localities meet the growing requests for food and shelter" (p. 45). However, the report notes the considerable uncertainty surrounding continued federal financial support for the coming years. The report concludes that although current shelter and food programs are necessary to address the immediate needs of homeless

people, they must be supplemented by other long-term solutions including the expansion of mental health services, low-income housing, employment and training, and assistance in helping homeless people gain access to available programs and benefits.

The U.S. Department of Housing and Urban Development issued a Report to the Secretary on the Homeless and Emergency Shelters (1984) which focused primarily on an attempt to estimate the number and describe the characteristics of the nation's homeless population. The report concludes that the "most reliable range" of estimates is between 250,000 and 300,000 homeless people on a single night during the winter of 1984. This finding generated considerable criticism by advocates for the homeless as a substantial underestimate (see for example Hopper, 1984).

The report proposes three major types of homeless persons: those with chronic physical or mental disabilities; those who have experienced a major personal crisis; and those who are victims of economic forces beyond their control. Interestingly, there is virtually no discussion of the contribution of the reduced supply of low-income housing to the growth of the homelessness problem. Another controversial finding is that roughly 30% of shelter beds nationwide on any given night are vacant, implying that the existing number of shelter beds is adequate to meet the need. The report concludes that "improving the condition of the homeless over the long term requires tailoring public

and private responses to fit their widely-varying needs rather than placing a singular emphasis on emergency shelter" (p. 50).

The U.S. Department of Health and Human Services Working Group on the Homeless (1984) produced a comprehensive briefing paper which, after describing the scope and dimensions of the problem as well as current interventions, discusses specific policy options for federal action. The paper lists the goals of its options as to: "provide emergency care for the homeless; develop linkages between shelters and service providers; and provide continuing care for those most in need" (p. 13). In recommending that efforts focus on the most needy of the homeless, the Working Group emphasized the plight of the mentally ill, and felt that expansion of efforts to help mentally ill homeless people would have a "ripple effect" on other homeless people by improving outreach, screening, shelter, feeding, health and other supportive services. Specific options which the paper describes include: expansion of outreach to reach potential recipients of federal entitlement programs; liberalized Supplemental Security Income (SSI) eligibility for shelter users; expansion of technical assistance by various federal agencies; federal funding of innovative service demonstration programs for the homeless mentally ill; federal funding of universities and State agencies for training of personnel to work with homeless mentally ill

individuals and; expansion of federal support for policy relevant research projects.

It is interesting to note that this briefing paper was made public by HHS upon a specific request by the House Committee on Government Operations' Subcommittee on Intergovernmental Relations and Human Resources (National Mental Health Association, 1985). Appended to the paper is an assessment of the Working Group's options, provided by the Office of the Assistant Secretary for Planning and Evaluation of HHS. Not surprisingly, this assessment is more of an explicitly political document and, as such, clearly reflects the Reagan administration's ideological bent. The assessment stresses the need to develop solutions at the local level in conjunction with voluntary and private organizations, rather than encouraging federal leadership. It generally rejects options which call for additional, categorical federal funding while emphasizing the availability of existing non-categorical funds for such purposes. The assessment also questions the usefulness of proposed changes in entitlement programs and well as expanded entitlement outreach.

#### State and Local Reports

The New York State Department of Social Services (1984) produced a lengthy report which describes the scope of the problem of homelessness in the State and offers a substantial number of policy recommendations. In order to

develop data upon which to base its analysis, DSS surveyed all shelter providers in the State through a mailed questionnaire. Using the results, the report presents estimates of the number of sheltered and unsheltered people, as well as data about reasons for homelessness and the populations' problems and service needs. The report cites a large and steady decrease in the State's low-income housing supply and a sharp rise in poverty and unemployment as major contributors to the growing number of homeless people. With regard to the mentally ill homeless, the report stresses the dramatic reduction in SRO units as a major factor in the genesis of the problem.

The policy recommendations which are offered are consistent with the report's emphasis on homelessness as primarily a housing problem. Thus, while mourning the recent cuts in federal housing funds, the report reluctantly calls for an expanded State role in the development of low-income housing. Also recommended is the development of specialized supportive and supervised housing for the mentally ill, alcoholics and substance abusers. The report also acknowledges the need to periodically review the adequacy of the public assistance shelter grant as it relates to the prevention of future homelessness. In contrast to the federal documents discussed above, the report makes quite specific program recommendations and establishes concrete level of need estimates for various types of services.



As the largest provider of temporary shelter at the local level, the City of New York has produced a number of policy oriented documents on the homeless. In 1981, the New York City Department of Mental Health, Mental Retardation and Alcoholism Services published the only City plan which deals strictly with the problems and needs of the mentally ill homeless. The plan cites deinstitutionalization, lack of community-based services and poor hospital discharge planning as primary contributors to the problem and notes several surveys (see below) which indicate that a significant proportion of municipal shelter users are mentally disabled. The plan notes that the existing service system for chronically mentally ill people is deficient in its capacity to provide "appropriate equivalents for the residential and custodial functions formerly served by State institutions..." and calls for "a major commitment to the creation of residential alternatives tailored to meet the specialized needs of the chronically mentally ill homeless" (p.10). Specific recommendations include: the creation of State-funded shelters for the mentally ill; expansion of the State-funded community residence program to accommodate homeless people; expansion of outreach teams and on-site rehabilitation programs in shelters; and the extension of the period after discharge during which patients can be returned to State hospitals for further care without first being treated in local hospitals.

One of the earlier comprehensive statements on homelessness by the City of New York was presented in its Plan for Homeless Adults (HRA, 1984). The plan focuses on single men and women rather than families, and deals with the mentally ill as a subgroup of the overall homeless population. Based upon interpretations of its surveys of shelter users, HRA starts with the assumption that the City is sheltering primarily "multi-problem individuals whose needs cannot be met simply by giving them a roof over their heads" (p. iii). In seeking to account for the dramatic increase in demand for shelter, the plan cites the following factors: deinstitutionalization in the mental health system; the decline in low income housing caused primarily by cutbacks in federal aid; the decline of unskilled and semi-skilled jobs; and the improvement of shelter conditions and services along with expanded outreach efforts. The plan serves as a justification for policy choices which the City has made as well as a statement of future directions for services for the homeless. For example, the plan defends the use of large (150-200 bed) shelters, a policy which has been heavily criticized by advocacy and community groups as creating unmanageable, unsafe institutions. The plan also offers comparisons with other American cities which attempt to demonstrate (not unconvincingly) that New York provides more services for the homeless than do other municipalities.

The most recent statement of the City's policy direction with respect to homeless singles is contained in the Five Year Plan for Housing and Assisting Homeless Single Adults (HRA, 1988). Following a demographic profile of the shelter population, the plan describes the service system as presently constituted. The plan then presents a rationale for a major new policy direction--shelter specialization. Specialization, which is to be phased in over the next several years, is "the policy of dividing the shelter population into its component groups of mentally ill, substance abusers, employables, the elderly, and other relevant categories in order to provide clients with targeted housing and services." It is based on the assumption that these groups have differing service needs which can be met most effectively in specialized settings. The plan outlines a process by which new shelter clients will be assessed in order to determine the most appropriate set of services and then referred to the particular shelter in which they are to be housed. After an unspecified period of transitional services, it is anticipated that clients will be referred out to long-term housing and associated services.

#### Non-Governmental Reports

One of the most significant recent contributions to the policy literature on the mentally ill homeless was produced by the American Psychiatric Association's Task Force on the

Homeless Mentally Ill (American Psychiatric Association, 1984). Published as a collection of papers by task force members, the report supplies a comprehensive review of the major policy issues, in addition to providing a series of recommendations for action which were endorsed by the panel. Only the papers which have primarily a policy focus are reviewed here. Others from this report will be discussed elsewhere in the literature review. Lamb (1984) views homelessness as a reflection of a lack of understanding of the needs of the chronically mentally ill during the implementation of deinstitutionalization policies. Stressing the high level of dependency which is symptomatic of chronic mental illness, he points out the need for "granting asylum in the community" (p. 58) to a large group of disabled individuals who are unable to live independently. Lamb believes that structured living arrangements are required by many of the deinstitutionalized mentally ill, and are the key to long-term survival in the community. He believes that many seriously mentally ill people exhibit a "tendency to drift" (p. 64) as a way to cope with difficulties in sustaining relationships and facing their dependency needs, and this, in turn, is a factor which contributes to homelessness. Nonetheless, Lamb places high value on the personal liberty which deinstitutionalization has bestowed upon the chronically mentally ill and rejects large-scale reinstitutionalization as a viable solution. He does however recommend greater use

of other forms of involuntary care for "gravely disabled individuals who do not respond to aggressive case management and are too mentally incompetent to make a rational judgement about their needs for care and treatment" (p. 71).

Placing the problem of homelessness in a historical context, Goldfinger and Chafetz (1984) see recurring shifts in public policy over the last several hundred years alternating between dispersion, rehabilitation and incarceration. Throughout these shifts, they note a consistent refusal to support dependent people without seeking to change or isolate them, as well as a failure to differentiate subgroups among the destitute population. They posit a number of qualities which should characterize an improved service system for the homeless mentally ill. Among others, the system should be comprehensive, continuous, individualized, flexible and meaningful. This final quality refers specifically to the importance of offering services which are relevant to needs as they are perceived by the client. Thus they state that "...our services must offer not only what we deem useful, but what they deem necessary" (p. 103).

Jones (1983), using the history of homelessness in Philadelphia as an illustration, notes that mental illness among the homeless was perceived as a serious problem as far back as the early eighteenth century. He points out that Dorothea Dix, who successfully advocated for the development of state mental hospitals during the nineteenth century, was

particularly concerned about the plight of the indigent insane who were housed in local poor houses.

Having persuasively argued in earlier works (Morrissey, Goldman & Klerman, 1980 and Morrissey, Goldman, 1984), that the history of mental health policy can be viewed as a cyclical pattern of institutional reforms which failed to meet public expectations, Goldman and Morrissey (1985) also adopt a historical perspective in which to place contemporary efforts to cope with the problem of homelessness. They believe that previous policy failures in the care of the mentally ill resulted from the the tendency on the part of advocates to transform social problems such as poverty and dependency into mental health problems. They warn mental health activists against "offering a mental health solution to the problem of all of the homeless..." while not permitting "social welfare activists to forget the psychopathology of the homeless mentally ill" (p. 729).

Stern (1984), using a paradigm developed by Blumer (1971), also stresses the importance of the definition of social problems and the fact that such definitions are interactionist in nature. In his analysis, mental illness and deinstitutionalization have won out as the primary paradigm through which to understand the problem of contemporary homelessness. He believes that this development can be at least partially traced to local government officials' efforts to blame state authorities for the problem. Baxter and Hopper (1984) preface their section

on shelter and housing with a ringing criticism of survey research as it relates to the homeless mentally ill. "The surveys generally identify a pattern of heterogeneous needs, the majority of which remain unmet, only to be identified again by subsequent surveyors...Measurement, at this stage, serves little other than our own curiosity" (p. 111).

Their point is that homelessness should be understood as "not fundamentally a social service or mental health problem [but as] a state of deprivation defined by the absence of a primary element of civilized life--a home" (p. 127). Thus survey research which seeks to specify and quantify aspects of homelessness as a prelude to service planning is largely irrelevant since what all homeless people need first is a home. They contend that the lack of success of mental health programs in shelters for the homeless can be attributed to the lack of suitable housing options for the population. Interventions, then, should focus on meeting the survival needs of homeless people (the need for housing chief among them), before more ambitious therapeutic efforts are attempted. This point of the primacy of addressing survival needs can be found in a number of other works by these authors, who have been among the most influential advocates for the homeless (see for example Baxter and Hopper, 1980).

Lipton and Sabatini (1984) see homelessness among the mentally ill as a reflection of the poor system of care for chronically mentally ill people in the

deinstitutionalization era. Their emphasis differs from Baxter and Hopper (1984) in that they see homeless persons' lack of residence as only one facet of their plight. "In reality," they state, "the homeless often have no job, no function, no role within the community; they generally have few if any social supports. They are jobless, penniless, functionless and without support as well as homeless" (p. 156). Thus while provision of housing is seen as a necessary component of a desired service system, the authors stress the importance of helping homeless mentally ill people develop a new social network and support system. Such an effort is required, it is argued, in order to enhance homeless individuals' "social margin," which, in turn, will increase their chances of escaping from a cycle of homelessness and isolation. [The construct of "social margin," which has been described by Segal, Baumhol and Johnson (1977) and Wiseman (1970), will be discussed in greater detail below.] Lipton and Sabatini advocate an expanded federal role in the development of a comprehensive support system for all chronically mentally ill people including the homeless.

In addressing the question of why mentally ill people become homeless, Levine (1984) offers a similar view. She notes that the chronically mentally ill as a group tend to have behavioral characteristics which make it difficult to gain access to housing or employment. These characteristics include: problems with tasks of daily living; difficulty in



seeking help from human service workers; tendency toward episodes of "acting out" behavior. Levine makes the point that mentally ill individuals' difficulty in negotiating bureaucratic systems often leaves them unable to obtain access to entitlements for which they are eligible. Without a stable source of income, housing is virtually impossible to obtain.

In analyzing legal issues and the homeless mentally ill, Peele, Gross, Arons and Jafri (1984) posit that legislative and judicial actions during the last twenty years "have limited the actions that the family, the police and psychiatric professionals can take in relation to mentally ill individuals, which in turn have reduced their ability to provide needed care for the seriously mentally ill" (p. 261). They note that the increased emphasis on civil rights for the mentally ill have severely limited the use of involuntary commitment proceedings, which has made it difficult to provide treatment to people who refuse care, even though mental health professionals may believe that they could benefit from it. Laws which protect the right of inpatients to refuse treatment are also cited as a potential impediment to care. In these ways, it is argued, the legal system makes it difficult to help mentally ill people from becoming homeless and to help homeless people achieve greater health and stability. The authors recommend major changes in commitment laws which would facilitate involuntary treatment for the seriously mentally ill. In

addition, conservatorship and guardianship for mentally disabled people should also be expanded.

Bassuk and Lauriat (1984) focus on the attitudes and opinions of those involved in the public debate on homelessness. They note the clash between political leaders over the causes of the problem as well as the appropriate government role in providing assistance to the homeless. One attitude commonly held by many government officials, they argue, is that much of the responsibility for helping homeless people should rest with religious and voluntary organizations. The authors believe that many mental health professionals have been slow to come to the aid of the homeless due to the stigma connected to chronically ill, dependent people who "misuse" the treatment system. Although officials, volunteers and professionals have cooperated to increase the supply of emergency shelter, it is argued that "effective long-range planning is blocked by factionalism" (p. 311). Bassuk and Lauriat believe that shelters, although popular due to their relative low cost, are an inadequate response to a pressing social problem. They claim that, ironically, the emergency shelter response may actually deflect attention from the need to develop more comprehensive and effective solutions. In another paper, Bassuk (1984) cites data from a single study which support her contention that a large majority of the homeless suffer from mental illness. As such, she views the changes in mental health policy over the last thirty years as the most

significant factor in the genesis of the homelessness problem. She remains critical of the emphasis on emergency shelter since she views this type of housing as inappropriate for the care and treatment mentally ill people. Bassuk, a psychiatrist, is representative of a school of thought which stresses the prevalence of major mental illness among the homeless population.

Hopper (1984), on the other hand, believes that "the bulk of research to date indicates that the majority of the homeless poor are not seriously mentally disabled..." (p. 14). He too is critical of the poor physical conditions which characterize public shelters and contends that these conditions ensure that those most in need of a protective setting will be unwilling to make use of such facilities. Hopper disapproves of the separation of "clinical from social responsibility for the mentally disabled homeless, embodied in the structure and practice of most health and welfare bureaucracies" (p. 16). He cites the potential danger in advocacy efforts on behalf of the mentally ill homeless which justify their claim to decent shelter by focusing on their pathology as opposed to their neediness. He sees this as contributing to "the invidious distinction between the deserving poor and the undeserving poor" (p. 16).

Cuomo (1983), in a report to the National Governor's Association for which Hopper was a consultant, makes many of the same points. He also emphasizes the destructive role

played by the Reagan administration's intensified disability review procedures which have "resulted in many qualified claimants losing their benefits" (p. 47). Cuomo, after calling for the creation of a national commission on the homeless, lists actions which can be taken by state and local governments. Among these is the development of supportive residences for the mentally disabled.

After studying the problem of homelessness in Boston, the United Community Planning Corporation emphasizes the need for greater leadership by public mental health authorities. Supportive housing as well as specialized transitional shelters for the mentally ill are recommended, as is a comprehensive case management/advocacy program for all homeless persons. Another recommendation is that shelters house no more than 30-35 people each, in order to prevent the creation of new institutions in the community. (The survey upon which this report is based will be reviewed below.)

### Summary

What does this plethora of recent analyses tell us about the problems of homelessness and the homeless mentally ill? There does appear to be a degree of consensus about the causes of contemporary homelessness. Increasing poverty and unemployment, cuts in public assistance programs, deinstitutionalization policies, and the housing shortage are continually cited as conditions which each play a

significant role in creating and maintaining the problem of homelessness. There is, however, considerably less agreement about the relative importance of each of these factors and the types of interventions which are indicated.

Although the importance of deinstitutionalization in creating homelessness is not disputed, there is considerable disagreement about the prevalence of mental illness among the homeless, and consequently about what should be done. Analysts also disagree about what types of assistance are most important to the homeless. Some, believing that homeless people are distinguished primarily by their lack of shelter, stress the need for housing above all else. Others see homelessness as one manifestation of a syndrome of severe psychiatric and functional deficits and therefore emphasize a therapeutic treatment approach of which housing is only one component. Another policy-related issue about which there is disagreement is the question of voluntary versus involuntary care as the major intervention strategy. Some observers believe that, since mentally ill homeless people are incapable of making voluntary use of housing and services, only a return to liberalized commitment laws and involuntary treatment will begin to address their problems (Rossi, 1989). Others argue that homeless mentally ill individuals often do not utilize the limited array of services which are available in the community because they are either seen as not addressing their needs (psychiatric treatment) or of dangerously low quality (public shelters).

These advocates contend that homeless people will voluntarily avail themselves of opportunities to improve their situation if relevant, decent-quality service are offered. Clearly, these issues have at their core questions about the needs and characteristics of mentally ill homeless people. These questions include the following: what proportion of homeless people are mentally ill?; how did they become homeless?; what types of problems do they have?; what use have they made over the years of existing social and psychiatric services?; what types of services do they need now?; will they take advantage of services if offered? Hopefully empirical research might shed some light on these and other related questions. It is to this literature that we now turn.

### Empirical Studies

Several recent reviews of the empirical literature on homelessness are in agreement that the literature tends to be characterized by significant methodological weaknesses which make it difficult to draw conclusions about the phenomenon under study (Archard, 1979; Bachrach, 1984a, 1984b, 1984c; Johnson, 1989; Milburn, Watts & Anderson, 1984; Robertson, 1986; Tessler & Dennis, 1989). These weaknesses include problems in defining the study population, and in devising acceptable sampling methods and measurement procedures. These difficulties are compounded

by the lack of a well-defined theoretical framework in which to consider the available data.

Survey research is the dominant method in work on homelessness. The surveys tend to present purely descriptive data based on small and quite limited study samples and generally involve the completion of a brief interview or diagnostic protocol. Often these studies focus on the identification of particular forms of deviant behavior or psychopathology within the study sample. Such studies often report little more than a few demographic characteristics on the sample, followed by a discussion of the prevalence of the pathological behavior or social dysfunction which is of particular interest to the researcher.

This type of descriptive/diagnostic survey generally relies on the selection of a particular service site or emergency lodging setting for the identification of its sample. Studies of lodging house or flop house dwellers include those by Priest (1970a, 1970b, 1970c, 1976), Fischer et al. (1986), and Lodge Patch (1970; 1971). Appleby, Slagg & Desai (1982) and Lipton, Sabatini & Katz (1983) used this basic method to study homeless former hospital patients. Numerous studies of this type have been done with clients of shelters for the homeless. These include: Bassuk, Rubin & Lauriat (1984); Crystal & Goldstein (1984b); Edwards et. al. (1968); Freeman et. al. (1979); New York State Office of Mental Health (1982); and Spitzer, et. al. (1969). Despite

the relatively large number of such studies, it is quite difficult to use them to develop general descriptions of homeless people, their characteristics and problems. Drawing as they do on small samples drawn from specific service or shelter sites, their findings cannot be seen as representative of the larger universe of homeless people. Sampling methods within these sites, when reported, are often less rigorous than would be required to convincingly demonstrate that the individuals studied are representative of even the identified sub-group of the homeless which is under study. Especially important is the lack of standardized diagnostic criteria for evaluation of individuals' pathology or disabilities.

A notable exception to this type of survey research is the recent effort by Rossi and associates (Rossi, Wright, Fisher & Willis 1987; Rossi, 1989) to apply a more rigorous methodology to the task of estimating the composition and size of Chicago's homeless population. This study, a number of whose substantive findings are discussed below, is one of the only studies to seek a comprehensive sample of homeless people (both shelter users and unsheltered individuals) from an entire geographic area in order to legitimately enumerate and describe "the homeless" in general.

### Theoretical Constructs

This section discusses the literature in terms of several important theoretical constructs which are relevant



to the study of homelessness in general and, more specifically, to the variables which are of greatest importance to the current study.

### Homelessness

The apparent simplicity of the idea of homelessness (that is, lacking a home) is belied by the failure of researchers to agree upon an operational definition of this basic construct (Levine, 1984). Morse (1984) notes that three general approaches to defining homelessness which can be identified in the literature. One views homelessness as connected with a particular geographical area, such that individuals are seen as homeless if they inhabit the area or neighborhood known as "skid row" in whichever locality is being observed. Studies which use this approach often focus on residents of lodging houses or flop houses which once represented a major housing resource in these areas (Bogue, 1963; Breakey & Fischer, 1985; Fischer et al., 1986). A second approach defines homelessness as a theoretical construct in which those considered homeless manifest characteristics of the particular construct which the researcher has developed. The work of Bahr & Caplow (1974), which equates homelessness with disaffiliation (see discussion below) is an example of this approach. Most of the more recent literature, however, relies on a definition which views homelessness as the lack of a standard place of residence. The HUD study (1984) described above utilizes

this type of definition as do Baxter & Hopper (1981). One can also find definitions which combine elements of these approaches such as that of the GAO (1985) which defines the homeless as "those persons who lack resources and community ties necessary to provide for their own adequate shelter" (p. 5). Here the notion of lack of community ties augments the lack of a domicile.

Morse (1984) correctly notes the problems associated with the two first approaches. The geographical definition wrongly includes people who may have been housed in a stable situation for many years merely because their residence (say an SRO or flophouse hotel) is located in a skid row neighborhood. Similarly, it excludes individuals who may lack housing but who subsist in commercial or residential areas far removed from skid row. This definition is particularly problematic today when many skid row areas are disappearing and their residents being dispersed. The second approach, which equates homelessness with a more abstract theoretical construct, presents difficulties because for a person to be considered homeless, he must possess a particular set of attributes which may be unrelated to the person's residential status. While it may be the case that certain homeless people may be found to possess particular attributes or characteristics, it is clearly invalid to exclude from the definition those who do not. Thus the most useful approach is one which relies primarily

upon identifying particular settings which the target population utilizes for temporary shelter.

Of course this type of definition can vary greatly in the scope which it adopts. For instance, Roth et. al. (1985) are at the broad end of the continuum when they include as homeless those individuals who are staying in "cheap hotels or motels when actual length of stay, or intent to stay, is 45 days or less," as well as people who are staying with family or friends for a period of 45 days or less (p. 5). Hopper and Baxter (1981) adopt a fairly narrow definition which includes "those whose primary nighttime residence is either in the publicly or privately operated shelters or in the streets, in doorways, train stations and bus terminals, public plazas and parks, subways, abandoned buildings, loading docks and other well-hidden sites known only to their users" (pp. 6-7). Morse (1984) utilizes a similar definition; "a person may be considered to be homeless if s/he resides at night in emergency housing shelters or in public or private places without official permission" (p. 4).

### Homeless Taxonomies

If there is one statement about contemporary homelessness that practically every recent study or journalistic report agrees upon, it is that the homeless population is characterized by extreme heterogeneity. Many sub-groups have been identified within the homeless

population including: single-parent households who have been evicted or burned out of their homes; unemployed men who lack skills which would enable them to find employment; victims of domestic violence; mentally ill individuals, some previously hospitalized, and others who have never received treatment; ex-offenders who have been recently released from prison; youths who have run away, been rejected by their families, or recently graduated from the foster care system (Hopper & Hamberg, 1984).

Morse (1984) notes that the identification of homeless subgroups has important implications for understanding both causality and service needs among homeless people. Little research has been done which attempts to explicitly document the relationship between homeless subgroups and their paths to homelessness. However, the implication of most descriptions of such groups (including Hopper & Hamberg's above) is that different groups have become homeless for different reasons. It is also clear that different subgroups of homeless people will differ in their patterns of utilization and need for social, psychiatric, substance abuse and other services. This has been documented by Morse (1982) Segal, Baumohl & Johnson (1977), Roth et. al. (1985), Tidmarsh and Wood (1972), Wood (1976) among others.

Homeless taxonomies found in the literature may be grouped into three major categories based upon their theoretical orientations and the variables which go into in their development. The earliest attempts at identifying

taxonomies of the homeless rely on a sociological approach. Anderson's (1923), early grouping of the homeless into hoboes, tramps and bums, influenced a number of later researchers, primarily those who studied skid row populations. Bahr and Caplow (1973), for instance, found the Bowery to be populated by hoboes, bums, old-timers and loners. Rooney (1980) uses a similar taxonomy which includes unemployed workers, pensioners, alcoholic spree drinkers and mission stiffes. These typologies have in common that they rely primarily on an analysis of individuals' roles and affiliations within the homeless sub-culture, although disability (typically alcoholism) may also be seen as relevant. Leach (1979) distinguishes between intrinsic and extrinsic types of homeless people; extrinsics become homeless "largely because of social disadvantages such as scarcity of accomodation and employment," (p. 98) while intrinsics become homeless as a result of chronic social and psychological disabilities such as mental illness and alcoholism.

The type of taxonomy which dominates the recent literature focuses primarily upon disabilities among the homeless. These categorizations, which generally grow out of survey research, group the homeless by an assessment of their "primary problem" (Crystal & Goldstein, 1984b; Morse, 1982; Breakey & Fischer, 1985; Wood, 1976). Such studies generally use psychiatric problems, substance abuse, physical disabilities and old age as primary categories,

with the occasional addition of a "none of the above" category (Crystal adopts the term "economic only" to refer to shelter clients who have no apparent disability). In addition to the difficulty in accounting for these non-disabled people, another obvious problem with these taxonomies is in classifying individuals who have disabilities in more than one area (although a recent effort by Struening and Padgett (1990) looked explicitly at the overlap of disabilities in developing such a typology).

A third type of taxonomy which may be found among several of the more recent surveys is based on current residential status or residential history (Arce et. al., 1984; Chavetz & Goldfinger, 1984; Grigsby et. al., 1990; Ropers & Robertson, 1984; Rosnow et. al., 1985; Roth et. al., 1985). The variables which are considered may include duration of current homeless episode, present place of residence (shelter versus street, etc.), and history of homelessness. Typical homeless sub-groups in this category are long-term, episodic and situational. Although these taxonomies have, to date, been utilized primarily in a descriptive way, it is likely that they hold significant promise for understanding etiology and service needs of the homeless, as well as providing insight into the population's strategies of coping and adaptation.

### Disaffiliation

The unifying construct which underlies the influential skid row studies of Bahr and his colleagues is disaffiliation, defined as "detachment from society characterized by the absence or attenuation of the affiliative bonds that link settled persons to a network of interconnected social structures" (Caplow, Bahr & Sternberg, 1968, p. 494). More specifically, these bonds may be grouped into six major types: family, school, work, religion, politics, and recreation (Bahr & Caplow, 1973). According to the authors, this construct is directly related to the major characteristics which had been used to describe the homeless populations studied at the time of his work: transience, skid row residence, chronic alcoholism, extreme poverty, and separation from family. Bahr and Caplow developed evidence which sought to demonstrate that skid row men as a group tended to be more disaffiliated on several important indicators, than either low-income or high-income non-homeless men. Although as Morse (1984) points out, this work may be criticized for using disaffiliation as a definition of homelessness, rather than as a correlate or cause, this construct continues to have relevance for the study of contemporary homelessness.

Several recent studies refer to the construct of disaffiliation, most often as an attribute which characterizes the population under study. Breakey & Fischer (1985) follow Bahr & Caplow closely by incorporating

disaffiliation into their definition of who should be considered homeless. They contend that residential status alone is insufficient to define homelessness since "a 'home' is more than four walls, for the idea of 'home' includes loving support" (p. 23). Thus the homeless may be distinguished by their paucity of affiliative ties to other people. Breakey & Fischer's discussion appears to use the constructs of affiliation, social networks and social supports interchangeably, a common problem in the homelessness literature. Bassuk, Rubin & Lauriat (1984), reporting on a clinical diagnostic study conducted at a Boston shelter, refer to the extreme "disconnection" found among those studied. They found that roughly three quarters of the total sample had no family relationships and the same proportion had no friends who could provide support. Those with psychiatric hospitalization histories were found to be even more disconnected from friends and family. The authors conclude that "the hallmark of homelessness is extreme disaffiliation and disconnection from supportive relationships and traditional systems that are designed to help" (p. 1549). Again, this formulation is related to Bahr and Caplow's construct but focuses on the social support dimension, whereas the original work placed greater emphasis on the lack of participation in social institutions.



### Social Networks

As noted above, while the construct of social networks is often used interchangeably with affiliation in studies of the homeless, it is in fact a more delimited, but not unrelated, concept. Where affiliation generally refers to connections between individuals and a broad range of social institutions (family, work, religion, etc.), the study of social networks focuses exclusively on the systematic properties of social relationships between individuals (Lipton, et. al., 1981). Social networks, then, are a way of describing the set of interpersonal relationships which an individual has with others. According to Hammer (1983), one of the pioneers in the study of social networks, networks have three critical functions. First, networks are transmission paths for many things in society including information and behavior patterns. Second, networks influence the formation of individuals' behavior and personality. Finally, networks serve a cushioning function during stressful events, providing support which may buffer the effects of such events.

Researchers have examined several conceptual models, from direct causal explanations (e.g., major social losses leading to depression) to a "mediating" model in which the network makes the likelihood of developing a condition more or less likely (e.g., social contacts influencing an individual becoming an alcoholic). Hammer (1983) notes that the network may "also make an event like losing one's home

results which may arise from surveys which approach the question with a priori assumptions about what constitute significant network ties.

Fischer et. al. (1986), for instance, report that the mission users they studied differ significantly from a non-homeless comparison group in the characteristics of their social network. The variables which were studied were marital status (the homeless were much less likely to be currently married, and more likely to have been never married), and whether or not subjects reported regular interaction with friends or relatives (the report implies that the homeless report less of such interaction). Roth et. al. (1985), in a survey of urban and non-urban homeless in Ohio, also found that homeless people were more isolated from friends and relatives than a non-homeless comparison group, looking primarily at frequency of contact. Bassuk (1984) reports that roughly three quarters of a sample of shelter users reported that they had no relationships with either family or friends. She notes that those who had been previously hospitalized for psychiatric reasons reported even less social contact. Rossi (1989) using a more sophisticated set of measures also reports that the homeless in his sample had relatively few ties to relatives or friends. These studies are representative of the method by which the construct of social networks has been applied to research on the homeless. They are also typical in their conclusions; the homeless are seen as having impoverished

social networks, findings based primarily on the relatively limited contact reported with family members and friends.

### Social Margin

The notion of social margin combines the concepts of affiliation, social support and social networks with additional resources and attributes to form a broader, more encompassing construct. Wiseman (1970), who first developed this construct in an ethnographic study of skid row alcoholics in Chicago, refers to social margin as an attribute, ascribed largely by others, which serves a protective function in insulating an individual against possible social disasters such as unemployment, homelessness and destitution. "Width of margin," she notes, "is historically determined by a person's known biography. This, in turn, affects the number of people willing to render aid in a tight spot" (p. 224). Social margin is enhanced by the possession of well-developed social networks as well as specific skills and attributes including: work history and skills; income and access to money; appropriate wardrobe; and personal history free from stigmatizing experiences such as time served in prison or mental hospitals.

Segal and his colleagues (1977) further developed this construct in a study of mentally ill street people in Berkeley, California. Defining social margin as "all personal possessions, attributes, or relationships which can

be traded on for help in time of need," (p. 387.) they hypothesized that the mentally ill subgroup of street people possessed less social margin than did their non-mentally ill peers. The construct was operationalized by examining social isolation (participation in social activities, friendships), family contact and support, and assistance by formal system of community services. The data provided support for the authors' hypothesis. Compared to their peers, the mentally ill were found to be more isolated from other street people, more alienated from their families, and to have been homeless longer. A related finding was that the mentally ill also had considerable difficulty in obtaining services (and thereby enhancing their social margin) from social service and mental health agencies which were ostensibly charged with providing assistance. This was attributed to the incongruence of expectations between service providers and their potential clients; street people felt their competence and autonomy threatened by service institutions and providers found street people to be non-compliant and difficult to help. The authors conclude that due to their lack of social margin, mentally ill street people are at particular risk of becoming chronically disordered and dependent individuals who will eventually require some form of institutional care.

The construct of social margin, encompassing ideas of affiliation, social support, and salient personal attributes, appears to be a significant one for

understanding varying profiles among the homeless. Indeed, several of the studies which specifically examined homeless persons' residential profiles, utilized variables drawn from among those which comprise this broad construct. These studies are considered below in some detail.

### Institutional Habituation

Numerous studies have demonstrated that institutionalization in a wide variety of settings may have a harmful impact on those institutionalized (Goffman, 1961; Wing, 1972; Ellenberger, 1960; Zusman, 1966). The behavioral and social adjustment difficulties associated with long-term institutional care were primary factors in supporting the move to an emphasis on deinstitutionalization as the policy of choice in the treatment of the mentally disabled. Goffman's seminal study (1961) of the "total institution" convincingly describes the process by which individual identity and self-reliance become impaired through the process of institutional adjustment.

One of the problems created by long-term exposure to institutional settings is a so-called "nestling in" process, by which individuals' adaptation to the institution replaces the original desire to live independently. In a study of institutionalized mental patients, Wing (1972) found that those who had experienced relatively long inpatient stays displayed less favorable attitudes toward discharge than the more recently admitted groups. Wing sees these findings as

offering support for the hypothesis that "patients gradually develop an attitude of indifference towards events outside the hospital which is part of a syndrome of institutionalism" (p. 38). Rosenblatt and Mayer's (1974) review of studies of hospital recidivism by mental patients also offers possible support for this position. Although there is little empirical data on which to evaluate the proposition, there is reason to believe that this dynamic may also operate with respect to individuals housed in shelters for the homeless. A Depression-era study of homeless shelter users (Sutherland & Locke, 1936) detailed precisely this phenomenon, naming it "shelterization." They found that, after varying periods of exposure to shelter life, a man "shows a tendency to lose all sense of personal responsibility for getting out of the shelter; to become insensible to the element of time; to lose ambitions, pride, self-respect and confidence; to avoid former friends and to identify himself with the shelter group" (p. 146). Segal and Specht (1983), noting a similar process taking place at a contemporary shelter in California, argue against institutional care for individuals whose only disability is their poverty. Grunberg and Eagle (1990), reporting on their clinical experience in one of New York City's larger shelters also report what they believe is evidence of this phenomenon.

### Residential Experience of Homeless People

A number of surveys and ethnographic studies report data directly related to questions about residential and homelessness histories among the homeless. Although many are limited to descriptive data, a small number utilize multivariate analyses in an attempt to shed light on the correlates of differing patterns of residential experience. Findings from these studies are summarized below, organized into sections which focus on the following areas: Homelessness History; Shelter Utilization; Geographic Mobility; Pre-Homeless Residential Setting.

#### Homelessness History

The study of individuals' histories of homelessness have focused primarily on questions of duration, most often of length of time since an individual experienced his first episode of homelessness. Some studies have also examined duration of the current or most recent homeless episode. As would be expected, frequency distributions of duration of homelessness vary widely across studies, reflecting the diverse range of populations studied. Several studies have attempted to correlate demographic and background variables, social support, and various forms of social pathology with duration of homeless experiences. Unfortunately, a number of studies fail to specify an operational definition when reporting data on these variables, making it difficult to compare their findings with other studies.

Rosnow and colleagues (1985) report longer durations of current homeless experience among older individuals as does Morse (1982). The New York State Office of Mental Health (1982) also reports this association although whether they studied duration of current or original experience is unclear. Although Rosnow et al. report longer durations among whites than others, a race correlation is not confirmed by other researchers. Morse (1984) found that men report longer durations of current homeless episodes and longer time since their first homeless experience than do women. Although this finding is not confirmed elsewhere, this may be due to the paucity of studies which include sizeable female samples. Morse (1982) also reports that length of time since first homeless experience is positively related to lower levels of education and remembrances of unhappy childhood family lives on the part of homeless respondents.

Rosnow et al. (1985), New York State Office of Mental Health (1982) and Morse (1982) each found longer durations of homelessness to be positively related to low amounts of contact with relatives and non-homeless friends, an intriguing, but difficult-to-interpret finding. One might hypothesize such a causal relationship based upon a theory of the buffering effects of supportive social networks, (low social support leading to longer periods of homelessness). However, such a finding may simply demonstrate that the longer an individual is homeless, the more difficult it



becomes to retain social relationships with individuals outside of the homeless subculture.

Similar questions are posed by the oft-found correlation between current psychopathology and duration of homelessness (Wood, 1979; Segal, 1977; Arce et al., 1983; Morse, 1982). Again, the direction of causality is difficult to demonstrate and plausible arguments have been made on both sides (see Baxter & Hopper, 1981, for discussion of the pathogenic effects of life on the street). Studies which relate histories of psychiatric hospitalization with duration of homelessness are equally non-definitive since the precise time sequence (did hospitalization precede homelessness?) is generally not reported. A recent study by Sosin, Piliavin and Westerfelt (1990), in an longitudinal survey of homeless people in Minneapolis, reflects one of the more sophisticated efforts to investigate patterns entrances into and exits out of homelessness. They found that, in many cases, homelessness was episodic in nature and reflected an extreme period in the lives of people for whom residential instability was commonplace.

In sum, the findings on duration of homelessness, though far from conclusive, point toward a number of potential relationships with demographic and personal history variables. Several studies indicate that age is positively related to duration of current homeless experience. Although the importance of gender has rarely

been examined, one of the more methodologically rigorous studies found it to be significant. The research indicates that social support variables and psychopathology are related to duration of homelessness, but the direction of causality has yet to be demonstrated.

### Shelter Utilization

Shelter residents are the most frequently studied segment of the homeless population (Milburn et al., 1984), perhaps due to the relative ease with which they may be located and observed. As such, a commonly reported set of data describes patterns of utilization of either the shelter under study, or shelters in general. Again, the lack of consistency across studies, as well as weaknesses in describing how variables were operationalized, make it difficult to generalize from their results.

Age was found to be positively related to duration of current shelter stay and time since first shelter contact by Crystal & Goldstein (1984a), and Crystal, Potter & Levine (1984), in the only previous study to examine this variable in the New York City municipal shelter system. The analysis relies on cross-tabulations comparing length of stay between two age groups--under-50 and over-50 years of age. Whether or not a more general age association would be found cannot be determined from these reports. The authors note that age has a stronger influence on length of current stay among men than women, and that males, as a group, are more likely to

stay longer than are females. Although they report no association between race and length of stay, Morrissey et al. (1985), in a study of a specialized shelter for the mentally disabled, found that Blacks and Hispanics were more likely than whites to have entered the shelter system four or more years before the study (this, of course, may not necessarily be related to length of current stay). Crystal and colleagues also report that higher levels of education are associated with shorter current shelter stays.

Roth et al. (1985), although not reporting on length of shelter stay, presents relevant data in a terms of variables associated with with particular sub-groups in a created typology of homeless people. They found that "shelter people" (those who slept in a shelter the night before the study or reported doing so during the preceding month) tended to have longer histories of homelessness than did non-shelter users. Shelter people were also more likely to be veterans and to have the highest rates of previous incarceration in the criminal justice system. These findings are of interest in light of their possible support for an "institutional habituation" explanation for chronic shelter use. Similarly, Roth et al. also report that previous psychiatric hospitalization is slightly more common among the shelter people than among others.

Several studies relate some measure of current psychopathology to heavier patterns of shelter utilization (Arce, 1983; Crystal & Goldstein, 1984a; Crystal, Potter &

Levine, 1984; Morse, 1984; Wood, 1976; Wood, 1979). As noted above, the direction of causality is difficult to determine. Crystal, Potter & Levine as well as Wood, in the only speculative explanation offered, each hypothesize that the psychiatrically disabled are more difficult for shelter workers to place due to their special needs for supportive transitional and long-term housing arrangements, thus their longer shelter stays. On the other hand, Baxter & Hopper (1981), contend that the mentally ill are less likely than the non-mentally ill to use shelters because they are particularly at risk in the dangerous conditions which they found to characterize the shelter system in New York City at the time of their study. Crystal, Potter & Levine also report that the association between shelter use and psychiatric background is more pronounced among men than women, a finding they believe may be explained by the greater availability of family and friends' support for women. Bassuk (1984), although not concerned with the gender issue, provides indirect support for this hypothesis through her finding that shelter use is more regular among individuals who have no family or friends available to provide support. Rossi (1989), in a recent study of the homeless of Chicago reported data comparing individuals interviewed in various residential settings. He found that street dwellers tended to be more disoriented, discouraged and dishevelled than their sheltered counterparts. In terms

of demographics, he also found that young women were more likely to use shelters than other groups.

As with homelessness histories, these findings do not allow for definitive conclusions. However, several studies indicate the potential significance of demographic variables such as age, sex and race to patterns of shelter utilization. Level of education, veteran status and institutional background may also be important. Current psychiatric disability and alcoholism/substance abuse have consistently been identified as positively associated with heavier shelter use, although no definitive explanations have been offered.

#### Geographic Mobility

The issue of homeless individuals' geographical mobility has been a source of some contention between advocates and local officials eager to demonstrate that the problem of homelessness has been "imported" from elsewhere. Sun Belt civic leaders suspect that the homeless come to them in search of employment and the hospitable climates, while New York City officials fear that the relatively generous provisions made for the homeless draw those from cities which do not provide as much. Several studies examined this question, looking primarily at homeless people's place of birth or time spent in the locale in which they were currently staying.

Ropers & Robertson (1984) compared data from studies from several cities reporting on period of residence in those respective cities. They found that the Phoenix study did, in fact, note the highest proportion of individuals who had lived in the city for a year or less (59%). The New York and Los Angeles studies, on the other hand, reported the highest proportion of individuals who were local residents for for more than five years (82% and 80% respectively). Crystal & Goldstein (1984b) found that roughly 2/5 of their sample of New York City municipal shelter users were born in the city, with a slightly higher proportion among women than men. Morse (1984), the only other author to examine a sizeable sample of women, found that men were more likely than women to have lived in several cities, but reports no data on place of birth.

According to Segal & Baumohl (1980), inter-city mobility is particularly pronounced among the mentally ill. They contend that this "wandering" phenomenon is the result of a "flight syndrome" in which mentally disordered people attempt to find relief from stress by "running from the commitments and obligations of close relationships...leaving behind failures and pejorative social judgements" (p. 359). This process, they note, is likely to leave such individuals impoverished, disaffiliated and homeless. Chavetz & Goldfinger (1984), Appleby, Slagg & Desai (1982), and Appleby & Desai (1987), who studied residential instability among psychiatric hospital patients, provide some support

for this notion. These studies found that a large proportion of psychiatric patients of large urban psychiatric centers are either homeless or "on the move" before and after their contact with the treatment system.

Wood's (1979) study of public shelter users in London, the only empirical study of homeless people which explicitly examined the relationship between mental illness and geographical mobility, found that the mentally ill were significantly more likely to be "locals" than were their non-mentally ill colleagues.

#### Pre-Homeless Residential Setting

Surprisingly, relatively few studies have inquired about the pre-homeless residential settings of their subjects. Crystal & Goldstein's (1984b) study of New York City municipal shelter users asked about respondents' usual home over the preceding three to six months. The most frequent response was one's own apartment, followed by with family and then with friends. A small proportion (5.6% of men, 1.8% of women) reported that the streets or subway were their usual home. Women were less likely to have previously resided in prison or a shelter, but more likely to have been in other institutional care. Women were also slightly more likely to report having been living with a friend, a finding which is consistent with the gender-related social support differences reported above. Another study of male long-term New York City shelter users (Human Resources Administration, 1982), found that men 30 years of age and under were

which these variables have been operationalized. About all that can be said reliably stated is that gender, age and psychiatric status have occasionally been found to be related to differences among a number of these variables, although few convincing explanations for such differences have been offered.

#### Homeless Persons' Self-Ratings of Service Need

The question of service preferences among the homeless population is obviously a central one for the design and implementation of effective interventions. Practice experience has demonstrated that many homeless people have had negative experiences with the social service and health service delivery systems and many feel that these systems are neither accessible or responsive to their needs. This has undoubtedly contributed to public perceptions that the homeless don't want help and will reject it if offered. Advocates have countered that homeless people will accept services if what is offered is seen as responsive to their needs. Thus it is seen as important to ask homeless people themselves how they perceive their needs and service willingness.

A handful of previous studies have investigated homeless persons' own judgements of their need for services. These studies have generally used the same basic methodology as does the present study: subjects were asked to respond to either open-ended or fixed-choice questions regarding what



considerably more likely than the older group to report having lived previously with family or friends, to have lived on the street, or to have been in jail or a hospital. The older men were more likely to have lived in their own apartment, an SRO hotel or in a Bowery flophouse.

Mowbray, Johnson & Burns (1985), in a study of 35 homeless inpatients in a state psychiatric hospital in Michigan, also gathered data on subjects' residential histories. In an attempt to understand the original cause of individuals' residential instability, they identified the following five categories of residential patterns (in order of frequency): parental rejection; marital rejection; situational; life-style; left dependent care. Although the small number of subjects and the descriptive nature of this study limits its usefulness, it is interesting in that it confirms the generally accepted wisdom that there are many varying routes into homelessness, even among a single homeless sub-population (the homeless mentally ill).

Rossi (1989) found that demographic differences were significantly associated with pre-homeless residential settings. While most men had lived in their own rooms or apartment before becoming homeless, the younger women tended to have lived with spouses or children.

The findings on variables related to mobility and residential histories are difficult to interpret due to the paucity of studies which have examined these issues as well as the lack of consistency which characterizes the way in

kinds of services would help them live a more satisfactory life.

An early study by Farrell (1981) of homeless men in Washington, D.C. found that the most often requested services were employment and unspecified social work services. This study also asked respondents to indicate their "biggest daily problem." Food, clothing, shelter and transportation were the most common ranking responses. Mulkern and Bradley (1986), reporting on a needs assessment study of homeless men and women in Boston, also found that the services most wanted were those related to meeting basic needs for food, clothing, housing and jobs.

Ball and Havassy (1984) interviewed 112 homeless people, all of whom had extensive histories of involvement with the mental health system in San Francisco. In response to an open-ended question regarding the type of resources or services which they needed in order to avoid rehospitalization, 86 percent said housing, 74 percent said financial entitlements, 40 percent said employment and 32 percent specified social activities. The authors note that supportive counseling was indicated by only 14 percent, strikingly low considering that presumably the entire sample was mentally ill. Ball and Havassy conclude that "there is a serious mismatch between the kinds of services that community mental health systems traditionally provide and the kinds of services this homeless population feel they need" (p. 920).

A recent study of homeless adults in two Los Angeles beach communities (Gelberg and Linn, 1988) compared expressed service needs between three groups, based upon their previous use of mental health services. Respondents were asked to report the three most important things that people like themselves needed in order to have a better life. The total sample gave the following priorities: improved social relations (49 percent); employment (36 percent); housing (34 percent); and money (31 percent). The "non-utilizer" group (those who reported no previous contact with the mental health system) were more likely to mention housing as important. This group was least likely to indicate health care as an important need. Those previously hospitalized for psychiatric problems were most likely to express a need for improved social relations. The authors report that, in other than these areas, the three groups generally did not differ with respect to this question. Another report based on the same study (Gelberg and Linn, 1989) found a number of differences on priorities between men and women regarding the need for employment and permanent housing.

Morse (1982) has provided a detailed multivariate analysis of homeless persons' self-ratings of service needs in a study of 165 male mission users in St. Louis. Using eight items which measured need in a range of areas, Morse reports that the most often requested needs were a job, permanent housing, financial assistance, and food.

Medical care, alcoholism and psychiatric treatment were significantly lower priorities overall. Employing multiple correlation techniques, the author then assessed the associations between a set of predictor variables and a single scale measuring overall level of self-rated need. Among his findings are the following: greater levels of self-rated need are associated with ethnic minority status, never married status, current psychopathology, current problematic drinking behavior and longer periods of prior homelessness. Subsequent reports by the same group (Morse & Calsyn, 1986; Hannappel, Calsyn & Morse, 1989) followed this line of inquiry. Among the findings is that variation in shelter utilization was not found to be associated with differential service need priorities.

An exploratory study by Struening and Barrow (1985) which employed the same data set as does the present study examined associations between selected predictors and self-rated need for help in several health-related areas. They found a history of treatment, diagnosis of mental disorder, current health and mental health status and current service oriented activity to be the strongest predictors of self-rated need for help.

A recent study by Padgett, Struening and Andrews (1990) touched on this issue in a broader examination of predictors of medical, mental health, alcohol and drug treatment services by New York City shelter users. They conclude that despite high levels of directly and indirectly assessed need

(including self-ratings by respondents), the majority of those surveyed have not recently used the needed services. The authors note that, given the overwhelming need for housing and income which most homeless people experience, it may be that treatment services, while needed, are simply lower on the hierarchy of need and therefore not sought out.

In sum, the few studies which have been done in this important area are in relative agreement that homeless people, as a group, place a higher priority on the need for employment, housing and income than they do on for services such as mental health and alcoholism counselling. There has been no work to date which investigates the ways in which self-rated service needs are found to co-exist in the homeless population. Correlates of differing self-ratings of service needs have also been little studied to date.

#### Mental Disorder and Mental Distress

Perhaps no other single issue regarding homelessness has been as extensively debated (or generated as much controversy) as has the relationship between homelessness and mental illness. Several recent articles which discuss the assessment of mental disorder among the homeless (Robertson, 1986; Susser, Struening & Conover, forthcoming; Koegel and Burnham, 1990; Bean et. al., 1987; Snow et. al., 1986; Tessler & Dennis, 1989; Wright, 1988) are in fundamental agreement that, despite the deluge of studies in this area, little consensus exists with respect to several

important methodological issues. An in-depth review of these issues is not possible here, however, several fundamental concepts which hold relevance for the present study will be briefly discussed below.

### Mental Health Indicators

Indicators of mental health status among the homeless generally fall into three categories: history of psychiatric hospitalization; psychological distress; and psychiatric disorder (Robertson, 1986). History of psychiatric hospitalization is the most often reported measure of mental health status. In her review, Robertson found a range of 15 percent to 42 percent of adult samples reporting previous hospitalization, a much higher rate than found in the general population. Previous hospitalization as a solitary indicator of mental illness has several obvious drawbacks. For one, particularly in recent years, obtaining admission to a psychiatric hospital has grown increasingly difficult. Therefore it is quite possible that a significant number of people with a history of mental illness have never been in a psychiatric hospital. In addition, a history of psychiatric treatment does not necessarily imply that an individual is currently symptomatic or in need of treatment. For these reasons, other indicators of mental distress are also important.

Psychological distress measurements are designed to assess the current level of psychological disturbance in an

individual by the administration of standardized protocols generally involving the self-report of various symptoms. Several such protocols have been developed by epidemiologists for use with samples of psychiatric patients, their families as well as in general community studies. Robertson (1986) reports that using these measurements as well, the homeless population tends to exhibit higher rates of psychological distress than does the general population (even though few comparative studies have been performed).

Although in some instances assessment protocols have been specifically adapted for use with the homeless, more often they have been used in their original form. Susser et. al. (forthcoming) convincingly note several major weaknesses in the utilization of such assessment methods. The authors point out that these instruments are not well suited for the study of severe disorders such as schizophrenia which, although rare in the community, is common among the homeless. Furthermore, they note, such instruments are not designed for a population under severe stress, which is certainly the case for undomiciled people. For these reasons, among others, the use of existing standardized protocols and screening scales to determine the incidence or prevalence of mental disorder among the homeless is a risky endeavor.

The assessment of psychiatric disorder by a formalized diagnostic process can be fraught with similar problems as

those described above (Susser et. al). The authors observe that:

"interviews are often hard to conduct: comfort and privacy may be difficult to obtain; those who are mentally ill may not be in treatment and may be afraid to reveal information about symptoms and treatment history...Substance abuse and psychiatric disorder may each be highly prevalent, and frequently coexist; without either records or followup, it can be difficult to determine whether symptoms acknowledged are due to substance abuse, other psychiatric disorder, or both." (p. 8)

Thus, even studies in which trained mental health professionals attempt to apply their diagnostic acumen to a sample of homeless people, reliability and validity can be questionable.

#### Childhood Experiences of Homeless People

Although many of those who have worked with homeless people report that a significant proportion of their clients have a history of parental separation, institutional placement and delinquent behavior dating back to childhood and adolescence, there has been surprisingly little empirical work which has sought to document these anecdotal reports. Virtually no research, with the exception of the studies described below, has attempted to investigate the association between childhood difficulties and subsequent life experiences among the homeless.

Morse (1982) included a single item concerning childhood family relations in his study of homeless mission users. Respondents were asked to rate, in a Likert-scale item, how happy their family life was as a child. Modest



associations were discovered between this variable and length of time since first homeless as well as a global measure of current psychopathology. Jones et. al. (1986) found that 23 percent of a sample of 158 homeless men and women in New York City said they had been abused as children.

Susser et. al. (1987), utilizing data from the same survey as does the present study (Housing Needs Assessment of the Homeless, 1985) reports the prevalence of various childhood experiences across several subgroups of homeless men. Although no control group was available the authors were struck by the "high frequency of institutional separation from the family during childhood. Similarly, a childhood history of delinquency and/or running away was common" (p. 1600). The authors found a significant association between history of psychiatric hospitalization and childhood placement. No evidence was found for an association between these experiences and length of stay in the shelters. The authors hypothesize that "a combination of scarce family resources and conflictual family relationships is an important determinant of such childhood experience as well as of adult homelessness ... [and] men with adverse family histories lack available and effective kin support to protect them from the hardships of the housing crisis" (p. 1600).

As far as can be determined, no other studies seeking to explore the relationship between childhood experiences of

the homeless and their subsequent life course have been reported.

### CHAPTER THREE

#### METHODOLOGY AND DESCRIPTIVE STATISTICS

As shown above, the existing literature is not terribly helpful as a guide toward understanding the dynamics of homelessness from a life course perspective. Nor does it provide many clues regarding fruitful avenues to investigate. Specifically, few hypotheses have been developed which seek to relate an individual's background and earlier life experiences to their later involvement with homelessness and current functional status. This study is exploratory in nature in its attempt to build upon this rather disjointed literature by seeking to identify personal attributes, characteristics and life history variables which are associated with current status and recent experiences of the homeless in several domains.

The main question to be answered is as follows: What is the relationship between homeless persons' childhood experiences, personal attributes and earlier life experiences and their more recent experiences, their present level of functioning, and their need for services?

The answers to these questions have both theoretical and practical implications. It is expected that the study will shed light on one of the more nettlesome controversies which surrounds the homelessness debate; the question of the degree to which homeless and residential instability result from personal incapacity (i.e. poor adjustment, delinquent

lifestyle, mental illness) as opposed to the pressing shortage of a critical social utility (affordable housing). Although there is consensus that both factors play a role in producing homelessness, little previous empirical work has attempted to determine whether a history of personal difficulties is indeed associated with poorer outcomes within the currently homeless population. If such an association is identified, the study will also help to specify a relatively small number of such life history variables which may be of particular salience.

In addition to contributing to further inquiry on homelessness by suggesting avenues for future research, the identification of these variables may hold promise for the development of programs and policies intended to prevent long-term homelessness among those most at risk. If particular sub-groups among the homeless who can benefit most greatly from specific types of services can be identified, scarce resources can be more effectively targeted and services more efficiently delivered.

#### The Housing Needs Assessment of the Homeless

All of the research questions will be examined using data gathered in the first wave of the Housing Needs Assessment of the Homeless Survey (HNAS), conducted in the spring and summer of 1985. The study was commissioned by the New York City Department of Mental Health, Mental Retardation and Alcoholism and the City's Office of

Management and Budget to provide an empirical basis with which to plan for the development of transitional and long-term housing for the shelter population. Extensive information was collected on the personal characteristics, life histories, service and housing needs, health status and patterns of service utilization of over 1400 male and female residents of eighteen public shelters for the homeless in New York City (see Appendix A for a brief history and description of the shelter system as it was configured at the time of the study). The study was conducted by the Department of Epidemiology of Mental Disorders of the New York State Psychiatric Institute with funds provided by the New York City Department of Mental Health and the New York State Office of Mental Health. Significant cooperation and collaboration were extended by the Bureau of Adult Services of the Human Resources Administration.

During the study period, the author was a member of the staff of the New York City Department of Mental Health. The author's role in the original study included serving as liaison between the research team and the relevant government agencies in the design and implementation of the survey as well as ongoing participation as a member of the research team in design and piloting of the instrument, training of interviewers, and development of sampling strategies in several shelter sites.

The study's findings have since become the primary data base for the creation of subsequent plans for the

enhancement of the city's system of services for homeless people (see for example Human Resources Administration, 1988 and Human Resources Administration, et. al., 1986). A second wave of data using a slightly revised version of the original study instrument was collected in 1987.

### The Survey Instrument

The survey instrument was constructed over the course of two months by a group of researchers and other individuals familiar with the target population and the shelter system under the general supervision of the principal investigator, Dr. Elmer Struening. Most sections of the instrument required the development of new questions designed specifically for this study. However, several standardized diagnostic and screening scales were adapted by the group for use with the homeless population. The draft instrument was then piloted in several shelters and revised accordingly. The final interview protocol (Appendix B) is 52 pages long and contains several hundred fixed-choice and open-ended items.

### The Study Sample

A sampling procedure was developed which sought to obtain a sufficiently large, representative sample of male and female residents of public shelters located in four boroughs of New York City. This procedure determined a target sample size required from each shelter which was

proportionate to its relative size within the total system as it was constituted at the beginning of the data collection process. In some cases, deliberate over-sampling was done in particular sites to permit the collection of large enough numbers of specific subgroups (women, older clients, clients of on-site mental health programs and new admissions) for analytic purposes.

Responses to the protocol were elicited from shelter residents by interviewers who had been trained for six weeks in intensive pilot work supervised by experienced interviewers and senior project staff. Interviewers solicited respondents from residents waiting in lines for meal tickets or service appointments or from bed lists made available by staff of the shelter. Shelter residents were sampled during both day and evening shifts. Representative samples were generated by considering every Nth person waiting in line or by randomly selecting subjects from bed lists. The purposes of the study and the content of the interview protocol were described to potential respondents selected from the lines and lists. A fee of five dollars was paid for completed interviews. Each participant in the study signed an informed consent form. The interviewing took place during the late spring and early summer of 1985.

Refusal rates ranged from site by site by ten to twenty-five percent, with an average of approximately twenty percent over the course of the entire study. Some refusals were related to appointments for jobs or housing

possibilities, attendance at a training or treatment program or to some other obligation. Other refusals were due to pleasant weather, distrustful attitudes toward the interviewers, the influence of drugs or alcohol, severe symptoms of mental disturbance or simply a reluctance to provide information of personal and sensitive nature.

After data collection was completed, a second sample of male respondents, called the substitution sample, was developed by crediting under-sampled shelters with subjects from other similar shelters. This weighted sample (N=695) differed only slightly from the general sample on 22 important variables and is felt to be the most representative of the men in the shelter system as a whole. This data set was made available to the author and is the source of the sub-sample developed for the analyses reported subsequently.

Several demographic variables of the substitution sample are worth noting. The mean age was 34.9 years with a standard deviation of 10.5. The distribution of age is skewed toward younger age as indicated by a median age of 32.0 years. 71% are in the Black, non-Hispanic category; 19% Hispanic; 6% White, non-Hispanic; 2% Asian; 2% Native American and other. 63% of the sample reported a marital status of never-married, 5% married, 18% separated, 11% divorced and 3% widowed. 6% had no formal schooling or some grade school, 4% finished grade school, 39% had some high school, 32% completed high school, 15% had some college, 3%



completed college, and 1% had some graduate training or completed a graduate degree. 85% were born in the United States (excluding Puerto Rico), 8.3% in Puerto Rico, 1.0% in Haiti, 1.3% in South America and 1.2% in Central America. Of those born in the United States, 60% were born in New York State.

#### Sample Used for Analysis

A subgroup of the substitution sample was used for all the analyses which follow. This subgroup was developed by selecting all subjects in the substitution sample who reported their age as between 28 and 50 at the time of the study (N=451). This cohort, which comprises over 50 percent of the weighted sample, was selected because it represents persons for whom the life course perspective and the selected outcomes have the greatest relevance. That is, these men are old enough to have had a chance, so to speak, to experience particular adult outcomes. Limiting the analysis to this group also reduces the possibility of cohort effects based on age which might obscure important relationships.

Next a preliminary analysis was performed in order to determine the prevalence of missing data for the 46 variables of primary interest among these cases. A value was computed for each case which corresponds to the number of variables which were reported missing for that particular case. These values could therefore hypothetically range

from zero (no missing data) to 46 (all missing data). The frequency distribution of these values is presented in Table 1. Cases with four or more missing data variables were dropped from the study, leaving a final N of 439 cases.

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**Table 1**

**Frequency Distribution of Missing Data for Each Case**

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| <u>Value</u> | <u>Frequency</u> | <u>Percent</u> |
|--------------|------------------|----------------|
| 0            | 234              | 51.9           |
| 1            | 138              | 30.6           |
| 2            | 45               | 10.1           |
| 3            | 22               | 4.8            |
| 4+           | 12               | 0.3            |
|              | -----            | -----          |
| Total        | 451              | 100            |

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#### Selection, Definition and Measurement of Study Variables

As noted above, this study attempts to understand the experience of homeless men from a life course perspective. It explores the relationships between family background and childhood events, adult experiences and current status by examining a relatively large number of variables from a number of different domains. The variables are described below in the context of this basic framework. Specific variables, their operational definitions and the relevant items from the survey instrument used to measure them are presented in Table 2.

Several variables are measured by multiple item indices which were developed in previous analyses and made available to me as part of the data set. Other multiple item indices required for the analyses were created by the author. Their development is described below. Unless otherwise noted, all descriptive statistics refer to the final sample of 439, the selection of which is described above.

#### Childhood Risk Factors

The following items regarding respondents' family backgrounds as well as several potentially influential childhood events were included in the questionnaire. Unless otherwise noted, all these questions refer explicitly to experiences before the age of 17. These events are seen as possible risk factors which may be associated with subsequent negative adult experiences and less favorable outcomes. Table 3 presents descriptive statistics for the childhood experience variables.

Separation from Parents--Respondents were asked whether or not they were living with their natural mother and/or natural father at age 12.

Foster Care--A number of studies have suggested that a significant proportion of the homeless population are young adults who have "aged-out" of the child welfare system or others who have had prior experience in foster care (Citizen's Committee for Children, Coalition for the Homeless & Runaway and Homeless Youth Advocacy Project, 1983; Sosin, Piliavin and Westerfelt, 1990). A recent

**Table 2****Variables, Definitions and Survey Items**

| <u>Variable</u>                  | <u>Operational Definition</u>                               | <u>Item</u> |
|----------------------------------|---|-------------|
| <b>Childhood Risk Factors</b>    |   |             |
| Parental Separation              | Not living with natural mother at age 12                    | p.16 #4     |
|                                  | Not living with natural father at age 12                    | p.14 #10    |
| Foster Care                      | Ever in foster care before age 17                           | p.16 #1     |
|                                  | Age first in foster care                                    | p.16 #2     |
|                                  | Number of foster families                                   | p.16 #3     |
|                                  | Years in foster care  | p.16 #4     |
| Group Home                       | Ever in group home before age 17                            | p.16 #5     |
|                                  | Age first in group home                                     | p.16 #6     |
|                                  | Years in group home   | p.16 #7     |
| Special Residence or Institution | Ever live in special residence or institution before age 17 | p.16 #8     |
|                                  | Age first in residence or institution                       | p.16 #9     |
|                                  | Years in residence or institution                           | p.16 #10    |
| Delinquency                      | Ever expelled from school                                   | p.42 #10    |
|                                  | Age first expelled from school                              | p.42 #11    |
|                                  | Jail or reform school before age 18                         | p.42 #8     |
|                                  | Age first sent to jail or reform school                     | p.42 #9     |
| Runaway Behavior                 | Ever ran away overnight before age 17                       | p.16 #11    |
|                                  | If ran away, stayed away week or longer                     | p.16 #14    |
|                                  | Number of times ran away overnight                          | p.16 #13    |
|                                  | Age first ran away overnight                                | p.16 #12    |

**Table 2 (continued)****Variables, Definitions and Survey Items**


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| <u>Variable</u>          | <u>Operational Definition</u>                                     | <u>Item</u> |
|--------------------------|---|-------------|
| <b>Adult Experiences</b> |   |             |
| Educational Attainment   | Highest grade completed   | p.44 #18    |
| Marital Status           | Ever married  | p.43 #6     |
| Children                 | Fathered one or more children                                     | p.44 #14    |
| Veteran Status           | Ever in armed forces  | p.47 #1     |
| Criminal Behavior        | Ever convicted of a crime   | p.42 #3     |
| Work History             | How much of past three years worked<br>at least 20 hours per week | p.18 #12    |
| Psychiatric Problem      | Ever hospitalized for emotional problem                           | p.34 #4     |
|                          | Ever prescribed psychotropic medication                           | p.29 #5     |
| Drinking Problem         | Ever hospitalized for drinking problem                            | p.35 #11    |
|                          | Ever in non-medical setting for drinking                          | p.36 #18    |
| Drug Problem             | Ever hospitalized for drug problem                                | p.36 #21    |
|                          | Ever in non-medical setting for drugs                             | p.37 #28    |
|                          | Ever prescribed methadone   | p.30 #14    |
| Homelessness             | Age first homeless  | p.9 #26     |
|                          | Duration first homeless episode                                   | p.9 #28     |
|                          | How much homeless past five years                                 | p.10 #34    |

**Table 2 (continued)****Variables, Definitions and Survey Items**

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**Current Status**

|                     |                              |            |
|---------------------|------------------------------|------------|
| Mental Status       | Index of psychotic symptoms  | p.49 #1-10 |
|                     | Index of depressive symptoms | p.48 #1-21 |
| Service Needs       | Self-rated service needs     | p.50 #1-20 |
| Shelter Utilization | Thinks of shelter as home    | p.2 #9     |

longitudinal study of foster care children confirmed that a significant number experienced homelessness following exit from care (Fanshel, Finch and Grundy, 1990). Respondents were asked the following questions regarding their foster care experience: "Did you ever live with a foster family?"; "If yes, how old were you when you moved in with the first foster family?"; "With how many foster families did you live?"; "How many years of your childhood (before 17 years of age) did you live in foster homes?".

Group Home--Respondents were asked if they had ever lived in a group home. Those replying affirmatively were then asked at what age they first entered the group home and how many years they spent in group homes.

Special Residence or Institution--Respondents were asked the following question: "Did you ever live away from home in a special residence or institution, such as a children's psychiatric hospital, a home for special children or a residence for handicapped children?" Those answering yes were then asked at what age they entered the institution and how many years they spent in institutions.

Reform School--Time spent in juvenile justice facilities was also felt to be a potentially important formative experience. Respondents were asked if they had been sent to jail or reform school before the age of eighteen. Those giving a affirmative response were then asked at what age they were sent to jail or reform school for the first time.

**Table 3**

Descriptive Statistics  
Childhood Experience Variables

N=439

| <u>Item</u> | <u>Variable</u>  | <u>% Yes</u> | <u>Mean</u> | <u>St. Dev</u> |
|-------------|--|--------------|-------------|----------------|
| 1           | Not living with natural mother at age 12                     | 21.1         |             |                |
| 2           | Not living with natural father at age 12                     | 44.7         |             |                |
| 3           | Ever in foster care before age 17                            | 8.3          |             |                |
| 4           | Age first in foster care                                     |              | 8.2         | 5.9            |
| 5           | Number of foster families                                    |              | 2.3         | 1.8            |
| 6           | Years in foster care   |              | 7.3         | 5.3            |
| 7           | Ever in group home before age 17                             | 5.8          |             |                |
| 8           | Age first in group home                                      |              | 10.4        | 4.6            |
| 9           | Years in group home  |              | 5.3         | 5.1            |
| 10          | Ever lived in special residence or institution before age 17 | 3.5          |             |                |
| 11          | Age first in residence or institution                        |              | 11.0        | 4.4            |
| 12          | Years in residence or institution                            |              | 5.3         | 5.8            |
| 13          | Ever ran away overnight before age 17                        | 25.1         |             |                |
| 14          | Age first ran away overnight                                 |              | 11.9        | 2.9            |
| 15          | Number of times ran away overnight                           |              | 3.5         | 7.5            |
| 16          | If ran away, stayed away week or longer                      | 14.5         |             |                |
| 17          | Ever expelled from school                                    | 22.6         |             |                |
| 18          | Age first expelled from school                               |              | 13          | 3              |
| 19          | Jail or reform school before age 18                          | 17.1         |             |                |
| 20          | Age first sent to jail or reform school                      |              | 14.6        | 3.5            |



School Expulsion--Having been expelled from school was viewed as an indicator of problematic childhood behavior or delinquency. Respondents were asked if they had ever been expelled from school and, if so, at what age their first expulsion took place.

Runaway Behavior--Childhood runaway behavior may be understood in a number of ways. It may be viewed as a rational response to painful or stressful conditions in the home such as verbal or physical abuse or as an early sign of poor adaptation to close personal or family relationships. It may simply reflect one of a number of possible responses to a poor "fit" between the needs and interests of the child and those of the family or community. Several studies of runaway youth have found that often the runaway's parents are abusive and/or involved with substance abuse (Garbarino, Schellenbach and Seles, 1986). Such environments, it is felt, may have deprived these young adults of the basic emotional security necessary to form trusting relationships with others (Price, 1987). Runaway behavior also has an implicit relationship with the notion of residential instability and homelessness. Respondents were asked the following questions regarding runaway behavior: "Did you ever run away overnight?"; "If yes, how old were you when you ran away for the first time?"; "How many times did you run away overnight?"; "Did you stay away for a week or longer?"

### Adult Experiences

The following variables depict a range of experiences and status measures which respondents have achieved during their post-childhood lives. All have been included because they have, in one or more previous investigations, been found to be associated with subsequent outcomes of interest.

Educational Attainment--In a study of social margin among the homeless (Wiseman, 1970) the completion of a significant level of education is seen as an attribute which may serve to protect individuals from chronic homelessness and dependency. Morse (1982), Crystal & Goldstein (1984a), and Crystal, Potter & Levine (1984) all detected a relationship between level of education and homelessness and shelter utilization.

Education was measured as highest grade in school completed on an ordinal scale ranging from 1 (no schooling) to 9 (graduate degree). Most people had completed some high school (36.7 percent). The mean score was 4.7 (slightly less than high school graduation) with a standard deviation of 1.2.

Marital Status--Marital status is of interest as an indicator that subjects established at least one intimate relationship with another person and formed an independent household. Numerous studies have noted the high prevalence of unmarried status among homeless people. In a comprehensive study of Chicago's homeless population, Rossi (1989) found that marital status was a major difference

between the homeless and a comparison group of low-income people. In the HNAS, respondents were asked their current legal marital status. Most reported a status of "never married" (58 percent). 20.4 percent were separated, 13.3 percent divorced and 1.6 percent were widowed. Only 6.6 percent reported being currently married.

Veteran Status--There has been a good deal of interest recently in the prevalence homelessness among veterans. There also appears to be a presumption that homeless veterans have a different set of problems and service needs than does the general homeless population (Robertson, 1987). Veteran status, although not in itself implying a successful tour of duty, may connote that an individual was at one time functioning at a high enough level to be motivated toward and to be accepted for military service. 29.6 percent reported having served in the armed forces.

Criminal Behavior--Involvement with the criminal justice system is not uncommon among the homeless population. Roth et al. (1985) found a relationship between shelter utilization and previous incarceration. A recent study by Fischer (1988) found that many arrests and convictions among the homeless were for relatively minor infractions which could be directly traced to attempts to meet subsistence needs. In the present study, respondents were asked if they had ever been convicted of a crime. No distinction was made between felonies and misdemeanors so that the seriousness of the crime committed cannot be

evaluated. 40.8 percent reported having been convicted of a crime.

Work History--The relationship of employment to homelessness has been discussed in several different contexts. Unemployment has been cited as an important cause of homelessness (Hopper, Susser & Conover, 1985). With respect to the construct of social margin, a solid work history is hypothesized to enhance one's degree of margin and thereby help to insulate against possible social disasters including homelessness (Wiseman, 1970). Additionally, homelessness may, in itself, be a cause of unemployment since employers may be understandably reticent about hiring someone who has no permanent address. Respondents were asked to indicate the number of months during the preceding three years in during which they worked at a job for 20 hours or more per week during this period. 31.1 percent reported zero months worked. The mean was 12.1 with a standard deviation of 12.1.

Psychiatric Treatment History--The relationship between homelessness and mental illness has been studied extensively in recent years (Robertson, 1986; Snow, Baker & Anderson, 1986; Susser & Struening, 1990; Tessler & Dennis, 1989; Wright, 1988). Several studies have found associations between mental illness and duration of homelessness, shelter utilization, social isolation (Drake, Wallach & Hoffman, 1989; Wood, 1979; Segal, 1977; Arce et al., 1983; Morse, 1982). Although the HNAS included a number of different

indicators of a prior history of mental disorder, the most salient for the purposes of this analysis is a history of previous treatment for serious mental disorder. 20.1 percent of the sample admitted to having experienced a previous psychiatric hospitalization or to having been prescribed psychotropic medications.

Alcoholism Treatment History--Alcoholism was seen as virtually synonymous with homelessness during the Skid Row era of the 1950s and early 1960s. Although this perception has changed dramatically in recent years, alcohol abuse among the homeless remains a significant problem (Garrett, 1989; Garrett & Schutt, 1987; Struening & Padgett, 1990). Respondents were asked if they had ever been hospitalized for treatment for a drinking problem. 18.2 percent reported that they had been. Since detoxification treatment for alcoholism frequently occurs in non-medical settings, respondents were also asked whether they had "ever been in a program for people with drinking problems where you stayed overnight, but not in a hospital." 7.5 percent answered affirmatively. 19.2 percent answered affirmatively to either one or the other question.

Drug Abuse Treatment History--Drug abuse among the homeless has been studied relatively little recently although impressionistic accounts indicate that drug use, particularly of cocaine and crack, exists at nearly-epidemic proportions in a number of shelters in New York City (Barbanel, 1988; Grunberg & Eagle, 1990). Recent surveys

have confirmed a high rate of drug use in several homeless samples (Fischer, 1989; Struening and Padgett, 1990). 18.4 percent of the present sample reported that they had been hospitalized for drug treatment. 10.5 percent said they had been treated in a non-hospital residential treatment setting and 20.1 percent said they had ever been prescribed methadone. A total of 26.7 percent answered affirmatively to any of these items.

History of Homelessness--Individuals' homelessness history has been measured in numerous ways in previous studies. Duration of current homeless experience has been used as has length of time since the individual's first homeless episode. These variables are often problematic due to the varying ways in which homelessness has been defined. Frequently, the operational definition of homelessness in a particular study is not provided at all (see for example, Gelberg, Linn & Leake, 1988).

Fortunately, the HNAS applied an explicitly stated definition of homelessness. All questions related to duration and conditions of initial homelessness were prefaced with the following:

"I'd like to ask you some questions about the first time you were ever homeless; that is, the first time you spent a night or more in a park, a shelter for the homeless, a church or abandoned building, a subway or bus station or somewhere in the streets."

Age at first homeless experience is felt to be particularly important from a life course perspective because it may help to differentiate between those individuals whose economic and social problems represent a chronic life pattern and those whose serious difficulties began later in life. Respondents were asked at what age they were first homeless for at least seven nights in a row. The mean value for this variable was 31.8 years of age with a standard deviation of 7.3. Respondents were also asked to provide the duration of their first homeless experience. The mean was 10 months with a standard deviation of 16.3.

The other variable to be utilized is proportion of time homeless during the past five years. This is an ordinal variable in which respondents were asked "During the past five years, about how much of the time were you homeless?" Most respondents (52.6 percent) said less than half the time. 6.6 percent reported having been homeless most of the time and only 1.5 percent said it was their first homeless night.

#### Current Status Measures

Subjects were evaluated on several domains which reflect their present level of functioning and service needs. Two items which sought to measure respondents' attitudes regarding their use of shelters were also included. A number of these measures are previously

developed multiple item scales which were made available to me along with the raw data files.

Psychotic Symptoms and Depressive Symptoms--The measures that described psychotic and depressive symptoms are revised versions of existing scales which were part of the original data set. The psychotic symptoms scale was adapted from the Psychoticism Scale of the Psychiatric Epidemiology Research Interview, previously developed by Dohrenwend et. al. (1980). Respondents were asked to consider how often they experienced 10 specific symptoms over the last year.

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**Table 4**

**Psychotic Symptom Scores**

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| <u>Value</u> | <u>Frequency</u> | <u>Percent</u> |
|--------------|------------------|----------------|
| 0            | 224              | 51.1           |
| 1            | 9                | 2.0            |
| 2            | 53               | 12.0           |
| 3            | 13               | 3.0            |
| 4            | 32               | 7.2            |
| 5            | 13               | 2.9            |
| 6            | 27               | 6.1            |
| 7+           | 68               | 15.7           |
|              | -----            | -----          |
| Total        | 439              | 100.0          |

Mean=3.3

Standard Deviation=5.6

---

The interviewer instructed the respondent to rate the symptom present only if it were not associated with having



used drugs or alcohol. The total possible score ranges from 0-40. Table 4 presents the distribution of psychotic symptom scores.

A revision of the Center for Epidemiological Studies Depression Scale (CES-D) was used to assess depressive symptoms. The scale is a twenty-item measure which measures the degree to which, during the last week, the respondent felt depressed, worried, lonely, sad, etc. In four separate field tests of the scale's reliability, Cronbach's alpha ranged from .84 to .90 (Radloff, 1977). Inter-item correlations for the homeless sample can be found in Struening (1986). The total possible score ranges from 0-60. Radloff suggests that scores of 16 are congruent with the level of depressive symptoms which characterize depressive disorder, however, a higher cut-off would clearly be warranted for this specialized population and setting. The depressive symptom scores are presented in Table 5.

Service Preferences--Several studies have attempted to gauge homeless persons' judgements regarding their own service needs (Farrell, 1981; Ball & Havassy, 1982; Gelberg & Linn, 1988; Morse, 1982). Following an open-ended question ("What kinds of services [do you need] to improve your quality of life and move toward a more stable living situation?"), respondents were presented with a list of twenty possible service needs and asked to indicate in a yes-no choice whether they would like help in that

particular area. Table 6 presents the responses to these items.

Shelter Utilization--Subjects were asked if they had stayed in a shelter "just about every night since the first of the year." Since interviewing was done during the late spring, a positive response to this item indicates that the respondent had stayed just about every night for four to six months. The purpose of this item was to distinguish between individuals who, at the time of the study, were using the shelters as their only housing option, from those who were using it more sporadically, indicating that they had at least one other housing resource on which they could

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**Table 5**  
Depressive Symptom Scores

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| <u>Value</u> | <u>Frequency</u> | <u>Percent</u> |
|--------------|------------------|----------------|
| 0-5          | 59               | 13.4           |
| 6-10         | 61               | 13.8           |
| 11-15        | 81               | 18.5           |
| 16-20        | 77               | 17.5           |
| 21-30        | 101              | 23.0           |
| 31+          | 60               | 13.7           |
|              | -----            | -----          |
| Total        | 439              | 100            |

Mean=18  
Standard Deviation=11.2

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**Table 6****Respondents' Self-Expressed Service Preferences**

N=439

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| <u>Item</u>   | <u>Percent Yes</u> |
|---|--------------------|
| Finding a place to live                                 | 91.5               |
| Having a steady income                                  | 82.1               |
| Finding a job   | 79.7               |
| Improving my job skills                                 | 66.4               |
| Getting on public assistance                            | 58.8               |
| Learning how to get what I have<br>coming from agencies | 45.9               |
| Health and medical problems                             | 44.2               |
| Learning how to manage money                            | 34.8               |
| Getting on SSI/SSD                                      | 24.8               |
| Nerves and emotional problems                           | 24.6               |
| Getting along with my family                            | 23.0               |
| Drinking problems                                       | 20.1               |
| Problems with drugs                                     | 17.1               |
| Learning how to read and fill out forms                 | 16.1               |
| Learning to get along better with other people          | 15.2               |
| Legal problems  | 14.5               |
| Getting around town on buses and subways                | 13.3               |
| Learning how to protect myself                          | 13.3               |
| Getting my veteran's benefits                           | 11.3               |
| Problems with the police                                | 8.4                |

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occasionally rely. 51 percent reported that stayed just about every night.

Subjects were also asked how many of the next six months they planned to stay in a shelter. 25.9 percent said they planned to stay the full six months. The mean was 3.0 months, with a standard deviation of 2.0. It would obviously be misleading to accept this response as an accurate prediction of future shelter stay. However, the responses can be viewed as an indicator of the degree to

which the individual views himself as "stuck" in the shelter system with few possible alternatives. In a similar vein, respondents were also asked the following question: "Do you think of the shelter as your home?" 31.4 percent said "Sometimes," 54.8 percent said "Never," and 13.8 percent said "Usually".

#### Plan For Addressing Research Questions

As described above, the primary objective of this study is to augment our understanding of how homeless individuals' childhood experiences, personal attributes, and earlier life experiences are related to their more recent residential experience, their present level of functioning and their need for services. The review of relevant literature, unfortunately, provides relatively few theories or formal hypotheses around which to build the analysis.

The major analytic approach to be employed is a broad-based exploration of the associations between a wide range of variables representing key attributes and experiences of homeless people. Several statistical procedures, all based upon correlational techniques, will be utilized. The underlying assumption is that some order between these variables can be detected, thereby leading to greater insight into the life course of individuals who have experienced homelessness as well as a more specific sense of what services may be required to assist them. The remainder

of this section describes the strategies to be employed in addressing the primary research questions.

To begin, appropriate data reduction procedures will be employed in order to distill a manageable number of variables for subsequent analysis. Where indicated, factor analysis will be used. Where factor analysis is not suitable (due, for instance, to structural correlations between variables) additive scaling procedures will be applied. After this initial step has been completed two complementary avenues will be followed.

Factor analysis has, in addition to its application in data reduction processes, been shown to be an especially powerful tool in exploring inter-relationships between a large number of variables, particularly when solid predictive hypotheses are lacking (Kachigan, 1986). As a technique for identifying life course dimensions, it has been successfully employed in longitudinal research on individuals in foster care (Fanshel, Finch and Grundy, 1990).

Through factor analysis, I intend to initially explore the inter-relationships between all variables in the study. These variables, which are specified in the preceding section as well as in the chapter to follow, represent the following domains: family background and childhood experiences; educational attainment; marital status; veteran status; work history; previous criminal justice involvement; previous treatment for psychiatric and substance abuse

problems; homelessness history; past and projected shelter utilization; current mental status; and expressed service needs. Several factor solutions will be examined toward the end of maximizing stability and interpretability of factors. If interpretable factors can be extracted, this analysis will reveal underlying dimensions or patterns of relationship between variables which will serve as a roadmap to subsequent procedures. Multiple regression analyses will then be performed in order to more specifically examine the strength and direction of associations between selected variables while controlling for the effect of others.

CHAPTER FOUR  
PRELIMINARY ANALYSIS:  
DEVELOPMENT OF MULTIPLE-ITEM INDICES

This chapter presents preliminary work required to prepare particular variables for use in ensuing analyses. First, it details the development of multiple-item indices measuring childhood experience variables. Subsequently, a factor analysis of an important variable set, individuals' expressed need for a comprehensive range of services, is reported.

Childhood Experience Variables

As noted in Chapter 3, the HNAS contains a considerable number of variables which describe several hypothetically significant childhood experiences of the sample (see Table 3). Due to the exploratory nature of this study, it will be important to include as many variables as possible from this group in the analyses to follow.

A problem arises, however, in entering a number of these variables directly into factor analyses. For factor analysis to be most effective, all variables in the analysis must be free to vary independently of one another (Nunnally, 1978). The difficulty emerges because several of these variables (e.g. "Ever live in foster home" with "Number of foster families") are structurally related. That is, the value of the latter is contingent upon the value of the former because of the content of the items themselves.

Performing factor analyses including these variables would necessarily extract misleading factors which would be heavily influenced by the built-in correlations between variables from the same domain. Thus, the resulting factor solutions would add little to our understanding of the phenomena under study.

A possible remedy to this problem would be to select a single variable from each domain for use in the subsequent factor analyses. While this would certainly overcome the preceding obstacle, it would come at the expense of excluding potentially important information. For example, four items measure childhood runaway behavior. Each is structurally related to the others. Three items could be dropped, leaving only "Did you ever run away overnight" as the sole indicator variable from this domain. However, it is conceivable that having ever run away is less powerful as a sole predictor of subsequent behavior than is the information contained in the other items. A plausible working hypothesis is that those individuals who, as children, ran away often, at a young age, and stayed away a week or longer are more likely to experience negative outcomes than those who did not run away or whose runaway behavior was limited to a single episode of less than a week's duration at a relatively later age. Dropping the three variables would obviously negate the possibility of detecting such a relationship.



A solution which allows for the retention of each of the relevant variables is to create a single ordinal index derived from the values of each of the original variables. If necessary, each variable is first re-scaled to a range from 0-1 (this step, in itself, may require well-considered presumptions regarding where cut-off points should be placed). The values of these variables are then summed to create the new index. The range of the index is from zero to the number of variables used to create it. In the example above, the individual who received the maximum score of 1 on each of the runaway items would have a total score of 4 on the derived index. An individual who reported that he ran away overnight but did not score positively on the remaining items would get a score of 1 on the index. This score can then be used to represent "runaway behavior" in subsequent factor analyses without generating the objections described above. The following sections describe the development of such indices for the childhood experience variables in this study.

#### Group Home Experience

Possible scores on the index representing childhood experience in a group home range from 0 to 3. The index is comprised of the values attained on items 7 through 9 in Table 3. Item 7 is dichotomous. Items 8 and 9 have each been recoded to a 0-1 scale. Those entering group care early (before age 14) were given a score of 1 on item 8.

Those having spent five or more years in group care received the maximum score of one on item 9. Those having spent between 1 and three years received a score of .5. The distribution of the resulting index is presented in Table 7.

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**Table 7**

**Index of Group Home Experience**

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| <u>Value</u> | <u>Frequency</u> | <u>Percent</u> |
|--------------|------------------|----------------|
| 0.0          | 412              | 94.0           |
| 1.0          | 3                | 0.6            |
| 1.5          | 9                | 2.1            |
| 2.0          | 6                | 1.3            |
| 2.5          | 4                | 0.8            |
| 3.0          | 5                | 1.2            |
|              | -----            | -----          |
| Total        | 439              | 100            |

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Institutional Care Experience

Possible scores on the index representing childhood experience in a "special residence or institution, such as a children's psychiatric hospital, a home for special children or a residence for handicapped children" range from 0 to 3. The index is comprised of the values attained on items 10 through 12 in Table 3. Item 10 is dichotomous. Items 11 and 12 have each been recoded to a dichotomous 0-1 index. Those entering care at an early age (before age 14) were given a score of 1 on item 11. Those having spent three

or more years in care received a score of one on item 12. Those having spent less than three years received a score of 0 on this item. The distribution of the resulting index is presented in Table 8.

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**Table 8**

**Index of Institutional Care Experience**

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| <u>Value</u> | <u>Frequency</u> | <u>Percent</u> |
|--------------|------------------|----------------|
| 0.0          | 423              | 96.3           |
| 1.0          | 4                | 0.9            |
| 2.0          | 6                | 1.5            |
| 3.0          | 6                | 1.5            |
|              | -----            | -----          |
| Total        | 439              | 100            |

---

**Foster Care Experience**

Possible scores on the index representing childhood experience in foster care range from 0 to 3. The index is comprised of the values attained on items 3 through 6 in Table 3. Item 3 is dichotomous. Items 5 and 6 have each been recoded to a 0-1 scale. Those having spent six or more years in foster care received the maximum score of 1. Those having spent between 1 and six years received a score of .5 on this item, and those who were never in foster care were scored 0. Individuals who report having lived with two or more different foster families were given a score of 1

on the recoded item. Those who lived with only one foster family got a score of 0.5, and those who never lived with a foster family were scored 0.

Item 4, age of entry into foster care, is not included in this index due to the difficulty in assessing its impact. As noted above, the conceptual basis for the construction of these indices that higher scores imply a higher degree of hypothesized "risk" resulting from the particular domain being measured. It is entirely possible that early entry into foster care (and with it the early removal of the child from an ostensibly noxious environment) might act as more of a mitigating factor than a risk factor. The distribution of the foster care index is presented in Table 9.

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**Table 9**

**Index of Foster Care Experience**

---

| <u>Value</u> | <u>Frequency</u> | <u>Percent</u> |
|--------------|------------------|----------------|
| 0.0          | 401              | 91.3           |
| 1.0          | 4                | 0.8            |
| 1.5          | 4                | 0.8            |
| 2.0          | 9                | 2.1            |
| 2.5          | 12               | 2.8            |
| 3.0          | 9                | 2.1            |
|              | -----            | -----          |
| Total        | 439              | 100.0          |

---

### Runaway Behavior

Possible scores on the index indicating childhood runaway behavior range from 0 to 4. The index is comprised of the values attained on items 13 through 16 in Table 3. Items 13 and 16 are dichotomous. Positive responses to these items result in scores of 1 on the index. Items 4 and 5 have both been re-scaled to a range of 0-1. Those reporting having run away from home before age 14 received a score of 1 on item 14. Those reporting having run away more than once but less than four times received a score of 0.5 on item 15. Those having run away more than three times received a score of 1 on this item. The distribution of the resulting index is presented in Table 10.

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**Table 10**

Index of Runaway Behavior

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| <u>Value</u> | <u>Frequency</u> | <u>Percent</u> |
|--------------|------------------|----------------|
| 0.0          | 321              | 73.3           |
| 1.0          | 16               | 3.6            |
| 1.5          | 5                | 1.1            |
| 2.0          | 37               | 8.3            |
| 2.5          | 17               | 3.9            |
| 3.0          | 16               | 3.6            |
| 3.5          | 12               | 2.8            |
| 4.0          | 15               | 3.4            |
|              | -----            | -----          |
| Total        | 439              | 100            |

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### School Expulsion

This is a two-item index derived from the scores on items 17 and 18 from Table 3. Those having a positive response to the dichotomous item 17 received a score of 1. Item 18 was recoded into a dichotomous variable. Those reporting school expulsion before age 14 received a score of 1; others were scored zero. The distribution of the resulting index is presented in Table 11.

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**Table 11**

Index of School Expulsion History

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| <u>Value</u> | <u>Frequency</u> | <u>Percent</u> |
|--------------|------------------|----------------|
| 0.0          | 338              | 76.8           |
| 1.0          | 57               | 13.1           |
| 2.0          | 44               | 10.1           |
|              | -----            | -----          |
| Total        | 439              | 100            |

---

### Jail or Reform School

This is a two-item index derived from the scores on items 19 and 20 from Table 3. Those having a positive response to the dichotomous item 19 received a score of 1. Item 20 was recoded into a dichotomous variable. Of those reporting school expulsion before age 14 received a score of 1; others were scored zero. The distribution of the resulting index is presented in Table 12.

Expressed Service Needs

An important domain of variables in this study consists of respondents' self-ratings of their need for help in a wide array of service areas. It was expected that the desire for assistance in particular areas could be described by underlying dimensions or factors which would then be of use in subsequent analyses. Of particular interest was the

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**Table 12**

Index of Childhood Jail and Reform School History

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| <u>Value</u> | <u>Frequency</u> | <u>Percent</u> |
|--------------|------------------|----------------|
| 0.0          | 364              | 82.9           |
| 1.0          | 49               | 11.2           |
| 2.0          | 26               | 5.9            |
|              | -----            | -----          |
| Total        | 439              | 100            |

---

question of whether a dimension comprised of needs in the area of concrete services (housing, employment, etc.) would be formed distinctly from a dimension describing services related more to treatment services in such areas as mental health, substance abuse etc. Principal-component analysis with Varimax rotation was employed to extract factors from the responses to items measuring respondents' service preferences. Descriptive statistics for these variables are found in Chapter 3. The results of two factor analyses are presented below.

### Factor Analysis 1

The rotated factor matrix can be found in Table 13. The matrix reveals an interpretable five-factor solution in which almost every variable loads strongly on only one factor. This solution accounts for approximately 47 percent of the total variance. Factor I, accounting for 19.5 percent of the variance, is comprised of six variables describing the need for help in the following areas: nerves and emotional problems; drinking problems; getting along with family; health and medical problems; problems with drugs; and learning how to handle or manage money. The first three variables load most highly on this factor and have negligible loadings on the remaining four factors. Help with health and medical problems also has a high loading on Factor IV. Help with drug problems loads almost as strongly on Factor V as on Factor I. Learning how to handle money also has relatively modest loadings on Factors II, III and IV. Factor I, then, appears to describe a broad dimension representing a desire for treatment services in the areas of personal adjustment, substance abuse and health problems.

Factor III, defined by four variables related to the need for services in the areas of employment, income and housing, explains 7.1 percent of the total variance. This dimension seems to describe the desire for help with



concrete services. The first three variables--finding a job, having a steady income, and finding a place to live--have high loadings on this factor alone. The fourth, improving my job skills, also has loadings of .22 and .24 on Factors I and II respectively. It is interesting to note that variables indicating the need for help with financial entitlements (SSI, Public Assistance and VA benefits) have only modest loadings on this factor of .03, .29 and .10, respectively.

Factor IV, accounting for six percent of the total variance, is defined primarily by the need for help getting on Supplemental Security Income/Social Security Disability (SSI/SSD) and Public Assistance (PA). The third variable loading most highly on this factor is "learning how to get what I have coming from agencies." However this variable's loading on the factor is a modest .41. It also loads on Factors I, II and III at .19, .22 and .25 respectively. One possible reason for this dispersion across factors may be that the item, due to its particularly broad wording, is not doing a terribly good job at measuring what it was intended to measure, presumably, the need for entitlements eligibility information. Since the "agencies" in question are undefined and leave open many possible interpretations, it is likely that the wording of this item is simply too general to convey the desired meaning. As noted above, the need for help with health and medical problems also has a

**Table 13**

Loadings on Rotated Factor Matrix  
Expressed Service Needs

N=439

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|              | Factor I<br>Treatment<br>Services | Factor II<br>Coping<br>Skills | Factor III<br>Concrete<br>Services | Factor IV<br>Entitlements<br>Assistance | Factor V<br>Legal<br>Services |
|--------------|-----------------------------------|-------------------------------|------------------------------------|---|-------------------------------|
| Nerves       | .68                               | .06                           | .03                                | .07                                     | .03                           |
| Drinking     | .61                               | .11                           | .18                                | .05                                     | -.22                          |
| Family       | .60                               | .17                           | -.06                               | .19                                     | .10                           |
| Health       | .50                               | .04                           | .02                                | .46                                     | .20                           |
| Drugs        | .47                               | -.12                          | .16                                | -.21                                    | .44                           |
| Handle Money | .47                               | .27                           | .25                                | .00                                     | .21                           |
| Read         | .09                               | .78                           | .09                                | .09                                     | .01                           |
| Protect Self | .12                               | .72                           | .03                                | .09                                     | .06                           |
| Travel       | -.03                              | .64                           | -.04                               | .11                                     | .16                           |
| Get along    | .34                               | .55                           | .07                                | .07                                     | .03                           |
| Job          | -.03                              | .01                           | .75                                | .08                                     | -.01                          |
| Income       | .03                               | .03                           | .69                                | .13                                     | .12                           |
| Housing      | .10                               | -.07                          | .60                                | .20                                     | .01                           |
| Job Skills   | .22                               | .24                           | .55                                | -.10                                    | -.02                          |
| SSI          | .20                               | .16                           | .03                                | .67                                     | .17                           |
| Welfare      | -.08                              | .08                           | .29                                | .66                                     | -.19                          |
| Agencies     | .19                               | .22                           | .25                                | .41                                     | .13                           |
| VA Benefits  | -.16                              | -.07                          | .09                                | .20                                     | .64                           |
| Legal        | .15                               | .26                           | -.01                               | .19                                     | .55                           |
| Police       | .10                               | .18                           | .00                                | -.11                                    | .46                           |

substantial positive loading of .46 on this factor. This association reflects the significant correlation of .32 between this variable and the need for help getting on SSI/SSD. This relationship makes logical sense since eligibility for SSI/SSD is limited to those persons who are either aged or disabled. Since this sample contains no one over age 50, the link between the need for SSI/SSD and a person having some form of disability (and the concomitant need for medical care) is reasonable.

Factor V, which accounts for 5.4 percent of the variance, is comprised primarily by three variables indicating the desire for help in the following areas: getting veteran's benefits; legal problems; and problems with the police. Factor V has some coherence, in that police and legal problems are logically associated with one another. Help with drug problems also has a large positive loading of .44, perhaps due to the well-known relationship between drug problems and criminal behavior, hence legal and police problems. A possible explanation for the loading here of the need for help with veteran's benefits is that some respondents may be experiencing difficulty obtaining benefits to which they believe they are entitled and may therefore desire legal representation to resolve the problem.

### Factor Analysis Two and Development of Factor Scores

As noted above, a long standing distinction has been drawn between those who are homeless as a result of some type of impairment and those who have been referred to as "economic only", meaning that they are homeless due only to their poverty (Crystal & Goldstein, 1984a; 1984b). Leach (1979) refers to these two groups as "intrinsic" and "extrinsic". This is admittedly a vast oversimplification with respect to an effort to develop any realistic typology of shelter residents; individuals cannot be meaningfully classified merely by whether or not they are disabled. However, it may be that this distinction will be useful as just one of a number of variables used to develop an empirically based typology of shelter residents.

Regarding service needs, it is reasonable to believe that respondents who view their primary obstacle to achieving a more stable living situation as related to disability or personal problems would be more inclined to express the need for help in the areas of health and personal adjustment. Those who see themselves as able-bodied and who feel that their homelessness derives more from the lack of opportunity to obtain employment and income would be more likely to request services in those areas. The initial factor analysis lends support to this notion, evidenced by the extraction of Factors I and III which clearly represent these two dimensions.

A second factor analysis was performed utilizing a subset of variables judged to be most important with respect to differentiating these fundamental dimensions of service needs among the shelter population. The purpose of this analysis was twofold. First, it was important to test the stability of these two factors in an analysis with a restricted number of variables. Second, if these two factors could be identified again, we could be reasonably confident in using the variables comprising each factor to compute scores representing the need for services along each of these two dimensions. These factor scores would then become important variables in subsequent analyses.

Variables which loaded primarily on Factors I and III in the first analysis were retained for this analysis. The only variable from these groups which was dropped was one representing the need for help in handling money. It was dropped because of its conceptual ambiguity; does it refer to obtaining adequate funds or to saving or wisely spending the funds which one does procure? This vagueness is a possible explanation for its significant loadings on four of the five original factors. In any case, this variable cannot logically be associated exclusively with either of the salient dimensions.

The results of this factor analysis are presented in Table 14. The two-factor solution demonstrates the stability of the personal adjustment and the concrete

services dimensions. Factor I, representing the need for help with personal adjustment and interpersonal problems, accounts for 26.2 percent of the variance. All five variables load highly on this factor and none load substantially on the second factor. The loadings on Factor II, need for concrete services, remain virtually identical with those obtained in the first analysis. Factor II accounts for 16.4 percent of the variance. The total variance accounted for by the two-factor solution is approximately 43 percent.

Factor scores were created by simply adding the unweighted scores on the variables comprising each factor. Since the variables are all dichotomous, a score of one is given for a positive response (indicating need for the particular service) and a score of zero is given for a negative response (the service is not needed). Since Factor I is defined by five variables, scores on this factor range from zero to five. The range of scores on Factor II is from zero to four. Each of these factor scores can now be understood and used as ordinal scales representing a continuum of need along the two dimensions. Frequency distributions for these scales are presented in Tables 15 and 16.

**Table 14****Factor Loadings for Selected Service Needs**

N=439

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| <u>Variable</u> | <u>Factor I<br/>Treatment<br/>Services</u> | <u>Factor II<br/>Concrete<br/>Services</u> |
|-----------------|--|--|
| Nerves          | .76  | .05  |
| Family          | .65  | -.04                                       |
| Health          | .61  | .14  |
| Drinking        | .56  | .17  |
| Drugs           | .47  | .07  |
| Finding Job     | -.03                                       | .76  |
| Income          | .06  | .73  |
| Housing         | .09  | .65  |
| Job Skills      | .23  | .52  |

---

**Table 15****Frequency Distribution of Factor Scores on Factor I:  
Need for Treatment Services**


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| <u>Value</u> | <u>Frequency</u> | <u>Percent</u> |
|--------------|------------------|----------------|
| 0.0          | 163              | 37.4           |
| 1.0          | 112              | 25.4           |
| 2.0          | 78               | 17.8           |
| 3.0          | 50               | 11.3           |
| 4.0          | 29               | 6.5            |
| 5.0          | 7                | 1.6            |
|              | -----            | -----          |
| Total        | 439              | 100.0          |

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**Table 16**

**Frequency Distribution of Factor Scores on Factor II:  
Need for Concrete Services**

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| <u>Value</u> | <u>Frequency</u> | <u>Percent</u> |
|--------------|------------------|----------------|
| 0.0          | 13               | 2.9            |
| 1.0          | 24               | 5.6            |
| 2.0          | 55               | 12.5           |
| 3.0          | 118              | 27.0           |
| 4.0          | 229              | 52.0           |
|              | -----            | -----          |
| Total        | 439              | 100.0          |

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### Summary

This chapter described the development of multiple-item indices which will be used in subsequent factor analyses and multiple regression analyses. Simple additive indices were created measuring childhood experience in group home, institutional care, foster care, running away from home, school expulsion, and jail or reform school.

Individuals' self ratings on their need for services in the full range of service need variables were factor analyzed in order to group these needs into coherent domains. An interpretable five-factor solution was obtained, indicating the following discrete service need dimensions: treatment services; coping skills; concrete services; entitlements; and legal problems. A subsequent



factor analysis using a restricted set of variables confirmed the stability of the treatment and concrete service dimensions. Factor scores were then computed on these two primary dimensions.

In the next chapter, the analysis turns toward its primary purpose as these indices and factor scores are employed as variables in a factor analysis intended to begin to unravel the relationships and continuities between a broad range of variables drawn from different dimensions and different phases of the lives of homeless shelter users.

CHAPTER FIVE  
EXPLORATION OF LIFE COURSE DIMENSIONS:  
RESULTS AND DISCUSSION

This chapter opens the examination of the inter-relationships between the full range of variables in the study. Its purpose is to focus on the associations between events which took place earlier in the lives of the subjects with subsequent experiences and assessments of their current status at the time of the study. Factor analysis will be employed as the primary statistical method. As in the preceding chapter, principal-component analysis with Varimax rotation will be used in order to study the associations between a large number of variables. The strength and predictive power of these associations will be more closely investigated in the following chapter through the use of multiple regression techniques.

It should be noted again that a primary purpose of this analysis, and the study as a whole, is to explore associations between disparate variables in order to generate hypotheses for subsequent inquiry. Factor analysis in particular is well-suited to this end. It does not, however, permit the researcher to isolate and report the strength of the relationship between variables while controlling for the effect of other variables. Nor does factor analysis yield results which either confirm or negate the existence of causal relationships between variables. Thus the discussion of the results is highly speculative in

nature, particularly when an effort is made to provide alternative causal hypotheses explaining various patterns of factor loadings.

### Life Course Variables

In order to shed light on possible dimensions which span subjects' life course, the variables for this analysis should provide information from each period in subjects' lives for which data was gathered. Most desirable, therefore, is a comprehensive set of variables which address childhood, adulthood and current status measures. In order to provide maximum information in the most parsimonious manner, indices or scaled scores are used wherever possible. The development of the childhood experience and service preference indices is described in the preceding chapter as is the operational definition of each of the other variables. Table 17 lists the variables which were used in the factor analysis.

### Results and Discussion

To begin, standard scores were computed for all variables for use in subsequent analyses. A principal components analysis was then run which extracted the maximum number of factors each having an eigenvalue of one or more. This produced a solution consisting of nine factors accounting for 56.8 percent of the variance. A scree plot was produced which revealed that the drop-off in eigenvalues (representing the proportion of variance explained) becomes

more pronounced following the extraction of the fifth factor. Another principal components analysis was run

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**Table 17**

**Variables Used in Life Course Factor Analysis**

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| <u>Variable Name</u>   | <u>Definition</u>                       |
|------------------------|---|
| <b>Childhood Phase</b> |   |
| FOSTOT                 | Index of foster care involvement        |
| RUNTOT                 | Index of runaway behavior               |
| GRPTOT                 | Index of group home involvement         |
| INSTOT                 | Index of institutional care             |
| REFTOT                 | Index of reform school experience       |
| EXPTOT                 | Index of school expulsion               |
| NOFATHER               | Not living with natural father @ age 12 |
| NOMOTHER               | Not living with natural mother @ age 12 |
| <b>Adulthood</b>       |   |
| EDUC                   | Educational attainment                  |
| EVMARRY                | Ever married                            |
| KIDS                   | Fathered child or children              |
| VET001                 | Served in armed forces                  |
| PROB003                | Ever convicted of a crime               |
| PSYCH                  | Psychiatric treatment history           |
| DRINK                  | Alcoholism treatment history            |
| DRUG                   | Drug treatment history                  |
| WORK3YR                | Full-time employment past 3 years       |
| FIRST001               | Age at first homeless experience        |
| MONTHS2                | Duration of first homeless experience   |
| FIRST011               | Homelessness past 5 years               |
| <b>Current Status</b>  |   |
| BELFEL                 | Scale of psychotic symptoms             |
| CESTOT                 | Scale of depressive symptoms            |
| NEEDFAC1               | Index of need for treatment services    |
| NEEDFAC2               | Index of need for concrete services     |
| HOUS017                | Perception of shelter as home           |

solving for five and four factors followed by varimax rotation. The four factor solution, explaining 33.2 percent of the total variance, proved to be the most interpretable. The rotated factor matrix for the four factor solution is presented in Table 18 and is discussed below.

#### Factor I--Mental Illness/Substance Abuse

Factor I, accounting for 12.3 percent of the total variance, clearly reflects a dimension described by psychiatric problems and substance abuse involvement. The highest factor loading is for the variable indicating self-rated need for help with treatment services (.67). There are high positive loadings on variables indicating current depression (.64), prior psychiatric treatment (.60), prior alcoholism treatment (.53) and psychotic symptoms (.44). Lower, but substantial, positive loadings were also obtained for prior drug abuse treatment (.40) and the degree to which the respondent views the shelter as his home (.37). The variable describing recent work history has a loading of -.35. Also loading strongly (.37) on Factor I is the variable indicating the proportion of the past five years during which the respondent was homeless.

The analysis reveals a strong and coherent primary factor formed around psychiatric and substance abuse treatment history, self-rated need for treatment as well as current psychiatric symptomatology. This finding lends support to previous research as well as clinical impressions

of many shelter workers who have reported that so-called "dual-diagnosis" (mental illness and substance abuse) is a common affliction among homeless people (see for example Koegel, Burnam & Farr, forthcoming; Romanoski, Nestadt, Ross, Fischer & Breakey, 1988; Struening & Padgett, 1990). This may be exemplified by a person with a primary diagnosis of a serious mental disorder such as schizophrenia who abuses drugs or alcohol in an effort to relieve his symptoms. Among others in this category are people whose primary problem is abuse of a drug such as crack or cocaine, the prolonged use of which may result in the development of psychiatric symptoms.

Interestingly, the high loading for self-rated need for treatment services implies that, for many, there is recognition of the seriousness of their problems in this area and a willingness to receive appropriate treatment. One should keep in mind that, with respect to substance abuse and psychiatric problems, the indicators which were used are measures of previous treatment rather than current disorder. Since it is logical that persons who have received treatment in the past will be more likely to accept it in the future, it may well be that this dimension overstates the true association between current substance abuse or psychiatric problems and willingness to receive treatment.

**Table 18**

Rotated Factor Matrix: Life Course Variables (N=439)

|          | FACTOR I<br>MI/Subst Abuse | FACTOR II<br>Child Sep | FACTOR III<br>Pos Adjust | FACTOR IV<br>Anti-Social |
|----------|----------------------------|------------------------|--------------------------|--------------------------|
| NEEDFAC1 | .67                        | .10                    | .05                      | .24                      |
| CESTOT   | .64                        | .06                    | -.09                     | .09                      |
| PSYCH    | .60                        | .23                    | .01                      | -.12                     |
| DRINK    | .53                        | -.12                   | .01                      | .19                      |
| BELFEL   | .44                        | .19                    | .01                      | -.12                     |
| DRUG     | .40                        | -.02                   | .26                      | .31                      |
| HOUS017  | .37                        | -.03                   | -.36                     | -.16                     |
| WORK3YR  | -.35                       | .06                    | .23                      | -.01                     |
| FOSTOT   | .08                        | .61                    | -.14                     | -.04                     |
| NOFATHER | .07                        | .57                    | .02                      | -.01                     |
| RUNAWAY  | .10                        | .56                    | .00                      | .22                      |
| NOMOTHER | .04                        | .55                    | -.02                     | -.04                     |
| GRPTOT   | -.05                       | .48                    | -.17                     | .21                      |
| INSTOT   | .04                        | .34                    | -.02                     | .12                      |
| EVMARRY  | .20                        | -.04                   | .73                      | .03                      |
| KIDS     | .04                        | -.02                   | .67                      | .22                      |
| FIRST001 | -.13                       | -.20                   | .45                      | -.03                     |
| FIRST011 | .37                        | .08                    | -.39                     | .03                      |
| MONTHS2  | .23                        | .05                    | -.24                     | .08                      |
| NEEDFAC2 | .06                        | .11                    | -.23                     | .15                      |
| REFTOT   | .05                        | .11                    | .05                      | .69                      |
| EXPTOT   | .03                        | .24                    | -.06                     | .62                      |
| PROB003  | .05                        | .16                    | .14                      | .44                      |
| EDUC     | -.08                       | .15                    | .32                      | -.40                     |
| VET001   | -.02                       | .29                    | .38                      | -.39                     |

Chronic homelessness seems to be related to this factor, given the fact that the variable measuring amount of homelessness in the past five years finds it highest positive loading here. This association makes conceptual sense on several levels. The interpersonal problems often caused by mental illness and substance abuse no doubt place considerable stress on individuals' relationships with family, friends and others with whom they may be living. This type of stress may, in some cases, contribute to people being forced to leave such shared accommodations and to experience difficulty in locating alternatives. Of course, those living alone may also be at risk of loss of housing resulting from destructive or otherwise unacceptable behavior caused by a period of exacerbation of psychiatric symptoms or a drug or alcohol "binge." Stigma against mentally ill people can, in itself, create an additional barrier to obtaining and maintaining housing.

Another way in which chronic homelessness is logically linked with this dimension is through poverty resulting from ongoing unemployment. Not surprisingly, recent work history has a strong negative loading on this factor. This is consistent with the well-established correlation between unemployment and mental illness and substance abuse. Simply, those who are unable to secure paid work, either because they are mentally ill or drug-addicted, will likely have great difficulty affording permanent housing. In the



absence of effective intervention or treatment, long-term homelessness may result.

As noted above, there is a strong positive loading on this factor for the variable indicating the degree to which the respondent views the shelter as home. This is a compelling variable in that a positive response to it implies that the individual may have begun to view homelessness and life in the shelter as a fairly permanent state of affairs. The high loading for depression on this factor, which taps, among other things, hopelessness and demoralization, is certainly consistent with such an attitude. This raises the important question as to the preceding experiences which might increase the likelihood of an individual adopting this point of view. Is it simply the amount of recent homelessness which the individual has experienced that is critical, or are other formative or more recent experiences more salient? This question will be explored subsequently through multiple regression.

#### Factor II--Childhood Separation/Family Disruption

Factor II accounts for 7.9 percent of the total variance. This factor is defined primarily by variables indicating a history of disruption in the respondents' family of origin and care away from the home as a child. Foster care (.61), not living with natural father at age 12 (.57), and not living with natural mother at age 13 (.55), all load highly and practically exclusively on this factor.

The variables indicating childhood runaway behavior and having lived in a group home as a child have slightly lower loadings, and also have respectable loadings on Factor IV. The childhood institutional care variable has a loading of .34 on this factor.

The strong positive loadings for foster care and parental separation are logically related; those in foster care at age 12 were, by definition, separated from their natural parents. Group home experience and runaway behavior are related but are also associated with Factor IV, defined more by delinquency and anti-social behavior. Two other important childhood risk factors, school expulsion and time spent in reform school, have only modest loadings on this factor and clearly belong to Factor IV.

Psychiatric treatment history and current psychoticism have modest loadings of .23 and .19 respectively on this factor. This is an intriguing finding as it suggests a possible association between family disruption during childhood and subsequent serious psychiatric disturbance. Indeed, one recent study (E. Susser, personal communication), discovered surprisingly high rates of childhood placement away from the family among selected inpatients at a major state psychiatric hospital. Several explanations could account for such an association. One possibility would be to understand these childhood experiences as risk factors which predispose individuals to developing psychiatric disorders as adults. Another theory

is that these individuals were initially separated from their families of origin due to behavior or other problems which were the result of psychiatric disorder which had already become manifest at that point in their lives.

In contrast, there are very small loadings on this factor for drug and alcohol problems and current levels of depression, implying that these difficulties are related to a somewhat different dimension, at least insofar as they are related to childhood experience variables.

Also interesting is that age at first homeless episode has a loading of  $-.20$ , implying a link, albeit a modest one, between childhood deprivation and an earlier onset of homelessness. Perhaps the most logical explanation for this association derives from the "social margin" perspective on the course into and out of homelessness (Wiseman, 1970). Simply put, Wiseman posits that one's likeliness of experiencing homelessness and other social calamities is inversely related to the amount of social margin--i.e., personal skills, resources and social networks--one can draw upon during times of stress. A person who possesses a strong family network would ostensibly be able to rely on its members for financial support, employment or temporary housing during periods of crisis. Separation from family would in many cases reduce the degree of social margin which the individual can use to buffer himself against the risk of early homelessness.

Childhood runaway behavior loads strongly on this factor and more modestly on Factor IV, suggesting that running away from home has varying causes and different meanings for various individuals. As noted above, on the childhood deprivation factor, it is associated with subsequent psychiatric involvement and somewhat earlier onset of homelessness. On Factor IV, reflecting a delinquency/anti-social behavior dimension, running away also loads with acting-out behavior such as school expulsion and subsequent drug use and criminal activities.

One can only speculate on the reasons which respondents chose to run away from home, however, it is likely that many were seeking to escape from home situations which they found unacceptable. Some may have been fleeing physical or sexual abuse. Others may have been pursuing a greater degree of personal autonomy in order to engage in activities (such as sexual experimentation or drug use) not sanctioned by adults in the household. Still others may have been "pushed out" by parents who were unable to provide adequate care as a result of their own problematic behavior. It is conceivable that those for whom running away was connected with especially painful family relationships tend more to have internalized these conflicts leading to later psychiatric disturbance. For others, running away may have been just one of a constellation of childhood delinquent activities culminating in adult criminality and/or substance abuse. To the degree that runaway behavior is seen as related to

possible physical abuse, these findings are consistent with the recent work of Fanshel, Finch and Grundy (1990) who found strong associations between childhood physical abuse and adult criminal behavior in a followup study of foster children.

It is curious that veteran status has a fairly high positive loading of .29 on this factor. On a psychological level, one might speculate that some individuals who have experienced disrupted family backgrounds or institutional care away from the home as children may be attracted to military service precisely because it is an institution and, as such, may appear somewhat familiar. Another possibility is that, lacking family networks which might help them secure entry into the workforce, such individuals join the armed forces at school-leaving age, as an alternative of last resort.

#### Factor IV--Anti-Social Behavior

Factor IV appears to represent a dimension defined chiefly by childhood delinquency and anti-social behavior during adulthood. The highest loadings on this factor are for childhood history of reform school (.69) and having been expelled from school (.62). A strong positive loading of .44 is found for the variable indicating a criminal conviction. Educational achievement and veteran status have strong negative loadings at -.40 and -.39 respectively. Also loading significantly on this factor is drug

involvement at .31 and self-rated need for treatment services at .24. As noted above, childhood runaway history loads at .22, as does having fathered a child. The total variance accounted for by this factor is 6.1 percent.

One can assume that the path to school expulsion and reform school is generally defined by serious acting-out behavior in childhood and adolescence. Loadings on this factor suggest that these experiences are associated with subsequent criminal behavior and limited educational attainment. Formal education is, by definition, interrupted by school expulsion. Criminal conviction as an adult can be seen as a continuation of acting-out or anti-social behavior begun as a juvenile. Drug involvement may also be viewed as a related problem, often beginning during adolescence and continuing as part of a spectrum of adult deviant behavior. Drug involvement has been viewed as a well-known cause of criminal behavior both because drug use itself is defined as a crime as well as the economic motivation to robbery and property crimes which addiction generates.

The significant loading of .24 on need for treatment services is most likely a reflection of need for help with substance abuse problems since psychiatric involvement is not represented on this factor. The high negative loading on the variable indicating prior service in the armed forces is logical in that a record of drug use or criminal behavior would tend to disqualify one for service. Interestingly, there is virtually no loading on the variable indicating

having been married but there is a modest loading on having had children (which is not present on Factors I and II). Despite the commonplace nature within some communities of men fathering children out of wedlock, it is also possible to view this as consistent with a dimension of irresponsible, acting-out behavior.

The negative loading of .16 on the degree to which the subject views the shelter as home suggests perhaps that along with this dimension is the idea that the shelter is being used as a temporary refuge, until other opportunities become available.

#### Factor III--Positive Adjustment/Achievement

Factor III, accounting for 7 percent of the variance, depicts a dimension indicating a greater degree of positive adjustment or achievement than is reflected by the other factors. The variables indicating having been married and having had children have strong positive loadings of .73 and .67 respectively. Educational achievement (.32) and recent work history (.23), although not loading as strongly, have higher positive loadings than on any other factor as does a history of military service at .38. The variable indicating age at which the respondent first became homeless has a positive loading of .45, meaning that a later onset of homelessness is associated with this factor. Similarly, the loading of -.39 on the variable enumerating the proportion of time the respondent was homeless during the past five

years, indicates a relationship between this factor and comparatively less homelessness during this period. The negative loading of .24 on duration of first homeless experience is consistent as it implies relatively shorter initial homeless experiences. The degree to which the respondent considers the shelter to be his home has a substantial negative loading of .36 on this factor.

Factor III seems to reveal attributes which reflect a more positive identity or a better "track record", if you will. The fact that educational attainment, marriage, children and late onset of homelessness load highly implies that this dimension is tapping individuals who were able to establish a household and, at least for awhile, maintain somewhat more productive lives than many of their homeless counterparts. The strong negative loading on the degree to which the respondent views the shelter as his home supports the idea that homelessness and shelter life is more "disyntononic" to this factor than to the others. This is consistent with the strong negative loading on need for concrete services. This probably reflects the fact that individuals with more education, work history and more experience living "productive" lives, don't tend to view themselves as needing help with employment, income and housing issues as much as others might.

There are no significant loadings on psychiatric symptoms, psychiatric treatment history or treatment for alcoholism problems. In fact, the only clearly "problem"



variable with a substantial loading is drug involvement at .26. This finding may lend support to the notion that drug problems contributed to downward mobility for a number of subjects whose earlier personal histories have had more of a positive flavor.

The fact that there are no significant positive loadings on variables indicating childhood deprivation or delinquency suggests an association between better childhood experiences and somewhat more positive outcomes in adulthood. The converse might be argued of course; all subjects regardless of previous experiences have reached the same level, i.e. homeless and living in the public shelter system. However the absence of additional complications such as mental illness, long-term unemployment and viewing the shelter as home imply that perhaps for individuals for whom this is a strong dimension, there is a greater likelihood of escaping from homelessness and dependency.

### Summary

Twenty-six variables representing a wide range of childhood, adulthood, and current status measures were factor analyzed using principal-components analysis with varimax rotation. An interpretable four-factor solution emerged which explains approximately 33 percent of the total variance. Listed in order of the proportion of total variance explained, the factors are as follows: Factor I--Mental Illness/Substance Abuse; Factor II--Childhood

Deprivation/Family Disruption; Factor III--Positive Adjustment/Achievement; Factor IV--Anti-Social Behavior.

Each factor reflects a coherent dimension in the lives of the study's subjects. Factor loadings suggest potential relationships between variables which span different dimensions and different phases of subjects' lives. A number of these associations will be examined in greater detail in the following chapter through the use of multiple regression techniques.

CHAPTER SIX  
CHILDHOOD EXPERIENCES AS PREDICTORS:  
RESULTS AND DISCUSSION

The previous chapter began to explore the relationships between a wide spectrum of variables by attempting to identify dimensions which shed light on the life course of homeless shelter users. Intriguing relationships between several disparate variables were suggested by the pattern of factor loadings in the rotated factor solutions. This chapter presents the results of a series of multiple regression analyses intended to enhance our understanding of the nature and strength of several of these associations. Specifically, these analyses explore the strength of association between childhood experience variables and subsequent adult experiences and current status measures.

It will be worthwhile here to revisit the purpose of these analyses and the study as a whole. As discussed earlier, the issue of causal inference is an important but difficult one to confront in the present study. The cross-sectional nature of the data, by definition, prevents one from proving the existence of causal relationships between events under study. Even where strong statistical associations can be demonstrated between events which are known to have occurred in an appropriate chronological sequence, the large number of potential intervening or confounding variables, make it particularly difficult to

infer causation. Furthermore, causal inference also requires the development and falsification of alternative interpretations of observed covariation (Cook and Campbell, 1979). The poorly developed state of our understanding of the association between individual histories and the larger social phenomenon of homelessness, as well as the limitations inherent in cross-sectional survey data, effectively preclude the demonstration of a definitive causal relationship between antecedent conditions and subsequent events.

Nonetheless, the attempt to specify and explain relationships between antecedent conditions and subsequent events is a central focus of this study. The goal is to shed light on such relationships with the hope of contributing to theoretical formulations which can subsequently be evaluated through the implementation of more appropriate research designs. The questions raised here clearly suggest the need for longitudinal studies which follow the course of those at risk for homelessness and shelter users over time.

Associations between childhood experiences and a number of subsequent outcomes were suggested by the analysis in the previous chapter. In this chapter, the strength of childhood experience variables as predictors of adult experience and current status outcomes will be further examined. To accomplish this, childhood experiences will be used as independent variables in a series of regression

equations predicting variation in adult experience and current status outcomes.

#### Factor Analysis: Childhood Experience Variables

In multiple regression, the occurrence of error related to chance relationships grows as the number of predictor variables in the equation increases. In this analysis, in which the potential variance explained by the predictors is bound to be modest, it will be especially desirable to limit the number of predictors as much as possible without sacrificing substantial predictive power.

The preceding chapter's analysis indicated that the eight childhood experience variables might themselves be related to a smaller number of common dimensions. This suggested that it could be possible to effectively combine the predictive power of the variables through factor analysis and the development of factor scores. In this way fewer independent variables (in the form of derived factor scores) would be required in the subsequent regressions. The following section describes the development of these factor scores.

As discussed in Chapter Five, the childhood experience variables loaded primarily on the dimensions reflecting parental separation and delinquency/deviant behavior. It was expected that a similar factor structure would again emerge when the childhood variables were the sole variables included in a factor analysis. Principal-component

analysis with varimax rotation was run using standard scores derived from the eight childhood variables which were used in the preceding chapter's analysis (several of these variables were themselves constructed scales, the development of which is described earlier). Using the criterion that requires each factor to have an eigenvalue greater than or equal to one, a solution consisting of two factors accounting for 42.3 percent of the variance was produced. A scree plot confirmed that the amount of variance accounted for by subsequent factors dropped off dramatically following the extraction of the second factor. The rotated factor matrix is presented in Table 19.

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**Table 19**

Loadings on Rotated Factor Matrix:  
Childhood Experience Variables

N=439

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|               | FACTOR I<br>Separation | FACTOR II<br>Delinquency |
|---------------|------------------------|--------------------------|
| FOSTER CARE   | .69                    | .05                      |
| NO MOTHER     | .67                    | -.02                     |
| NO FATHER     | .60                    | .05                      |
| GROUP HOME    | .43                    | .35                      |
| INSTITUTION   | .41                    | .03                      |
| REFORM SCHOOL | -.08                   | .80                      |
| EXPELLED      | .04                    | .79                      |
| RAN AWAY      | .39                    | .44                      |

---

This solution reveals two interpretable factors which differ very little from the pattern of loadings in the preceding chapter's analysis. Factor I, accounting for 25.7 percent of the variance reflects separation from the family of origin. Factor II is defined primarily by the variables associated with delinquency. Runaway behavior loads substantially on both factors. As discussed earlier, running away from home can have many meanings and causes and thus its ambiguous loading is not surprising. Group home experience also loads on both factors although it is more heavily weighted toward the family separation factor.

Next a second principal-components analysis was run solving for three factors. The purpose was to see whether this would produce an interpretable factor structure with a "cleaner" set of loadings for these two variables. The rotated three-factor solution did not achieve this however; the loadings for runaway behavior remained roughly equally split between two factors.

Given the ambiguous nature of the runaway variable's association and meaning, a final principal-components analysis was run without this variable. This produced a two-factor solution accounting for 46.7 percent of the variance. The rotated factor matrix is presented in Table 20. The pattern of loadings remains the same in this solution except that group home experience moves over to the delinquency factor with a loading of .46. This variable's loading on the childhood separation factor is .33. Thus it

appears that the group home variable, while obviously related to parental separation, is somewhat more closely associated with delinquency. This suggests that placement in a group home, at least within this sample, is related to delinquent behavior. The fact that its primary loading changes from one factor to another when the runaway variable is withdrawn, demonstrates that it is not exclusively associated with either factor.

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**Table 20**

Rotated Factor Matrix:  
Childhood Experience Variables (without Runaway)

N=439

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|               | FACTOR I<br>Separation | FACTOR II<br>Delinquency |
|---------------|------------------------|--------------------------|
| NO MOTHER     | .72                    | .02                      |
| FOSTER CARE   | .71                    | .05                      |
| NO FATHER     | .62                    | .09                      |
| INSTITUTION   | .44                    | .04                      |
| REFORM SCHOOL | .01                    | .81                      |
| EXPELLED      | -.01                   | .81                      |
| GROUP HOME    | .33                    | .46                      |

---

Despite the slight ambiguity related to the group home variable, it was decided to base the development of factor scores on this two-factor solution, leaving the runaway variable on its own as a predictor.



Factor scores were then computed as follows. Values on the four variables comprising Factor I were totaled in simple additive form to produce a Parental Separation factor score. The variables indicating that the respondent was not living with either their natural mother or father are dichotomous; a value of one was given for the absence of the respective parent. Possible scores on the indices measuring foster care and institutional care experience range from 0 to 3 (see Chapter Five for frequency distributions of scores on these indices). Factor scores on this new variable range from 0 to 7.5 (mean=.93, SD=1.3). In a similar fashion, values on the three variables comprising Factor II were totaled to produce a Delinquency factor score. Possible scores on the indices measuring school expulsion and reform school experience range from 0 to 2. Scores on the group home experience index range from 0 to 3 (frequency distributions of scores on these indices are presented in Chapter Five). The Delinquency factor scores range from 0 to 6 (mean=.67, SD=1.2). The four-point scale indicating runaway behavior was retained unchanged (mean=.66, SD=1.2).

#### Regression Analysis I

The purpose of the next step in the analysis was to identify the adult experience and current status outcomes for which the childhood variables explain significant amounts of variance. An essentially identical multiple regression equation was developed for each outcome. In each

equation, the control variables (age and race) were entered first and the amount of explained variance was assessed by examining the resulting  $R^2$ . Next, the three childhood predictors (factor scores for parental separation, delinquency and runaway behavior) were entered into the equation simultaneously and the  $R^2$  change was again evaluated. The increase in  $R^2$  would indicate how much more variance the childhood experience variables, as a set, explain beyond that which is accounted for by the controls already in the equation. Only the outcomes for which the childhood variables explain a significant amount of variance would be retained for further analysis. The results of this examination are summarized in Table 21.

A significant increment in the amount of variance explained by the childhood predictors was found for ten of the seventeen outcomes. The outcomes for which childhood experiences are the strongest predictors are criminality, self-rated need for treatment services, psychiatric history, and psychotic symptoms (all significant at the  $p < .001$  level). The amount of variance explained for military service, self-rated need for concrete services, depressive symptoms, homelessness past five years, age at first homeless and drug abuse history is more modest but nonetheless significant. Before going on to examine the relative importance of individual childhood variables in explaining variance in the outcomes for which a significant increment in  $R^2$  was obtained, it is important to touch on

**Table 21**

Variance in Adult Experience and Current Status Outcomes  
Explained by Childhood Experience Variables in Multiple  
Regression Equations Controlling for Age and Ethnicity

N=439

---

| <u>Outcome Variable</u>          | <u>R<sup>2</sup></u> |
|----------------------------------|----------------------|
| <b>Adulthood Phase</b>           |                      |
| Education                        | .012                 |
| Ever Marry                       | .001                 |
| Fathered Child                   | .016                 |
| Military Service                 | .030**               |
| Criminal Conviction              | .072***              |
| Work History                     | .009                 |
| Psychiatric History              | .039***              |
| Alcohol History                  | .016                 |
| Drug Abuse History               | .019*                |
| Age First Homeless               | .019***              |
| Length First Homeless Experience | .011                 |
| Homelessness Past Five Years     | .020*                |
| <b>Current Status</b>            |                      |
| Psychoticism                     | .037***              |
| Depression                       | .020*                |
| Need for Treatment Services      | .061***              |
| Need for Concrete Services       | .021*                |
| Views Shelter as Home            | .011                 |

\* p<.05

\*\* p<.01

\*\*\* p<.001

the outcomes for which a significant  $R^2$  change was not observed.

The previous chapter's factor analysis suggested that childhood delinquency would be a significant predictor of educational attainment. Surprisingly, this was not borne out by the regression analysis. A possible explanation is that individuals who, as a result of their behavior, came to the attention of educational or juvenile justice authorities may have been mandated to attend school and have had their attendance more closely supervised. This may have prevented such individuals from having the opportunity to drop out.

Having married, which appears to be strongly associated with a dimension defined by positive adjustment, is not predicted by the childhood variables. This suggests that, within this sample, the decision to form a family of one's own is not significantly influenced by having experienced the childhood problems documented in the study. Variance in recent work history is also not explained by these predictors. This negative finding is not surprising, given both the large temporal difference between the predictors and the outcome as well as the lack of a conceptual connection between these events.

The predictors do not explain a significant amount of variance in one of the three homelessness indicators-- duration of initial homeless episode. The variable measuring the degree to which the respondent views the shelter as home is also found not to be significantly

associated with the childhood predictors. Although the  $R^2$  attributable to the childhood predictors is not significant for the variable indicating a drinking problem, it does approach significance ( $p=.07$ ).

#### Relative Importance of Individual Predictors

The above discussion summarizes the capacity of the predictor variables as a group to explain variance in the respective outcomes. It does not, however, address the relative importance of the individual predictors in accounting for variance when the effect of the other predictors is controlled for. Nor does it illuminate the direction of association between predictors and outcomes. The next set of regressions was designed to address these questions.

Estimating the relative importance of individual independent variables in multiple regression is an especially nettlesome problem when these variables are correlated with one another (see Pedhazur (1982) for a comprehensive treatment of the difficulties inherent in most "variance partitioning" techniques). About the best that can be done is to compare the regression coefficients which are obtained after the controls and independent variables have all been entered. Since the independent variables being used each have different ranges and standard deviations, it will be most appropriate to examine the standardized regression coefficient, known as the *beta*

weight, rather than the unstandardized coefficient (B). Comparing the betas permits the assessment of the relative importance of individual predictors when the variance explained by the other predictors in the equation is partialled out. This section explores the relative importance of each of the individual childhood experience factor scores in explaining variation in the independent variables of interest.

Table 22 presents, for the three dependent variables, the beta weight for the predictors when each is entered simultaneously into a multiple regression equation following the entry of the control variables. The following sections discuss the findings for each respective dependent variable. Where relevant, the discussion will address hypothesized relationships between variables which were introduced in the preceding chapter.

#### Military Service

The childhood variables, as a group, explain three percent of the variance in this outcome. Inspection of the beta weights reveals that delinquency is by far the strongest predictor, accounting for roughly four times as much variance as do either of the other variables. Its negative sign means that a delinquent background is associated with a lower likelihood of military service. This is probably best interpreted by the relationship between childhood delinquency and subsequent drug and criminal involvement (see below). As discussed in chapter

**Table 22**

Standardized Regression Coefficients for Childhood Risk Factors  
in Multiple Regression Equations Employing all Three Predictors,  
Controlling for Age and Ethnicity

N=439

| <u>Dependent Variable</u>   | <u>Predictors</u> |                    |                 |
|-----------------------------|-------------------|--------------------|-----------------|
|                             | <u>Separation</u> | <u>Delinquency</u> | <u>Run Away</u> |
| MILITARY SERVICE            | .08               | -.16**             | .08             |
| CRIMINAL CONVICTION         | .00               | .19***             | .14**           |
| PSYCHIATRIC HISTORY         | .12*              | .05                | .10             |
| DRUG ABUSE PROBLEM          | .01               | .14**              | -.02            |
| AGE FIRST HOMELESS          | -.07*             | -.06               | -.06            |
| HOMELESSNESS PAST 5 YEARS   | -.01              | .09                | .09             |
| PSYCHOTICISM                | .10               | .00                | .14**           |
| DEPRESSION                  | .02               | .06                | .10*            |
| NEED FOR TREATMENT SERVICES | .13**             | .16**              | .05             |
| NEED FOR CONCRETE SERVICES  | .13*              | .05                | .00             |

\* p<.05  
 \*\* p<.01  
 \*\*\* p<.001

Six, either of these problems would likely disqualify an individual from service in the armed forces.

### Criminal Conviction

As shown in Chart 21, the childhood predictors together account for a greater proportion of variance in this outcome ( $R^2=.072$ ) than they do for any other in the study. As noted above, childhood delinquency is the strongest predictor of subsequent criminal conviction. This is not an unexpected finding as it supports the notion that delinquent behavior as a child is associated with criminal activity as an adult. This is consistent with a number of studies which found that, particularly when childhood delinquency occurs in combination with other problem behaviors, it is associated with subsequent anti-social behavior in adulthood (Fanshel, Finch and Grundy, 1990; Robins, 1966; Rutter and Madge, 1976).

Interestingly, runaway behavior maintains fair predictive power of its own. A plausible explanation is that some children who were in fact involved with delinquent or anti-social behavior successfully avoided school expulsion or being sent to an institution by running away from home. They thus were not identified as delinquent for the purposes of this study and instead this dimension is picked up under runaway behavior. Controlling for delinquency and running away, family separation does not contribute at all to the explained variance, suggesting that



the experiences comprising this factor are not, in themselves, associated with subsequent criminal behavior.

### Psychiatric History

3.9 percent of the variance in this criterion variable is explained by the combined childhood predictors.

Separation is the only individual variable whose beta attains significance, accounting for approximately one and a half times as much variance as does runaway history and almost five times as much variance as does delinquency. Before attempting to interpret this finding, it is important to reiterate that this outcome reflects the self-report of having been treated; either as a psychiatric inpatient or having been prescribed psychotropic medication. The variable therefore does not address whether or not the respondent is currently experiencing symptoms of psychiatric disturbance.

This finding is consistent with both of the two explanations offered in the previous chapter. It may be that separation from the family of origin was caused by behavioral or emotional problems which were precursors of psychiatric disorder in adulthood. On the other hand, disrupted family relationships may themselves have led to psychological problems or stressors which contributed to the development of subsequent psychiatric disorder.

### Drug Abuse History

The childhood variables together account for roughly two percent of the variance in this outcome. Inspecting the beta weights reveals that practically all the explained variance is derived from the delinquency variable. Again, this is not surprising as it confirms the oft-demonstrated link between childhood delinquency and substance abuse problems (Jessor and Jessor, 1977; Robins and McEvoy, 1990). Two explanations are equally plausible here. It is possible that subjects who were involved in delinquent activities as children were already involved in the use of illegal drugs at that time. For some, perhaps, their school expulsion or time spent in some type of correctional institution was directly or indirectly due to a drug problem. For others, childhood delinquency may have simply provided the initial exposure to a criminal subculture in which illegal drug use would have been a generally accepted activity.

### Age First Homeless

A modest 1.9 percent of the variance in this outcome is explained by the three childhood predictors. Only separation has a beta weight which attains significance at the .05 level, although the relative strength of the runaway variable is only slightly lower. It should be noted that very large amount of the total variance (55.6 percent) in this variable is accounted for by the control variables. This is due to the strong association between age and age

first homeless ( $r=.75$ ). The structure of the equation, in which the controls are entered before the predictor variables, effectively reduces the chance that the predictors have to explain the variance since so much of the explained variance is already "taken up" by the controls.

The results confirm the presence of an association, if only a modest one, between childhood separation from the family and earlier onset of homelessness. This lends support to the notion that lack of a strong family network deprives the individual of a source of support which may delay or prevent the initial experience of homelessness.

#### Homelessness Past Five Years

The predictors together account for a modest 2 percent of the variance in this variable. None of the individual childhood variables has a beta weight large enough to attain significance at the .05 level. It is clear, however, that the largest relative amount of explained variance is associated with delinquency and runaway behavior, with separation contributing virtually nothing.

#### Depressive Symptoms

2 percent of the variance on the depressive symptoms scale is explained by the childhood predictors. Runaway history is the only variable among the three having a significant beta weight. This a difficult finding to interpret, especially given the uncertainty about the

meaning of high scores on this scale. As Susser et. al. (1988) point out, feelings of demoralization and distress measured by this scale may very well be the norm during episodes of homelessness, rather than indicators of depressive illness. Such feelings may abate dramatically once stable housing is obtained. The authors also note that depressive symptoms often coexist with and are magnified by other physical, psychiatric or substance abuse disorders. As runaway behavior is also correlated with psychotic symptoms (see below), it may be that its association with depressive symptoms is an artifact of underlying psychotic illness.

#### Psychotic Symptoms

3.7 percent of the variance on the psychoticism scale is accounted for by the childhood predictors. This is almost twice as much variance than is predicted in the depression scale. As with the depression scale, there is some question as to the meaning of high scores on this scale. Particularly with items designed to assess paranoid ideation (i.e. "Have you ever felt that there were people who wanted to harm or hurt you?") positive responses may in part reflect the real dangers connected with shelter living. Nonetheless, it is likely that this type of scale does provide a more reliable tool for identifying symptoms of serious mental illness than do the scales focusing on measures of general distress (Susser et. al., 1988).

As with the depression scale, runaway behavior accounts for the largest share of the explained variance and is the only variable for which the beta achieves significance ( $p < .01$ ). As discussed in the previous chapter, running away from home is a phenomenon which likely has many different precursors and outcomes and consequently must have widely varying significance to different runaways. Unfortunately, we lack data regarding the reasons why a respondent ran away, and thus the true meaning of this event remains ambiguous. Any hypothetical explanation linking runaway behavior with subsequent events or conditions must therefore remain highly speculative.

One plausible formulation would view runaway behavior as a proxy for the respondent having experienced physical, emotional or sexual abuse in the home. In this model, respondents would have run away from home to escape abuse. The association between the experience of abuse as a child and later elevated levels of psychiatric symptoms has been documented in several studies (Fanshel, Finch and Grundy, 1990; Tong et. al.; Burgess, Hartman, and McCormack, 1987; Mrazek and Mrazek, 1981; Meiselman, 1978). In a clinical sample, for example, a recent study of psychiatric patients demonstrated a strong association between a history of abuse and a range of psychiatric symptoms (Bryer, Nelson, Miller, and Krolet, 1987). It may be, then, that the correlation between runaway behavior and psychotic symptoms is actually

reflecting an association between such symptoms and a history of abuse during childhood.

#### Need for Treatment Services

A substantial 6.1 percent of the variance on the factor score gauging self-rated need for treatment services is explained by the childhood predictors. This factor reflects the general need for help with "nerves", substance abuse and family problems. Examination of the beta weights reveals that both delinquency and separation contribute with the former accounting for roughly one and a half times as much variance as the latter. It is likely that the delinquency variable is contributing primarily through the dimension related to drug abuse and the health complications and family difficulties which drug problems may engender. The separation variable, on the other hand, is probably more associated with the desire for help with emotional problems or possibly a desire for assistance in resolving problematic or fractured family relationships.

#### Self-Rated Need for Concrete Services

2.1 percent of the variance on the factor score indicating self-rated need for concrete services is explained by the childhood predictors. The betas show that practically all the explained variance can be attributed to childhood separation. One formulation consistent with this finding is that individuals who were separated from their

parents or in institutional care as children did not have the experience of stable role models from whom basic coping skills could be learned. They therefore now see themselves as more in need of help with obtaining job skills, income, housing and employment. A related explanation would attribute this association to the weaker current family network which likely exists for subjects who experienced early family disruption. Thus individuals who have less family connections on whom to rely for support may likely view themselves as requiring more help from "the system."

#### Section Summary

Is it possible to detect any meaningfulness in the pattern with which particular outcomes are associated with specific childhood factors? Several speculative comments are in order. On a general level, it can be noted that for each outcome in which significant variance is explained, only one of the predictors is accounting for a significant relative amount of that variance. Table 22 shows that only for one outcome (criminal conviction) do betas for two predictors attain a level of significance.

The separation factor, defined primarily by placement away from the home and separation from natural parents, is associated with psychiatric treatment, earlier homelessness and a higher degree of self-rated need for services. These outcomes appear to share a common thread of elevated dependency or "clienthood" which may be seen as consistent with a childhood experience marked by having been deprived

of a nurturing relationship with parents and/or primary care having been provided under the auspice of social service agencies. The separation factor, then, seems to reflect the experience of having experienced one or more significant deprivations as a child.

The findings with respect to the delinquency factor suggest the presence of a pattern of troubled behavior which has persisted from childhood into adulthood. Thus, childhood delinquency predicts subsequent drug and criminal involvement as well as the need for treatment services. A legitimate inference here is that the adult criminal behavior as well as the need for treatment may be related to drug involvement.

As noted above, the runaway variable is particularly interesting and difficult to interpret. At a fundamental level, running away from home suggests that a person has made a rather dramatic decision to seek change in his life situation. It also implies the notion of escaping from conditions perceived to be unpleasant or otherwise unsatisfactory. From the regressions it can be seen that running away is associated with criminality but not drug involvement. One possible interpretation here is that the criminal activities associated with a runaway history are not primarily drug-related. Another possibility, of course, is that involvement with drugs (and associated crime) is indeed related to this predictor, but that drug treatment



(which serves as the drug abuse indicator) has not been sought.

The runaway factor is the only variable for which the beta is significant in the regressions predicting current mental status, being associated with higher levels of both psychotic and depressive symptoms. Nonetheless, it is not related to self-rated need for services of either type. Thus running away predicts a higher level of symptoms but not the perceived need for help. A plausible, if highly speculative, explanation is that childhood runaway behavior implies a coping style defined by the attempt to escape from or avoid painful circumstances. Such a personality style might intentionally avoid treatment despite experiencing substantial psychological distress.

#### Chapter Summary

This chapter explored the ability of childhood experience variables to account for variance in variables describing adult experience and current status measures. Childhood experience variables were factor analyzed in order to reduce the original number of variables to a smaller number of factors. Factor scores were then computed for dimensions reflecting separation from the family, delinquency and runaway behavior. The three factor scores were subsequently employed as independent variables in a series of seventeen multiple regression analyses using adult experiences and current status measures as dependent

variables. After the effects of age and ethnic group were controlled for, the independent variables as a group accounted for a significant amount of variance in ten dependent variables, with the proportion of variance explained ranging from 1.9 to 7.2 percent. In the next step of the analysis, the standardized regression coefficients (beta weights) resulting from the regressions were examined in order to analyze the relative importance of each individual variable in predicting variance in the respective outcomes when the correlations between predictors were partialled out.

A number of associations suggested by Chapter Six's analysis were confirmed. Childhood delinquency was found to predict a higher likelihood of subsequent criminal conviction, drug problems, and self-rated need for treatment services. Delinquency also predicted a lower likelihood of subsequent military service. The expected association between delinquency and lower educational attainment was not supported by the results of the regression analysis. Childhood separation from the family was found to predict a greater chance of subsequent psychiatric involvement, the need for treatment and concrete services, as well as an earlier onset of initial homelessness. A history of runaway behavior in childhood was found to predict criminal conviction and current ratings of both psychotic and depressive symptoms. Expected associations between running away and subsequent psychiatric involvement as well as

earlier onset of homelessness were not demonstrated.

Finally, a number of speculative assertions were offered in the attempt to discern some meaningful pattern in the relative strength of the independent variables in the respective regressions.

## CHAPTER SEVEN

## CORRELATES OF EXPRESSED SERVICE NEEDS:

## RESULTS &amp; DISCUSSION

The issue of service needs among the homeless population is a salient one, particularly when attention turns to the pressing need to expand and enhance the service delivery system. Although the availability of temporary shelter for the homeless has increased dramatically over the last several years, the provision of other services has remained woefully inadequate. Advocates have charged, with some justification, that available services are often not responsive to the needs which homeless people themselves judge to be most important. Clearly, if more comprehensive solutions to the problem of homelessness are to emerge, it will be necessary to define more carefully the level of need which homeless people express for differing types of services and the ways in which service needs vary within the homeless population.

A handful of recent studies has begun to provide data regarding the service priorities of the homeless population (Barrow et. al., 1989; Struening and Barrow, 1985; Mulkern and Bradley, 1986; Ball and Havassy, 1984; Gelberg and Linn, 1988). As summarized in Chapter Two, these studies tend to show that homeless people as a group place a higher priority on services related to housing, income and employment than they do on counselling or mental health services. Thus the service domain which I have referred to above as concrete

services is seen as more important than the more treatment-oriented services. This is an important finding in itself, however we know that the homeless represent an extremely heterogeneous population. As such, it would be expected that there might be significant variation in the ways in which specific individuals and sub-groups of homeless people would assess their level of need for particular services.

A major focus of the present study is the exploration of continuities between previous experiences and current status among homeless respondents. The previous chapters have demonstrated that there are indeed a number of significant continuities between earlier life experiences and a wide range of outcomes. Building on the exploration of self-rated service needs begun in the previous chapters, this chapter employs a similar procedure to analyze the correlates of differential service need as expressed by respondents.

Self-rated need for concrete services and treatment services were selected as the outcomes for which the attempt would be made to identify significant correlates. As discussed previously, these dimensions have a good deal of coherence from a conceptual point of view and the factor analysis showed them to represent largely stable and orthogonal factors within this sample.

Factor scores for the indices measuring these two dimensions were used as dependent variables in multiple regression equations (see Chapter Four for a description of

the development of these scores). Independent variables include the range of variables which had been employed previously in the life course factor analysis, with two exceptions. In order to restrict the number of predictors as much as possible, childhood risk factors were limited to those variables which had been demonstrated in Chapter Seven to be associated with the respective outcomes. Thus, childhood separation and delinquency were employed in the equation predicting need for treatment services, while only separation was used in the equation predicting concrete service need. In addition, age at first homeless episode was excluded in order to avoid potential multicollinearity problems resulting from its strong correlation with the control variable of age ( $r=.75$ ).

The control variables age and ethnicity were entered into the equations first so that the impact of the subsequent predictors could be assessed independently of their contribution. After entering the controls, the predictors were all entered simultaneously into the respective equations. Factor scores, indices and continuous variables were entered in their original form. Dichotomous variables (veteran status, ever married, fathered child, psychiatric, drug or alcohol history, criminal conviction) are coded 1 for present and 0 for absent.

### Treatment Services

Table 23 presents the results of the regression analysis for the dependent variable measuring respondents' need for treatment services. As described in Chapter Five, this index reflects respondents' self-rated need for help in the following areas: nerves; health; drinking; drugs; and getting along with family. The zero-order correlations between individual predictors and the dependent are presented in the middle column. Beta weights (standardized partial regression coefficients) are presented in the right hand column. Since the betas are in standardized form and are derived from a single equation in which all independent variables have been included, they reflect the relative contribution of each predictor to the total explained variance.

After the effect of the control variables is taken into account the predictors yield an  $R^2$  of .30, ( $F$  change = 11.62,  $p < .0001$ ) meaning that together they explain roughly 30 percent of the variance in the dependent variable.

Comparing the betas reveals that the score on the depression scale is by far the strongest relative contributor to the explained variance, accounting for roughly two and a half times as much variance as does the next most potent predictor (drinking treatment history). As touched upon earlier, the meaning of this scale must be interpreted in light of the difficult circumstances under

**Table 23**

Zero-Order Correlations and Standardized Partial Regression Coefficients (Beta) for Multiple Regression Equation Predicting Self-Rated Need for Treatment Services

N=439

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| <u>Variable</u>                    | <u>Zero-Order<br/>Correlation</u> | <u>Beta</u> |
|------------------------------------|-----------------------------------|-------------|
| Childhood Risk Factors             |                                   |             |
| Separation                         | .17***                            | .11**       |
| Delinquency                        | .19***                            | .09*        |
| Educational Attainment             | -.04                              | .02         |
| Veteran Status                     | -.11*                             | -.07        |
| Family Formation                   |                                   |             |
| Ever married                       | .08                               | .06         |
| Fathered child                     | .03                               | .01         |
| Duration First Homeless Experience | .01                               | -.07        |
| Treatment History                  |                                   |             |
| Drinking                           | .32***                            | .17***      |
| Drugs                              | .30***                            | .13**       |
| Psychiatric                        | .29***                            | .11*        |
| Ever Convicted of Crime            | .12*                              | .04         |
| Work History                       | -.05                              | .03         |
| Homelessness Past 5 Years          | .10*                              | .04         |
| Views Shelter as Home              | .15**                             | .10*        |
| Depressive Symptoms                | .41***                            | .27***      |
| Psychotic Symptoms                 | .19***                            | .02         |

$R^2 = .30$  (excluding contribution of control variables)

\*      $p < .05$   
 \*\*     $p < .01$   
 \*\*\*    $p < .001$



which respondents found themselves at the time of the interview. Psychiatric epidemiologists point out that intense feelings of distress measured by this scale may be the norm during episodes of homelessness. Elevated scores may not necessarily be indicative of the presence of depressive illness but may simply represent respondents' subjective rating of feelings of psychological distress. Higher scores could thus be understood as indicating a greater degree of sadness, worry or dissatisfaction with one's current state of affairs (Susser et. al, 1988). The strong association between scores on this scale and self-rated need for treatment services is consistent with such an interpretation. Those who are currently experiencing greater feelings of distress and dissatisfaction are more likely to express interest in receiving treatment services, which ostensibly would be seen as providing some relief from the distressed state.

It is interesting to note that the score on the psychoticism scale, although having a significant zero-order correlation with the outcome, is not a significant predictor when the effects of the other variables are controlled for. This can probably be explained by the significant zero-order correlations between psychoticism and depressive symptoms ( $r=.32$ ,  $p<.001$ ) and between psychoticism and psychiatric history ( $r=.26$ ,  $p<.001$ ), both of which are highly correlated with need for treatment services.

Conceptually, the interpretation of psychoticism scores poses some similar difficulties as those relating to depression. As discussed earlier, the validity of items designed to elicit paranoid symptoms may clearly be influenced by the dangerous and intimidating nature of the shelters themselves (Susser and Struening, 1990). Thus many respondents with elevated scores may not in fact be psychotic but may be understandably frightened and suspicious of the people around them. In this context, it is not surprising that psychoticism scores are not predictive of need for treatment.

In instances in which the psychoticism scale is identifying respondents who are indeed manifesting serious mental disorder, the lack of association with self-rated need for treatment services is understandable. Psychoticism, as measured by this scale, is characterized by paranoia, grandiosity, externalization and poor reality testing. An individual whose thought process is truly psychotic is likely to lack insight into or awareness of his psychological and cognitive difficulties. It stands to reason then, that such psychoticism would not, in itself, contribute to an individual expressing the need for treatment services.

As would be expected, the treatment history variables are significantly associated with this outcome, indicating that previous diagnosis of or treatment for drug, alcohol or psychiatric problems predict individuals' assesement of

current need for help in these areas. This finding is consistent with two explanations, both of which may be operating simultaneously. Those with documented treatment histories are probably more likely to be currently experiencing problems in these areas; therefore, they would see themselves as needing this type of help. The presence of a treatment history also suggests greater openness to treatment by virtue of such individuals having received treatment before.

The variable gauging the degree to which the respondent views the shelter as home is modestly but significantly associated with this outcome ( $\beta=.10$ ,  $p<.05$ ). Perhaps those who view the shelter as their home see themselves as having few other options or opportunities to improve their situation. Such a view might be consistent with a greater willingness to accept treatment services. Interestingly, homelessness during the past five years, which has a significant zero-order correlation with the outcome ( $r=.10$ ,  $p<.05$ ) is no longer significantly associated when the other variables are controlled for. This is most likely due to its correlation with viewing the shelter as home ( $r=.17$ ,  $p<.001$ ) and the depression scale score ( $r=.14$ ,  $p<.01$ ). Thus, the perception of the shelter as home is a modest predictor of need for treatment services but the proportion of time the individual was actually homeless is not.

As noted in the previous chapter, the childhood risk factors together explained 6.1 percent of the variance in

self-rated need for treatment services, with separation and delinquency each contributing at a significant level. When these predictors are considered along with the full range of other variables, both childhood variables remain significantly associated with the outcome. In fact, separation accounts for roughly the same amount of explained variance ( $\beta = .11$ ,  $p < .01$ ) as does psychiatric treatment history and just slightly less than does drug treatment history. This lends support to the notion that the childhood events in question are indeed important determinants of a range of subsequent experience.

#### Concrete Services

Table 24 presents the results of the regression analysis for the dependent variable measuring respondents' expressed need for concrete services. As described in Chapter Five, this index reflects respondents' self-rated need for help in the following areas: housing; income; finding a job; and job skills. The zero-order correlations between individual predictors and the outcome are presented in the middle column. Beta weights are presented in the right-hand column.

After the effect of the control variables is taken into account the predictors produce a modest  $R^2$  increase of .11, ( $F$  change = 3.67,  $p < .0001$ ) meaning that together they explain roughly 11 percent of the variation in the dependent

variable. That the predictors explain less than half as much of the variance as they do on the treatment services outcome is in itself of interest. The frequency distribution of the service need variables demonstrates that the need for concrete services among the homeless is a more universal one than is the need for treatment. Thus, there is simply less variation to explain in the need for concrete services than there is in the need for treatment services. The areas which comprise the concrete services factor score are those which, by definition, would be of the most immediate relevance to vast majority of homeless people in general (i.e., housing, income, employment). Treatment services, on the other hand, would likely appeal primarily to those who see themselves as having a "treatment-relevant" problem. This is consistent with previous research which has found that homeless people, as a group, place greater priority on the need for concrete services than they do for other types of assistance.

The most powerful predictor of need for concrete services is the indicator of ever married status ( $\beta = -.26, p < .0001$ ) which accounts for roughly five times as much explained variance as does the next most important predictor (childhood separation). This finding is consistent with the analysis in Chapter Five which suggested that having been married identifies individuals who have previously exhibited a higher level of social functioning. Ever married status,

**Table 24**

Zero-Order Correlations and Standardized Partial Regression Coefficients (Beta) for Multiple Regression Equation Predicting Self-Rated Need for Concrete Services

N=439

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| <u>Variable</u>                     | <u>r</u> | <u>Beta</u> |
|-------------------------------------|----------|-------------|
| Childhood Risk Factor<br>Separation | .14**    | .12**       |
| Educational Attainment              | -.10*    | -.05        |
| Veteran Status                      | -.08     | -.05        |
| Family Formation                    |          |             |
| Ever married                        | -.22***  | -.26***     |
| Fathered child                      | -.06     | .09         |
| Duration First Homeless Experience  | -.04     | -.09        |
| Treatment History                   |          |             |
| Drinking                            | .02      | -.02        |
| Drugs                               | .00      | -.03        |
| Psychiatric                         | .06      | .04         |
| Ever Convicted of Crime             | .04      | .02         |
| Work History                        | .05      | .08         |
| Homelessness Past 5 Years           | .11*     | .11*        |
| Views Shelter as Home               | .02      | -.03        |
| Depressive Symptoms                 | .13**    | .10*        |
| Psychotic Symptoms                  | .08      | .05         |

$R^2 = .11$  (excluding contribution of control variables)

\*      $p < .05$   
 \*\*     $p < .01$   
 \*\*\*    $p < .001$

it will be recalled, is the variable loading most highly on the positive adjustment dimension which emerged in the factor analysis which employed the full variable set. It follows that those men who have once maintained a family household (which is likely to be the case if they were married), would be more likely to have had the previous experience of independently securing housing, income or employment. Thus they are more prone to see themselves as already possessing the knowledge and skills required to secure housing, employment and income and therefore may view concrete services as largely superfluous.

In a similar vein, negative beta weights are also obtained for educational attainment and veteran status. Although neither of these associations attains significance, their direction is consistent with the explanation offered above. Both these variables are reflective of positive adjustment and achievement and would therefore predict a lower level of need for concrete services.

The variable indicating the amount of homelessness during the past five years has a modest but significant beta weight of .11 ( $p < .05$ ). This association lends support to the notion that those for whom homelessness has become a long-term proposition would be more prone to request help with services linked directly to escaping the homeless state (i.e. income, housing, employment). Scores on the depression scale also have a modest but significant association with the outcome ( $\text{beta} = .10$ ,  $p < .05$ ). As

discussed above, the scale appears to capture subjective feelings of general distress which might logically be associated with a desire for help in most domains. Childhood separation continues to be significantly associated with the need for concrete services, a relationship which is discussed in some detail in the preceding chapter.

### Summary

This chapter explored the ability of a range of variables to account for variation in two dependent variables--need for treatment services and need for concrete services. The dependent variables were factor scores derived from the service need factor analysis described in Chapter Four. Multiple regressions for each of these dependent variables were run and the  $R^2$  as well as the standardized regression coefficients (betas) were examined.

Roughly 30 percent of the variance in the need for treatment services was explained by the independent variables after the effect of the control variables was accounted for. The most powerful predictor of need for treatment was the depression scale score, followed by history of treatment for drinking problems. History of psychiatric and drug treatment as well as childhood separation, childhood delinquency and viewing the shelter as home were also significantly associated with the dependent variable. Psychotic symptoms, although having a high zero-



order correlation with the outcome, was not significantly related when the effects of the other variables were controlled for.

Approximately 11 percent of the variance in need for concrete services was explained by the set of independent variables. Having been married was associated with a lower degree of concrete service needs and was by far the strongest predictor. Childhood separation, amount of homelessness during the last five years, and depressive symptoms were more modestly but nonetheless significantly associated with higher levels of need for concrete services.

## CHAPTER EIGHT

### CONCLUSION:

#### MAJOR FINDINGS, LIMITATIONS AND IMPLICATIONS

This study probed the relationships between a number of disparate variables drawn from a wide range of dimensions and time points in the lives of a representative sample of homeless male shelter users. Employing data reduction procedures and correlational methods, the purpose was to discover some order within a seemingly rather disordered set of data. Given the paucity of explanatory theories from which to draw significant guidance, the study was truly exploratory in that it set out not to confirm or disprove clearly established hypotheses, but to demonstrate associations which might begin to illuminate the process of homelessness and, in so doing, generate hypotheses around which future research could be conducted.

This chapter summarizes the study's key findings and implications for the organization and delivery of services to the homeless. The important limitations inherent in the study's methodology are addressed followed by a discussion of the need for further research.

#### Major Findings

The main research question which the study set out to investigate was as follows: What is the relationship between homeless persons' childhood experiences, personal

attributes and earlier life experiences and their more recent experiences, their present level of functioning, and their need for services?

The initial step in this process was to develop multiple-item indices related to childhood experience variables and self-rated service needs which would then be used in subsequent analyses. Next, the relationship between scores on these indices and a wide range of other variables were analyzed using factor analysis. This analysis provided insight into a number of life course dimensions which suggested associations between particular variables drawn from childhood, adulthood and recent experiences and status ratings. Finally the strength and direction of these associations was further examined employing multiple regression procedures.

#### Life Course Continuities

At a general level, the data support the conclusion that there are, for this homeless population, detectable continuities between earlier life experiences and a number of important outcomes. The factor structure which emerged clearly suggests several distinct dimensions each defined primarily by different types of background experiences and outcomes. One important dimension is defined chiefly by mental illness, substance abuse and need for treatment and concrete services. There is also a coherent dimension which revolves more around experiences suggesting a previous level

of positive adjustment or social competence, indicated by family formation, educational attainment, later onset of homelessness and somewhat lower need for services. Juvenile delinquency, adult criminal behavior and drug involvement comprise another major dimension. A final dimension is defined by childhood separations from the family of origin, runaway behavior and earlier onset of initial homelessness.

These findings are consistent with the emerging perspective of the contemporary homeless population as defined by significant heterogeneity. Even within this sample, which is relatively homogeneous from a demographic standpoint, the factor structure corroborates the view that there are many different pathways to homelessness as well as many widely varying types of people who count themselves among today's homeless. The analysis does not, however, indicate how these dimensions are distributed and coexist within various members of the homeless population. A logical next step would involve the development of a typology which would illuminate the patterns of overlap between these dimensions and would permit the estimation of the proportion of the homeless population which can be placed into various ideal types. This could be pursued through inverse or "q sort" factor analysis (Nunnally, 1978) or various cluster analytic approaches (Lorr, 1983; Romesburg, 1984).

### Childhood Experiences

Roughly 21 percent of the sample were not living with their natural mother at age 12. Almost 45 percent were not living with their natural father at this age. Experiences of separation from the family of origin through either institutional placement or foster care were reported by almost ten percent of the sample. Foster care was the most frequently reported of this category of experience; roughly nine percent reported some foster care experience. Six percent reported having been in a group home and approximately four percent reported previous care in a special residence or institution. Having been expelled from school was reported by more than 23 percent of the sample and over 17 percent said they had been sent to jail or reform school as children. Slightly less than 27 percent of respondents reported that they had run away from home and stayed away overnight on at least one occasion while 14 percent said they had run away on more than one occasion.

The findings suggest that these childhood experiences are associated with different dimensions in that the pattern of their occurrence within the sample forms an interpretable factor structure. Not living with natural parents at age 12, foster care, and institutional placement appear to cluster together in what I refer to as a separation factor. School expulsion, reform school and group home experience form what is referred to as a delinquency factor. Runaway

behavior appears not to be related exclusively to one or the other of these two primary factors.

When viewed as risk factors associated with subsequent adult experiences and current status outcomes, childhood experiences predict significant amounts of variation in several important outcomes. Separation is associated with subsequent psychiatric history, earlier onset of homelessness and greater self-rated need for both treatment and concrete services. Delinquency is related to adult criminality, drug abuse and need for treatment services. Runaway behavior predicts adult criminality and elevated scores on both the psychoticism and depression scales. Delinquency and runaway behavior taken together (but neither alone) account for a small but significant amount of variation in the amount of time respondents have been homeless during the last five years.

In their comprehensive synthesis of the research on inter- and intra-generational continuities of social disadvantage, Rutter and Madge (1976) make several observations consistent with these results. They found childhood separation experiences (particularly multiple separations) to be associated with subsequent personality disorder and psychiatric disturbance; however they point out that the circumstances of the separation appear to be particularly salient. Specifically, they note that these associations tend to occur in separations which were the result of family discord or disorder. This leads them to

conclude that, in themselves, "separations play only a minor part in the causation of persistent psychiatric disorders...[but they are] important factors in the genesis of chronic disorders by virtue of the fact that they may involve unpleasant experiences and, even more important, by the fact that they often reflect long standing family disturbance" (p. 207).

The intriguing associations in this study between childhood runaway behavior and elevated psychological symptoms suggest the need for further research. Runaway behavior appears to be a clear risk indicator, but the actual "risk mechanism" remains unclear (Rutter, 1988). Having run away from home can have many causes, meanings and outcomes depending on a host of social and individual circumstances. Do these relationships imply that childhood runaway behavior is a manifestation of already existing psychopathology or do children run away to escape conditions (such as physical, sexual or psychological abuse) which may in themselves put them at risk for developing mental disorder? It would have been useful to have items on the survey instrument which asked specifically about individuals' experience of such abuse as children so that its association with running away and other key outcomes could have been carefully investigated. Clearly additional research on childhood runaway behavior is warranted.

Although not explicitly addressed by this study, it is also possible that individuals who have extensive histories

of running away from home as children are at greater risk of becoming homeless as adults. Certainly the associations noted above as well as the essential similarity between running away from home and being without a home make this a legitimate hypothesis for study. Since all subjects in this study were homeless, this question could not be appropriately investigated. In any case, it would appear that children and adolescents who are extensively involved in runaway behavior are at high risk for subsequent problems. The findings suggest that service interventions designed to prevent psychiatric disorder and dependency ought to be targeted toward children who manifest such behavior. Perhaps effective interventions at this point might serve to prevent some individuals from becoming homeless as adults.

The observed relationship between childhood separation from the family of origin and subsequent psychiatric treatment, early onset of homelessness and high service needs suggests that these experiences play a role in contributing to more negative outcomes in later life. At a general level, separation experiences seem to be associated with higher levels of dependency and a greater degree of "clienthood." Assuming for the moment that there is indeed a causal relationship operating, the data do not illuminate the mechanism by which this process takes place. As discussed earlier, psychological disorder on the part of the individual as a child or adolescent may be seen as cause or



effect (or both) of separation from the family. Subsequent dependency may be the result of such disorder on the part of the individual, or of the absence of a functional and involved family which could provide needed support during stressful times. Individuals who have had significant childhood experience as clients of the social service system may be more comfortable with relying on these systems as adults. Perhaps the most likely explanation involves all of these processes operating simultaneously.

#### Service Needs

Developing a better understanding of the service needs of the homeless population is a pressing issue for social service, health and mental health providers. In public debate, discussion of this issue has often been addressed at the level of gross stereotype. Laymen, professionals and advocates have tended to view the issue in dichotomous terms. Thus, there is a common impression that homeless people "don't want help" and will reject services (particularly treatment-oriented services) if offered. Many in the advocacy community believe that homeless people need and will accept help with finding employment or housing but, until these needs are met, will reject treatment-oriented services. Some believe that those individuals who have previously been clients of the treatment system are particularly loathe to accept help in this area because of

the negative experiences they may have had with unresponsive treatment institutions and professionals.

The findings here confirm this in part but also support a somewhat different view. First, the results indicate that the distinction between concrete and treatment services often drawn by service providers is in fact a meaningful one from the perspective of the respondents. Homeless people themselves do see concrete and treatment oriented services as belonging to fundamentally discrete dimensions. The factor loadings described in Chapter 4 reveal relatively orthogonal factors differentiating concrete services (help with housing, income, employment and job skills) from treatment services (help with health, emotional and substance abuse problems as well as help getting along with family members).

The descriptive data show that concrete services are desired by the vast majority, but treatment services are also requested by a large percentage of the sample. Help with housing is requested by over 90 percent of respondents, help with income by 82 percent, help finding a job by roughly 80 percent and help improving job skills is requested by over 66 percent. Help with health problems is requested by 44 percent of respondents, help with emotional problems by roughly 25 percent, and help getting along with family members by 23 percent. Help with drinking and drug problems is desired by 20 and 17 percent respectively.

The regression analyses revealed a number of significant correlates of need for services along these two dimensions. With respect to concrete services, having been married has + a strong negative association with service need. It appears that this variable may serve to identify a group of shelter users who have previously exhibited substantially higher levels of social and economic independence. This group may see itself as already possessing knowledge and skills in these areas, thereby rendering these types of service unnecessary. Amount of homelessness during the past five years and depression scale scores are both modest but significant predictors of enhanced need for concrete services. As noted above, childhood separation experiences are also significantly associated with higher levels of need in this domain.

The strongest predictor of need for treatment services is the depression scale score, meaning that those respondents who are experiencing a greater degree of either clinical depression or subjective distress and dissatisfaction see themselves as needing more help in this area. Treatment history is also a strong predictor of elevated need for services in this area. Thus homeless people who have previously received treatment services continue to express the need for these services, suggesting the chronic nature of the disabilities for which they require help. It also suggests that, contrary to the notion that many homeless people have become "turned off" by their

previous contacts with medical, psychiatric and substance abuse providers, these former clients appear to comprise the group which expresses the highest level of need for these services.

Nonetheless, a recent study has demonstrated that the level of actual use of needed services among the homeless falls far below the level of assessed need in the area of treatment services (Padgett, Struening and Anderson, 1990). Given the overwhelming needs for housing and income experienced by most homeless people, the authors speculate that treatment services may be viewed as simply of lower priority than are services related to "survival needs." Alternatively, these findings may simply reflect the lack of accessibility to needed services which is experienced by many homeless people.

These results support the need to adopt a client-centered approach to the design and delivery of services to the shelter population. While it does seem clear that concrete services are most often requested, treatment services are desired by a large proportion of the population, particularly those with previous histories of such treatment. These individuals do not appear to feel that treatment must wait until after concrete service needs are met. In some cases, it is possible that effective treatment services (psychiatric or substance abuse, for example) may allow individuals to escape the homeless condition by controlling their symptoms to the degree that

friends or family members would agree to take them in. The delivery system ought therefore to make available and accessible the full range of services from which homeless people may then select those that they view as potentially most helpful. Toward this end, it is clear that, particularly with respect to treatment services, specialized outreach and referral efforts will be required.

The findings also suggest that practitioners engaged in work with homeless shelter users might usefully focus intensive efforts on the subgroup which appears to have had some history of prior positive adjustment and social competence. These are people who, provided with short-term, focused interventions aimed at re-connecting them with employment and possibly a supportive family network, might be able to make a relatively quick transition back into productive life.

#### Limitations of the Study

A number of caveats are in order regarding the study's limitations. Although the subjects comprise a representative sample of men between the ages of 28 and 50 in the public shelter system, the sample should not be assumed to accurately represent the whole of New York's homeless population. Women and children, who together make up the majority of the city's sheltered homeless population, were not included. Furthermore, the sample excluded homeless people who were not making use of the public

shelter system during the survey period (those living on the streets, subways, park benches or in hospitals or other institutions). The accumulated research also suggests great geographic variability with respect to characteristics of the homeless population. Thus, these findings cannot be assumed to accurately characterize the homeless populations in other parts of the United States.

A major limitation to the present study is its reliance on cross-sectional data to illuminate the relationships between a number of antecedent conditions and subsequent outcomes. Notwithstanding the obvious difficulties in implementing such studies, longitudinal designs would obviously be more appropriate for examining key issues regarding the life course of homeless people and those at risk for homelessness.

Another limitation is the study's exclusive reliance upon respondents' self-reports for data on a wide range of important life experiences. One might legitimately question the accuracy of reporting, particularly with respect to negative or potentially stigmatizing experiences. To date, only psychiatric hospitalization history has been studied in an attempt to compare self-reported data of homeless people with official records. A fair degree of degree of concordance was discovered, however 25 percent of the sample studied failed to reveal to an interviewer an officially confirmed previous state hospitalization (Struening, 1987).

It should also be pointed out that while this study sought to investigate a relatively wide range of life course variables and current status measures, cross-sectional survey research can reflect only a narrow window on the actual life experiences of homeless people. There is no doubt that ethnographic and other forms of qualitative research are needed to better flesh out the problems, needs and life course patterns of the homeless (Koegel and Ovrebo, 1990). Other constraints were created by the fact that the study was making use of data which was originally collected for another purpose. Therefore a number of provocative questions could not be fully pursued because the needed information was simply not part of the data set.

Finally, it must be emphasized that this study, as does all research which focuses exclusively on homeless people themselves as the unit of inquiry, ignores many social, economic and cultural factors which are critically important for understanding contemporary homelessness. Advocates have long asserted that a major weakness of much homelessness research is that it excludes consideration of key variables which contribute powerfully to the problem. Hopper and Sosin (1990), for example, catalogue a range of factors--the local economy, housing availability, income maintenance and mental health policies, social and family networks, racism and stigma among others--which ought to be reflected in such research. The need to understand issues of individual experience within the broader social context cannot be

disputed, particularly in the arena of a problem so clearly driven by "macro" forces as is homelessness.

#### Need for Further Research

The attempt should be made to replicate some of the present findings in other samples of homeless people. For instance, the life course dimensions which were revealed here may very well differ significantly in a female population or a population of non-shelter users. Similarly, the ways in which this sample views their needs for services may, for example, be quite different from the service priorities of homeless people in other cities or in rural areas.

Particularly useful from a service planning perspective would be an effort to use the life course and service need dimensions to develop typologies of homeless people and to use these typologies to estimate levels of need for particular interventions. If reliable typologies could be established, for instance, it might be possible to more effectively plan for the types of services which could best address the needs of specific groups. Following a needs assessment, services could be better targeted to specific shelters or other locations where they are most needed. Evaluations of the effectiveness of outreach and service delivery approaches would also be informed by a clearer understanding of the sub-groups of clients who are receiving or rejecting services.



As noted above, a cross-sectional study is not the most effective design for investigating what are essentially longitudinal phenomena. This study has provided some evidence for a number of associations between antecedent experiences and subsequent outcomes. To more carefully assess these associations, particularly as they suggest issues of causality, the need for prospective designs are clearly indicated. For instance, it would be useful to follow a cohort of individuals who are believed to be at risk for subsequent homelessness and other negative outcomes as suggested by the analysis of childhood experiences. Additional research should be focused upon children who run away from home, have involvement in delinquent activities or who experience other risk factors discussed in this study. Such research, it would be hoped, could begin to unravel the mechanism by which these risk factors actually operate.

Particularly important is the need to study the course of homelessness itself among the homeless population and those at risk. What are the predictors, for example, of prolonged, chronic homelessness versus more episodic homelessness? The present study suggests that mental illness and substance abuse are associated with individuals' experiencing a greater degree of homelessness during the past five years. A longitudinal approach would permit a much clearer examination of these relationships as well as the effects of potentially mediating experiences such as the availability of family support, referral to supportive

housing, and the receipt of case management, treatment and concrete services. A number of these questions may be answered by a follow-up study of homeless individuals in New York City's public shelter system which is currently being planned (E. L. Struening, personal communication, December, 1990).

There are obviously major impediments to conducting longitudinal research with the homeless population. To effectively investigate issues related to the life course of homeless people, the time frame of the study must be a long one. The homeless population tends to be geographically mobile, and to experience many different living situations over a relatively short period of time, making follow-up that much more difficult. Many homeless people are understandably fearful of the authorities and seek to avoid contact with representatives of "officialdom." Despite these obstacles, the need for such efforts is clear.

### Conclusion

A matter of ongoing contention between practitioners, advocates and policy makers has been the extent to which homelessness should be seen primarily as a manifestation of impairment on the part of homeless individuals themselves, as opposed to a symptom of a dysfunctional society unable to provide to its less fortunate members the fundamental necessity of permanent home. This is a critical issue as it has clear implications for the types of interventions which

ought to be invoked. The latter definition of the problem suggests the need to focus primarily on expanding the supply of basic social goods such as housing and employment. The individual impairment model, on the other hand, implies the need for emphasizing the provision of therapeutic and treatment services to the homeless and those at risk.

This study focused exclusively upon the victims of homelessness while ignoring the critical political, social and economic forces which have propelled the problem to epidemic proportions. A danger of this approach is that issues of individual impairment come to unfairly dominate our understanding of the nature of the problem and justify our avoidance of undertaking the types of broad-based reforms which are clearly required. Many homeless people have experienced considerable economic, educational and interpersonal deprivation throughout their lives. A good number have also been directly and indirectly affected by psychiatric disorder and substance abuse. In the context of the pressing shortage of affordable housing and the lack of unskilled jobs which pay a living wage, these burdens place such individuals at great risk of continued homelessness and chronic dependency.

Our challenge is to begin to address both levels of problems simultaneously. Vastly enhanced services intended to ameliorate the impact of individual deprivation and disorder are clearly required. Improved education and training, support for families in crisis, expanded substance

abuse services, and a more responsive system of community-based psychiatric care will all contribute to the prevention of homelessness and will mark an initial path out for some already in its grasp. Such services, however, will be only marginally effective until our society becomes better able to provide sufficient economic and housing opportunities to sustain those whose personal and financial resources remain limited. Given the clouded economic future we now face, incremental reform in any of these spheres is probably the most that can be realistically expected. Nevertheless, we must not fail to try.

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## APPENDIX A

HISTORICAL BACKGROUND AND DESCRIPTION  
OF THE NEW YORK CITY MUNICIPAL SHELTER SYSTEM--1985

New York City has been providing shelter to homeless persons for over ninety years. The first municipal shelter, an old barge, was replaced by the Municipal Lodging House in 1896. This lodging house was in use until 1909 when it was replaced by a new building located on East 25th Street in Manhattan. In 1915, an additional site was added at a pier on 24th Street. This configuration remained constant until the huge demand for shelter during the Great Depression forced the opening of a new facility, Camp LaGuardia in Chester, New York, in 1935. This, followed by the addition of several additional shelter sites during the late 1930s, permitted the City to house an average of over 9,000 men and women during 1936, the peak for shelter demand during the Depression (Human Resources Administration, 1984).

The homeless population dwindled during World War II, due to the increase in employment opportunities and military conscription. The Shelter Care Center for Men at 8 East Third Street opened in the late 1940s, originally housing up to 500 men. Eventually, sleeping accommodations at the shelter were largely replaced by the distribution of vouchers which are used by homeless men to obtain a bed at

the nearby Bowery commercial lodging houses ("flop houses"). Homeless women were housed in the Pioneer Hotel from 1950 until 1970, when the Shelter Care Center for Women at 350 Lafayette Street was opened. By 1978, the existing municipal shelters (Shelter Care Center for Men, Shelter Care Center for Women and Camp LaGuardia) were housing approximately 2,000 individuals a day (Human Resources Administration, 1984).

The shelter system began to change dramatically in 1979, when the New York State Supreme Court, ruling in the Callahan v. Carey case, formally recognized a legal right to shelter based upon the State constitution. A temporary order, issued in December of that year, required the City and the State to provide shelter, clean bedding, wholesome board and adequate security and supervision to all homeless men who applied. This was followed in 1981, by the settlement of the suit by agreement to a consent decree by which the City and State agreed to provide shelter to all men who seek it. The decree also spelled out certain qualitative standards for shelter conditions and facilities, including mandated minimum staffing levels. Eventually, the City also agreed to provide shelter to homeless women as well (Hopper & Cox, 1982).

A major result of the new city policy was a dramatic increase in the number of shelters and individuals served. In 1978, approximately 2,000 individuals were served daily in three shelters and commercial lodging houses (Human

Resources Administration, 1984). At the time of the study, approximately 6,850 individuals (6,000 men and 850 women) were served daily in 19 shelters (Bureau of Adult Institutional Services, 1985). City and State expenditures on the shelter system have also increased enormously over the last several years, due to operating costs as well as the capital expenditures required to renovate buildings being converted to shelter use.

The 19 separate shelters which constituted the municipal shelter system for homeless individuals in 1985 were administered by the Bureau of Adult Services of the Human Resources Administration (HRA). Other than the Charles H. Gay Shelter, which operates under contract by the Volunteers of America, the shelters are staffed and managed by HRA employees. Shelters are located in a variety of publicly-owned buildings including schools, hospitals and armories. The capacities of these sites vary, but most accommodate well over 200 persons. In all cases, men and women occupy separate facilities. Individuals may apply for shelter at any site or at one of the central intake points (Shelter Care Center for Men at East 3rd. St. and the Shelter Care Center for Women at Lafayette Street). If necessary, new entrants may then be transported to locations having available beds. There are no admission criteria and no restrictions on length of stay; anyone requesting shelter is served and may remain indefinitely so long as he or she abides by shelter rules and regulations.

In addition to a bed, clean linen and clothing, shelters provide three meals a day. Some form of recreation is generally available, ranging from a television lounge to athletic facilities and libraries in some shelters. Limited social services, including intake interviews, counseling and referral for entitlements are provided by social service staff assigned to each shelter. On-site medical and psychiatric services are available in a limited number of shelters; generally clients must use local municipal emergency rooms and walk-in clinics. A Work Experience Program (WEP) is in place in most sites. Under the supervision of HRA staff, WEP participants work twenty hours a week on crews which clean the shelters or local community facilities such as parks and subway stations. WEP participants receive a modest weekly personal allowance for their work.

The shelter system is characterized by great variation between facilities and heterogeneity among its clientele. Some shelters are located in isolated, non-residential areas, while others are in busy residential and shopping districts. Shelters vary in capacity from 50 beds to 1000, with most well over 200 beds. Sleeping areas range from huge drill floors accommodating several hundred persons, to semi-private rooms. Curfews and bed assignment systems differ in particular shelters, as do other policies such as those governing resident participation in work programs and mandatory involvement with social service staff.

As one would expect, many different types of people use the shelters. Demographic profiles of shelter users demonstrate an enormous range of ages, ethnic backgrounds, educational levels, family and work histories and disabilities (Crystal & Goldstein, 1984b; Human Resources Administration, 1982). Although there is no comprehensive triage mechanism operating within the shelter system, certain shelters have been designated for particular sub-populations. The Park Avenue Armory, for instance, was, at the time of the study, exclusively for men over 50, while the Lexington Avenue Armory admitted only young women. Most shelters, though, have no special admission criteria and therefore house a highly varied mix of individuals.

The fact that the shelters appear to be serving as quasi-permanent accommodations for many homeless individuals is perceived as a serious problem for two major reasons. First, the shelters are not equipped to provide the types of specialized care which is needed by many homeless men and women, particularly those who are either physically or mentally disabled. Consequently, such individuals residing for long periods of time in the shelters are not likely to be receiving the level of care which is required, producing further deterioration in their condition. Second, the accumulation of a large long-stay population, when coupled with a steady flow of new applicants for shelter, puts a great demand on the system for continued expansion. Indeed, the City now projects the need for the development of

several thousand new beds for homeless singles over the next five years (Human Resources Administration, 1988).



APPENDIX B  
INTERVIEW PROTOCOL  
HOUSING NEEDS ASSESSMENT OF THE HOMELESS  
SPRING 1985

**THE INTERVIEW PROTOCOL**  
**FOR THE**  
**HOUSING NEEDS ASSESSMENT SURVEY**  
**SPRING 1985**

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## SHELTER SURVEY

|                                     |  |                   |
|-------------------------------------|--|-------------------|
| IDENTIFICATION                      | <div> <div>1</div> <div>0</div> <div>1</div> <div>0</div> <div>1</div> </div> <div> <div>SITE</div> <div>R NO.</div> <div>T</div> <div>FORM</div> <div>CARD #</div> </div> | COL.<br>[ 01-10 ] |
| INTERVIEWER NUMBER                  | <div> <div>1</div> <div>0</div> </div>   | [ 11-12 ]         |
| DATE OF INTERVIEW: Month            | <div> <div>1</div> <div>0</div> </div> <div>Day</div> <div> <div>1</div> <div>0</div> </div> <div>Yr.</div> <div> <div>1</div> <div>0</div> </div>                         | [ 13-18 ]         |
| TIME: START OF INTERVIEW:           | <div> <div>1</div> <div>0</div> </div> <div>AM=1 - PM=0</div> <div> <div>1</div> <div>0</div> </div> <div>HOUR</div> <div> <div>1</div> <div>0</div> </div> <div>MIN</div> | [ 19-23 ]         |
| CONSENT GIVEN BY R: YES = 1, NO = 0 | <div> <div>1</div> <div>0</div> </div>   | [ 24 ]            |

## HOUSING SECTION

1. EXPLAIN PURPOSE OF THE STUDY TO R AND ESTABLISH RELATIONSHIP WITH CONVERSATION SENSITIVE TO HER/HIS SITUATION, NEEDS AND PROBLEMS OF LIVING. THEN ASK WHERE R STAYED/SLEPT LAST NIGHT. DESCRIBE NAME AND LOCATION OF PLACE IN SPACE BELOW AND CODE, USING LIST BELOW. (CIRCLE APPROPRIATE NUMBER). WHERE DID YOU SLEEP/STAY LAST NIGHT?

PLACE \_\_\_\_\_

LOCATION \_\_\_\_\_

- |   |    |
|---|----|
| In a public shelter.....                                | 01 |
| In a private shelter.....                               | 02 |
| In a church.....  | 03 |
| In a terminal or public building (Penn Station, etc)..< | 04 |
| In the streets, in doorways, on grates, etc.....        | 05 |
| In subway stations .....                                | 06 |
| In an abandoned building.....                           | 07 |
| In a sit-up.....  | 08 |
| In a park.....  | 09 |
| In apartment or house of a friend(s).....               | 10 |
| In apartment or house of a relative(s).....             | 11 |
| In my own rented apartment or home.....                 | 12 |
| In a friend's room in a hotel or rooming house.....     | 13 |
| In my own room in a hotel or rooming house.....         | 14 |
| In my own room in an SRO hotel.....                     | 15 |
| In a PPHA (Adult Home).....                             | 16 |
| In a medical hospital.....                              | 17 |
| In a mental hospital.....                               | 18 |
| In a prison or jail.....                                | 19 |
| In another place.(Identify above).....                  | 20 |

[ 25-26 ]

2. Have you stayed in any of the other shelters in New York City?

Yes..... 1 [ 27 ]  
No..... 0

3. Please give me the names of three other shelters where you have stayed?

1. \_\_\_\_\_ [ 28, 29]

2. \_\_\_\_\_ [ 30, 31]

3. \_\_\_\_\_ [ 32, 33]

4. Which of the shelters you have stayed in did you like the best?

Best \_\_\_\_\_ [ 34, 35]

5. Which of the shelters you have stayed in did you like the least?

Least \_\_\_\_\_ [ 36, 37]

6. What makes a shelter a good place to stay? Probe for 3.

1. \_\_\_\_\_ [ 38, 39]

2. \_\_\_\_\_ [ 40, 41]

3. \_\_\_\_\_ [ 42, 43]

7. What makes a shelter a poor place to stay? Probe for 3.

1. \_\_\_\_\_ [ 44, 45]

2. \_\_\_\_\_ [ 46, 47]

3. \_\_\_\_\_ [ 48, 49]

8. What are some of the problems you have had while staying in shelters? [Probe for 3, including personal safety, loss of possessions, noise, lack of hot water, etc.]

Problem 1 \_\_\_\_\_ [ 50, 51]

Problem 2 \_\_\_\_\_ [ 52, 53]

Problem 3 \_\_\_\_\_ [ 54, 55]

9. Do you think of the shelter as your home?

Sometimes.....1

Never.....2 [ 56]

Usually.....3

10. Have you stayed in a shelter just about every night since the first of this year [that is, since the first of January or New years day]?

Yes.....1

[ 57 ]

No.....0

11. If NO to above Q 10; where else have you stayed since the first of the year? [Probe for 3. Use page 1 code.]

Place 1 \_\_\_\_\_

[ 58, 59]

Place 2 \_\_\_\_\_

[ 60, 61]

Place 3 \_\_\_\_\_

[ 62, 63]

12. Where did you stay/sleep at night over the past week? [Start with night previous to last night. Use code of page 1]

|    | NAME AND LOCATION OF PLACE | CODE  |           |
|----|----------------------------|-------|-----------|
| Mo | _____                      | _____ | [ 64, 65] |
| Tu | _____                      | _____ | [ 66, 67] |
| We | _____                      | _____ | [ 68, 69] |
| Th | _____                      | _____ | [ 70, 71] |
| Fr | _____                      | _____ | [ 72, 73] |
| Sa | _____                      | _____ | [ 74, 75] |
| Su | _____                      | _____ | [ 76, 77] |

- 12a. Who referred you to this shelter?

Describe \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Code... \_\_\_\_\_

[ 78, 79]

|      |   |     |   |      |   |
|------|---|-----|---|------|---|
| Site | R | No. | 1 | 3    | 1 |
|      |   |     | T | Form |   |

13. Over the past two months (date \_\_\_\_\_) where else have you stayed/slept at night? Circle numbers at left. Then ask for approximate amount of time spent in each of the places circled.

| ABOUT:              | All of Time | Most of time | Half of Time | Part Of Time | Now & Then | Never |
|---------------------|-------------|--------------|--------------|--------------|------------|-------|
| 01. Public shelter  | 5           | 4            | 3            | 2            | 1          | 0     |
| 02. Private shelter | 5           | 4            | 3            | 2            | 1          | 0     |
| 03. Church          | 5           | 4            | 3            | 2            | 1          | 0     |
| 04. Terminal        | 5           | 4            | 3            | 2            | 1          | 0     |
| 05. Streets         | 5           | 4            | 3            | 2            | 1          | 0     |
| 06. Subway          | 5           | 4            | 3            | 2            | 1          | 0     |
| 07. Abandoned bldg. | 5           | 4            | 3            | 2            | 1          | 0     |
| 08. Sit-up          | 5           | 4            | 3            | 2            | 1          | 0     |
| 09. Park            | 5           | 4            | 3            | 2            | 1          | 0     |
| 10. Apt/friend      | 5           | 4            | 3            | 2            | 1          | 0     |
| 11. Apt/relative    | 5           | 4            | 3            | 2            | 1          | 0     |
| 12. Own rented apt. | 5           | 4            | 3            | 2            | 1          | 0     |
| 13. Friend's room   | 5           | 4            | 3            | 2            | 1          | 0     |
| 14. Own room        | 5           | 4            | 3            | 2            | 1          | 0     |
| 15. Own room/SRO    | 5           | 4            | 3            | 2            | 1          | 0     |
| 16. PPHA            | 5           | 4            | 3            | 2            | 1          | 0     |
| 17. Medical Hosp.   | 5           | 4            | 3            | 2            | 1          | 0     |
| 18. Mental Hosp.    | 5           | 4            | 3            | 2            | 1          | 0     |
| 19. Jail/Prison     | 5           | 4            | 3            | 2            | 1          | 0     |
| 20. Other _____     | 5           | 4            | 3            | 2            | 1          | 0     |

CODE: Place Time

Place 1 \_\_\_\_\_ [ 11,12 , 13]

Place 2 \_\_\_\_\_ [ 14,15 , 16]

Place 3 \_\_\_\_\_ [ 17,18 , 19]

14. During the past THREE YEARS, in which of the following places have you stayed/slept at night? Circle number at left. Then ask for the approximate amount of time spent in each of the places indicated.

## NOTES

| ABOUT:              | All of Time | Most of time | Half of Time | Part Of Time | Now & Then | Never |
|---------------------|-------------|--------------|--------------|--------------|------------|-------|
| 01. Public shelter  | 5           | 4            | 3            | 2            | 1          | 0     |
| 02. Private shelter | 5           | 4            | 3            | 2            | 1          | 0     |
| 03. Church          | 5           | 4            | 3            | 2            | 1          | 0     |
| 04. Terminal        | 5           | 4            | 3            | 2            | 1          | 0     |
| 05. Streets         | 5           | 4            | 3            | 2            | 1          | 0     |
| 06. Subway          | 5           | 4            | 3            | 2            | 1          | 0     |
| 07. Abandoned bldg. | 5           | 4            | 3            | 2            | 1          | 0     |
| 08. Sit-up          | 5           | 4            | 3            | 2            | 1          | 0     |
| 09. Park            | 5           | 4            | 3            | 2            | 1          | 0     |
| 10. Apt/friend      | 5           | 4            | 3            | 2            | 1          | 0     |
| 11. Apt/relative    | 5           | 4            | 3            | 2            | 1          | 0     |
| 12. Own rented apt. | 5           | 4            | 3            | 2            | 1          | 0     |
| 13. Friend's room   | 5           | 4            | 3            | 2            | 1          | 0     |
| 14. Own room        | 5           | 4            | 3            | 2            | 1          | 0     |
| 15. Own room/SRO    | 5           | 4            | 3            | 2            | 1          | 0     |
| 16. PPHA            | 5           | 4            | 3            | 2            | 1          | 0     |
| 17. Medical Hosp.   | 5           | 4            | 3            | 2            | 1          | 0     |
| 18. Mental Hosp.    | 5           | 4            | 3            | 2            | 1          | 0     |
| 19. Jail/Prison     | 5           | 4            | 3            | 2            | 1          | 0     |
| 20. Other _____     | 5           | 4            | 3            | 2            | 1          | 0     |

CODE: Place Time

Place 1 \_\_\_\_\_ [ 20, 21, 22]  
 Place 2 \_\_\_\_\_ [ 23, 24, 25]  
 Place 3 \_\_\_\_\_ [ 26, 27, 28]



15. Have you lived outside New York City during the past three years?

Yes.....1  
No.....0

[ 29 ]

16. Where were you born?

City.....  
State.....  
Country.....

[ 30, 31 ]  
[ 32, 33 ]  
[ 34, 35 ]

17. When were you born?

Month.....  
Day.....  
Year.....

[ 36, 37 ]  
[ 38, 39 ]  
[ 40, 41 ]

18. How old are you?

Age.....

[ 42, 43 ]

LONGEST PERIOD OF RESIDENCE OUTSIDE THE SHELTER  
SYSTEM IN PAST THREE YEARS.

19. During the past three years, what was the longest period of time that you lived in one place outside the shelter system?

Number of Months.....

[ 44, 45 ]

20. About when did you leave this place of residence?

Month.....  
Year.....

[ 46, 47 ]  
[ 48, 49 ]

21. What kind of housing did you live in during this time? (Circle #).

SRO Hotel.....01  
PPHA (Adult Home).....02  
Rented Apt. or House.....03  
Halfway House.....04  
Supervised Apt.....05  
OMH Com. Residence.....06  
Hotel or Motel.....07  
Rented Room.....08  
Other.....09

[ 50, 51 ]

22. With whom were you living most or all of the time during this period of your life? (CIRCLE ONE)

DESCRIBE \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

|   |    |
|---|----|
| Alone.....                                      | 01 |
| With spouse.....                                | 02 |
| With spouse and children.....                   | 03 |
| With children only.....                         | 04 |
| With one parent.....                            | 05 |
| With both parents.....                          | 06 |
| With one parent, brothers and sisters.....      | 07 |
| With both parents and brothers and sisters..... | 08 |
| With other relatives.....                       | 09 |
| With friends.....                               | 10 |
| With other residents.....                       | 11 |
| Other.....                                      | 12 |

[ 52, 53]

23. What was the most important reason that you left this residence? (CIRCLE ONE)

DESCRIBE \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

|   |    |
|---|----|
| Building was closed.....                      | 01 |
| Couldn't pay rent.....                        | 02 |
| Problems with management.....                 | 03 |
| Problems with family members.....             | 04 |
| Conflict with spouse.....                     | 05 |
| Physical conditions of residence poor.....    | 06 |
| Building disaster (Fire, condemned, etc)..... | 07 |
| Problems with other residents.....            | 08 |
| Problems with other relatives.....            | 09 |
| Asked to leave.....                           | 10 |
| Eviction due to Conversion(J51).....          | 11 |
| Other.....                                    | 12 |

[ 54, 55]

24. What did you like most about this place of residence?  
CHOOSE THREE MOST IMPORTANT AND CIRCLE, THEN CODE.  
DESCRIBE \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
I liked the location.....01  
I had my own room and privacy.....02  
My property was safe and secure.....03  
I could afford the rent.....04  
I felt close to my family.....05 — — [ 56, 57]  
I had a number of good friends.....06 — — [ 58, 59]  
Social Services were available.....07 — — [ 60, 61]  
I felt like I was living in a home.....08  
Mental Health Services were available.....09  
I liked living with my relatives.....10  
Food was available and not expensive.....11  
Other.....12

25. What were the worst things about this place of residence?  
CHOOSE THREE MOST IMPORTANT AND CIRCLE, THEN CODE.  
DESCRIBE \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
I was robbed.....01  
It was very noisy.....02  
I didn't like the location.....03  
The rent was too high.....04  
I couldn't make friends.....05 — — [ 62, 63]  
I didn't feel safe.....06 — — [ 64, 65]  
Transportation was a problem.....07 — — [ 66, 67]  
Food was difficult to get and expensive.....08  
Social Services were not available.....09  
Too many residents were mentally ill.....10  
Mental Health Services were not available.....11  
Other.....12

## FIRST HOMELESS EXPERIENCE

I'D LIKE TO ASK YOU SOME QUESTIONS ABOUT THE FIRST TIME YOU WERE EVER HOMELESS; THAT IS, THE FIRST TIME YOU SPENT A NIGHT OR MORE IN A PARK, A SHELTER FOR THE HOMELESS, A CHURCH OR ABANDONED BUILDING, A SUBWAY OR BUS STATION OR SOMEWHERE ON THE STREETS.

26. How old were you the first time you were homeless for at least 7 nights in a row?  
Approximate Age \_\_\_\_\_ [ 68, 69]
27. What year were you homeless for at least 7 nights in a row for the first time? What month?  
Month..... \_\_\_\_\_ [ 70, 71]  
Year..... \_\_\_\_\_ [ 72, 73]
28. How long were you homeless during this first time?  
Number of Months..... \_\_\_\_\_ [ 74, 75]
29. Where did you spend the first night when you were homeless for the first time? CIRCLE NUMBER.

DESCRIBE \_\_\_\_\_

- |   |    |           |
|---|----|-----------|
| In a public shelter.....                                | 01 |           |
| In a private shelter.....                               | 02 |           |
| In a church.....  | 03 |           |
| In a terminal or public building (Penn Station, etc)... | 04 |           |
| In the streets, in doorways, on grates, etc.....        | 05 |           |
| In subway stations .....                                | 06 |           |
| In an abandoned building.....                           | 07 |           |
| In a sit-up.....  | 08 |           |
| In a park.....  | 09 |           |
| In apartment or house of a friend(s).....               | 10 | [ 76, 77] |
| In apartment or house of a relative(s).....             | 11 |           |
| In my own rented apartment or home.....                 | 12 |           |
| In a friend's room in a hotel or rooming house.....     | 13 |           |
| In my own room in a hotel or rooming house.....         | 14 |           |
| In my own room in an SRO hotel.....                     | 15 |           |
| In a PPHA (Adult Home).....                             | 16 |           |
| In a medical hospital.....                              | 17 |           |
| In a mental hospital.....                               | 18 |           |
| In a prison or jail.....                                | 19 |           |
| In another place.(Identify above).....                  | 20 |           |

30. How long did you stay at the place indicated in Q 29?  
Number of Months \_\_\_\_\_ [ 78, 79]

Site R No. T Form

31. With whom were you living? (CIRCLE #)

Alone.....1  
A friend.....2  
Someone I met while traveling.3  
People I didn't know at all...4  
Other.....5

[ 11]

32. Why did you leave?

DESCRIBE \_\_\_\_\_ Code \_\_\_\_\_

[ 12, 13]

33. With whom were you living just before your first homeless experience? (CIRCLE ONE)

DESCRIBE \_\_\_\_\_

Alone.....01  
With spouse.....02  
With spouse and children.....03  
With children only.....04  
With one parent.....05  
With both parents.....06  
With one parent, brothers and sisters.....07  
With both parents and brothers and sisters.....08  
With other relatives.....09  
With friends.....10  
With other residents.....11  
Other.....12

[ 14 , 15]

33a. Why did you leave? \_\_\_\_\_ Code \_\_\_\_\_

[ 16 , 17]

DESCRIBE: \_\_\_\_\_

34. During the past 5 years, about how much of the time were you homeless? (CIRCLE ONE)

Almost all of the time.....01  
More than half of the time.....02  
About half the time.....03  
Less than half the time.....04  
Just a few times, now and then.....05  
Last night was my first homeless night.....06  
Other.....07

[ 18 , 19]

35. How long was the longest time in a row that you were homeless? (That is, stayed at night in shelters, parks, the streets, etc.)

Longest time in Months ..... [ 20, 21]

36. During this time, where did you spend most of your nights? (USE ITEM 37 LIST)

Code ..... [22 , 23]

37. What was the best place you ever lived in? CIRCLE ONE, THEN CODE.

Describe .....

Code ..... [24 , 25]

in a public shelter..... 01  
 in a private shelter..... 02  
 in a church..... 03  
 in a terminal or public building (Penn Station, etc)..04  
 in the streets, in doorways, on grates, etc.....05  
 in subway stations .....06  
 in an abandoned building.....07  
 in a sit-up.....08  
 in a park.....09  
 in apartment or house of a friend(s).....10  
 in apartment or house of a relative(s).....11  
 in my own rented apartment or home.....12  
 in a friend's room in a hotel or rooming house.....13  
 in my own room in a hotel or rooming house.....14  
 in my own room in an SRO hotel.....15  
 in a PPHA (Adult Home).....16  
 in a medical hospital.....17  
 in a mental hospital.....18  
 in a prison or jail.....19  
 in another place.(Identify above).....20

38. What was the worst place you ever lived in? CIRCLE ONE, THEN CODE.

Describe \_\_\_\_\_

Code \_\_\_\_\_ [26 , 27]

In a public shelter..... 01  
 In a private shelter..... 02  
 In a church..... 03  
 In a terminal or public building (Penn Station, etc)..04  
 In the streets, in doorways, on grates, etc.....05  
 In subway stations .....06  
 In an abandoned building.....07  
 In a sit-up.....08  
 In a park.....09  
 In apartment or house of a friend(s).....10  
 In apartment or house of a relative(s).....11  
 In my own rented apartment or home.....12  
 In a friend's room in a hotel or rooming house.....13  
 In my own room in a hotel or rooming house.....14  
 In my own room in an SRO hotel.....15  
 In a PPHA (Adult Home).....16  
 In a medical hospital.....17  
 In a mental hospital.....18  
 In a prison or jail.....19  
 In another place.(Identify above).....20

#### CURRENT LOCATION AND HOUSING PREFERENCES

39. If you could choose, which borough would you most like to live in?

#### LOCATION

Describe \_\_\_\_\_ Brooklyn.....01  
 \_\_\_\_\_ Bronx.....02  
 \_\_\_\_\_ Manhattan.....03  
 \_\_\_\_\_ Queens.....04 [28 , 29]  
 \_\_\_\_\_ Staten Island.....05  
 \_\_\_\_\_ Outside NYC.....06  
 \_\_\_\_\_ Other.....07

40. Which borough would be your second choice?  
 (Use above list to code borough)

Code \_\_\_\_\_ [30 , 31]

41. Now I would like to ask you about the reasons  
you would like to live in \_\_\_\_\_  
(Preferred Borough). Is it because, compared to  
the other boroughs,
- |  |           |       |
|--|-----------|-------|
| It is safer there?.....                    | Yes.....1 | [ 32] |
|  | No.....0  |       |
| There are more clinics and hospitals       | Yes.....1 |       |
| there.....                                 | No.....0  | [ 33] |
| It is easier to get to places that help    | Yes.....1 |       |
| you to get food and clothing.....          | No.....0  | [ 34] |
| There are more things to do there.....     | Yes.....1 | [ 35] |
|  | No.....0  |       |
| You have more friends there.....           | Yes.....1 | [ 36] |
|  | No.....0  |       |
| You have family there.....                 | Yes.....1 | [ 37] |
|  | No.....0  |       |
| Public transportation is better there..... | Yes.....1 | [ 38] |
|  | No.....0  |       |
| You know it better.....                    | Yes.....1 | [ 39] |
|  | No.....0  |       |
| There are more people who are like you     | Yes.....1 | [ 40] |
| there: .....                               | No.....0  |       |
| You have lived there more.....             | Yes.....1 | [ 41] |
|  | No.....0  |       |
| Other Reason.....                          | Yes.....1 | [ 42] |
|  | No.....0  |       |
42. Which of the five boroughs would you consider  
the worst place to live? USE CODE LIST OF  
ITEM 39. Code \_\_\_\_ [ 43, 44]



I WANT TO TALK WITH YOU NOW ABOUT WHAT KIND OF PLACE  
YOU WOULD LIKE TO LIVE IN, HOW YOU MIGHT PAY FOR IT  
AND WHAT YOU LIKE AND DISLIKE ABOUT DIFFERENT KINDS  
OF PLACES TO LIVE.

43. Where do you plan to stay/sleep at night during the  
next six months? ALSO CIRCLE 1 OF 20 PLACES BELOW.

DESCRIBE \_\_\_\_\_ Code \_\_\_\_\_ [ 45, 46 ]

- \_\_\_\_\_
- \_\_\_\_\_
- In a public shelter..... 01
  - In a private shelter..... 02
  - In a church..... 03
  - In a terminal or public building (Penn Station, etc).....04
  - In the streets, in doorways, on grates, etc.....05
  - In subway stations .....06
  - In an abandoned building.....07
  - In a sit-up.....08
  - In a park.....09
  - In apartment or house of a friend(s).....10 99[ 47, 48]
  - In apartment or house of a relative(s).....11
  - In my own rented apartment or home.....12
  - In a friend's room in a hotel or rooming house.....13
  - In my own room in a hotel or rooming house.....14
  - In my own room in an SRO hotel.....15
  - In a PPHA (Adult Home).....16
  - In a medical hospital.....17
  - In a mental hospital.....18
  - In a prison or jail.....19
  - In another place (Identify above).....20

44. How much of the next six months do you plan to stay  
in a shelter at night?

Number of Months..... [ 49, 50]

45. What kind of place (other than a shelter) would be  
acceptable or satisfactory for you to live in over  
the next year? (Use Q 43 list to Code)

DESCRIBE \_\_\_\_\_ Code \_\_\_\_\_ [ 51, 52]

\_\_\_\_\_  
\_\_\_\_\_

46. NOW PLEASE TELL ME SOME IMPORTANT THINGS ABOUT PLACES (SRO HOTELS, APARTMENTS, ADULT HOMES) WHERE YOU WOULD NOT LIKE TO LIVE. PROBE FOR 3.

THINGS ABOUT PLACES WHERE R WOULD NOT LIKE TO LIVE

|       |            |            |
|-------|------------|------------|
| _____ | Code _____ | [ 53, 54 ] |
| _____ | Code _____ | [ 55, 56 ] |
| _____ | Code _____ | [ 57, 58 ] |

47. NOW I'M GOING TO READ A LIST WHICH DESCRIBES CONDITIONS IN PLACES TO LIVE, SUCH AS SRO HOTELS, APARTMENTS, ADULT HOMES, OMH HOUSING, AND SO FORTH. HOW WOULD YOU FEEL ABOUT EACH OF THE CONDITIONS DESCRIBED BELOW?

1. I could live with it, I would accept it.
2. I wouldn't like it
3. I wouldn't live there, I wouldn't accept this condition.

INTERVIEWER: PLEASE INDICATE R'S RESPONSE BY PLACING A 1,2, or 3 in space to right of item number.

|   | R's Response |
|---|--------------|
| You would have to share your room with another person....01   | _____ [ 59 ] |
| The rent takes most of your income. (> 75%).....02  | _____ [ 60 ] |
| There have been a lot of robberies in the neighborhood...03   | _____ [ 61 ] |
| Quite a few residents were mental patients.....04   | _____ [ 62 ] |
| There aren't many residents with interests and backgrounds like yours.....05                            | _____ [ 63 ] |
| There are no social services (case workers, case managers, counselors) in the residence or nearby....06 | _____ [ 64 ] |
| A number of residents take illegal drugs.....07   | _____ [ 65 ] |
| Usually there isn't any hot water for a shower.....08   | _____ [ 66 ] |
| There is sometimes so much noise that you can't sleep....09   | _____ [ 67 ] |
| You have to be in every night by a certain time - you can't come and go as you like.....10              | _____ [ 68 ] |
| The residence is more than five blocks from a bus or subway that you use.....11                         | _____ [ 69 ] |
| Mental health services are not available in the residence or nearby.....12                              | _____ [ 70 ] |
| It's a place where it is hard to develop friendships.....13   | _____ [ 71 ] |
| There are quite a few rules about what you can and can't do at the residence.....14                     | _____ [ 72 ] |
| Food is not served at the residence and it's expensive to get in the neighborhood.....15                | _____ [ 73 ] |
| The residence is located on the grounds of a mental hospital.....16                                     | _____ [ 74 ] |

Site 1 R No. 1 0 1  
T Form

### CHILDHOOD EXPERIENCES

NOW I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT YOUR CHILDHOOD.  
BEFORE YOU WERE 17 YEARS OLD:

1. Did you ever live with a foster family? Yes.....1 [ 11]  
No.....0
2. If yes to Q. 1, how old were you when you moved in with the first foster family?  
Age in years ..... [ 12 , 13]
3. With how many foster families did you live?  
Number of families ..... [ 14 , 15]
4. How many years of your childhood (before 17 years of age) did you live in foster homes?  
Number of years.. ..... [ 16 , 17]
5. Did you ever live in a group home? Yes.....1 [ 18]  
No.....0
6. If yes to Q. 5, how old were you when you first moved into a group home?  
Age in years..... [ 19 , 20]
7. How many years did you spend in group homes? Number of years.... [ 21 , 22]
8. Did you ever live away from home in a special residence or institution, such as a children's psychiatric hospital, a home for special children or a residence for handicapped children. Yes.....1 [ 23]  
No.....0
9. If yes to Q. 8, how old were you when you entered the institution?... Age in years..... [ 24 , 25]
10. How many years did you spend in institutions? Number of years.... [ 26 , 27]
11. Did you ever run away overnight? Yes.....1 [ 28]  
No.....0
12. If yes to Q. 11, how old were you the first time you ran away overnight? Age in years..... [ 29 , 30]
13. How many times did you run away overnight? Number of times... [ 31 , 32]
14. Did you ever stay away for a week or longer? Yes.....1 [ 33]  
No.....0

## WORK EXPERIENCE

NOW I WOULD LIKE TO TALK TO YOU ABOUT YOUR EXPERIENCES WITH JOBS.

1. When was the last time you worked for pay for  
at least 20 hours per week for one month or more?  
Approximate Date ....Month...\_\_ \_\_ [34,35]  
Year....\_\_ \_\_ [36,37]
2. On this job, were you self-employed or did you  
work for someone?  
Not self-employed.....1 [38]  
Self-employed .....0
3. What kind of work did you do?  
Describe\_\_\_\_\_Code \_\_ \_\_ [39,40]
4. In what kind of business or industry did you work?  
Describe\_\_\_\_\_Code \_\_ \_\_ [41,42]
5. Was it located in New York City?  
Yes.....1 [43]  
No.....0
6. How long did you work on this job?  
Year....\_\_ \_\_ [44,45]  
Months..\_\_ \_\_ [46,47]
7. Why did you stop working on this job?  
Describe\_\_\_\_\_Code \_\_ \_\_ [48,49]
8. During the past month, that is since 1 month ago  
(date), did you work at the same job for at least  
20 hours per week?  
Yes.....1 [50]  
No.....0
9. During the past month how many hours did you  
work for pay, not counting the shelter work  
programs? (Code 000 if not working)  
Number of hours \_\_ \_\_ \_\_ [51,52,53]
10. During the past month, how many hours did you  
work in a shelter work program? (Code 000 if not  
working in a shelter program.)  
Number of hours \_\_ \_\_ \_\_ [54,55,56]
11. How many months in a row have you been  
working at least 20 hours per week, including  
both shelter and regular work?  
Number of months \_\_ \_\_ [57,58]

12. During the last three years how much of the time did you work in jobs on which you put in at least 20 hours per week?  
Number of Months \_\_\_\_ [ 59,60 ]
13. Describe the best paying, steady job you ever held?  
Description: \_\_\_\_\_ Code \_\_\_\_ [ 61,62 ]
14. When did you leave this job?  
Year \_\_\_\_ [ 63,64 ]
15. Why did you leave this job?  
Reasons: \_\_\_\_\_ Code \_\_\_\_ [ 65,66 ]
16. What is your current income from all jobs in dollars per week?  
(Code 000 for not working) Dollars per week \_\_\_\_ [ 67,68 ,69]

Site R No. T 0 1 Form

## ENTITLEMENTS

NOW I AM GOING TO ASK YOU A FEW QUESTIONS ABOUT GOVERNMENT BENEFITS WHICH YOU MAY BE RECEIVING. I WANT TO REMIND YOU THAT ALL THE INFORMATION YOU GIVE ME IS STRICTLY CONFIDENTIAL AND WILL NOT BE SHARED WITH THE SHELTER DIRECTOR OR THE CASEWORKERS.

1. Not counting money you get from working or from your friends or other people, do you receive any kind of income on a regular basis?  
 Yes.....1 [11]  
 (If R answers No, skip to item 6) No.....0

2. Where does this money come from?  
 (Code Yes=1; No=0; If NO to Q1; Score DNA = 6)  
 Public Assistance (home relief, welfare)..... [12]  
 SSI (Gold Check) ..... [13]  
 Social Security Disability..... [14]  
 Social Security Pension..... [15]  
 Other Pension..... [16]  
 Veterans Benefits..... [17]  
 Unemployment Insurance..... [18]  
 AFDC..... [19]  
 Other..... [20]  
 Don't know..... [21]

3. How often do you receive the check(s)?  
 [Circle for each of 3 checks]
- |                      | C H E C K |   |   |      |
|----------------------|-----------|---|---|------|
|                      | 1         | 2 | 3 |      |
| Every Week .....     | 1         | 1 | 1 | [22] |
| Every Two Weeks..... | 2         | 2 | 2 | [23] |
| Every Month.....     | 3         | 3 | 3 | [24] |
| Other.....           | 4         | 4 | 4 |      |

4. How much money is each check for? (If more than one check is received, list each separately, code 000 if no check is received)
- |           | Amount in \$ |  |  |            |
|-----------|--------------|--|--|------------|
| Check # 1 |              |  |  | [25,26,27] |
| Check # 2 |              |  |  | [28,29,30] |
| Check # 3 |              |  |  | [31,32,33] |

5. Where do you pick-up the check(s)?  
 Post Office Box.....1  
 Friend or Relative's Address.....2 [34]  
 Shelter.....3  
 Other.....4

6. Did you apply for any government benefits during the last year and you are waiting to hear about whether you are eligible to receive payment or not? (If R answers NO, skip to item 8)
- Yes.....1 [35]  
 No.....0  
 Don't know.....8
7. Which benefits did you apply for? (Yes=1, No=0)
- Public Assistance (home relief, welfare)..... [36]  
 SSI (Gold Check) ..... [37]  
 Social Security Disability..... [38]  
 Social Security Pension..... [39]  
 Other Pension..... [40]  
 Veterans Benefits..... [41]  
 Unemployment Insurance..... [42]  
 AFDC..... [43]  
 Other..... [44]  
 Don't know..... [45]
8. Have you had your benefits terminated during the last three years? That is, were you getting money and then your case was closed?
- Yes.....1 [46]  
 No.....0  
 Don't Know.....8
- (If R answers NO, skip to item 10)
9. Where was that money (the money you lost) coming from? (Yes = 1, No = 0)
- Public Assistance (home relief, welfare)..... [47]  
 SSI (Gold Check) ..... [48]  
 Social Security Disability..... [49]  
 Social Security Pension..... [50]  
 Other Pension..... [51]  
 Veterans Benefits..... [52]  
 Unemployment Insurance..... [53]  
 AFDC..... [54]  
 Other..... [55]  
 Don't know..... [56]
10. Are you on Medicaid or Medicare?  
 (Circle to indicate answer)
- Medicare.....1  
 Medicaid.....2  
 Neither.....3 [57]  
 Both.....4  
 Don't know.....8

## FAMILY CONTACTS

NOW I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT ANY CONTACTS THAT YOU HAVE HAD WITH YOUR FAMILY DURING THE PAST MONTH. THIS COULD BE WITH YOUR PARENTS OR CHILDREN, OR IT COULD BE WITH YOUR GODPARENTS, FOSTER CHILDREN, SECOND COUSINS.

1. During the past month have you had some contact with your family or relatives? (e.g. seen them, talked over phone, etc.)
 

Yes.....1 [58 ]  
 No.....0
  
2. How many times during the past month have you.....
 

Stayed overnight at the home of someone in your family \_\_\_\_\_ [59 ]  
 Had a meal with someone in your family..... \_\_\_\_\_ [60 ]  
 Talked in person with someone in your family..... \_\_\_\_\_ [61 ]  
 Spoken on the telephone with someone in your family... \_\_\_\_\_ [62 ]  
 Mailed a letter or package to someone in your family, \_\_\_\_\_ 9 [63 ]  
 or received one..... \_\_\_\_\_ [64 ]  
 Other, specify \_\_\_\_\_ [65 ]
  
3. Who was this person? Code:..... [66,67]
  
4. During the past year have you had some contact with your family or relatives?
 

Yes.....1 [68 ]  
 No.....0
  
5. How many times during the past year have you.....
 

Stayed overnight at the home of someone in your family \_\_\_\_\_ [69 ]  
 Had a meal with someone in your family..... \_\_\_\_\_ [70 ]  
 Talked in person with someone in your family..... \_\_\_\_\_ [71 ]  
 Spoken on the telephone with someone in your family... \_\_\_\_\_ [72 ]  
 Mailed a letter or package to someone in your family, \_\_\_\_\_ 9 [73 ]  
 or received one..... \_\_\_\_\_ [74 ]  
 Other, specify \_\_\_\_\_ [75 ]
  
6. Who was this person? Code:..... [76,77]

## CODES FOR Qs. 3 and 6

## RELATIONSHIP CODES

|                     |    |                     |    |
|---------------------|----|---------------------|----|
| Husband.....        | 01 | Father-in-law.....  | 14 |
| Wife .....          | 02 | Brother.....        | 15 |
| Natural daughter... | 03 | Sister.....         | 16 |
| Natural son.....    | 04 | Brother-in-law..... | 17 |
| Step daughter.....  | 05 | Sister-in-law.....  | 18 |
| Step son.....       | 06 | Aunt.....           | 19 |
| Adopted daughter... | 07 | Uncle.....          | 20 |
| Adopted son.....    | 08 | Cousin.....         | 21 |
| Foster daughter.... | 09 | Grandmother.....    | 22 |
| Foster son .....    | 10 | Grandfather.....    | 23 |
| Mother.....         | 11 | Other, Specify:     |    |
| Father.....         | 12 |                     |    |
| Mother-in-law.....  | 13 |                     | 24 |



|      |   |     |   |      |   |
|------|---|-----|---|------|---|
| Site | R | No. | 1 | 0    | 1 |
|      |   |     | T | Form |   |

### SERVICE CONTACT

I WOULD LIKE TO ASK YOU ABOUT WHERE YOU HAVE GONE TO TALK TO PEOPLE (OTHER THAN FRIENDS AND FAMILY) ABOUT MEDICAL PROBLEMS, JOB PROBLEMS, OR OTHER TYPES OF PROBLEMS. I'M ONLY INTERESTED IN THE PAST MONTH. FOR EACH QUESTION THAT I ASK YOU, YOU CAN LOOK AT THIS CARD -- IT MAY REMIND YOU OF PLACES YOU HAVE BEEN. (HAND CARD A TO R AND READ THE ITEMS WITH ASTERISKS). IF THERE ARE OTHER PLACES WHERE YOU SPOKE TO PEOPLE ABOUT YOUR PROBLEMS, TELL ME ABOUT THEM TOO. (IF R GIVES MORE THAN TWO PLACES, RECORD THE FIRST TWO MENTIONED).

1. During the past 3 months (Date 3 month ago \_\_\_\_\_),  
have you talked to someone outside the shelter about jobs?  
(If Yes, go to Q. 2) Yes.....1 [ 11 ]  
(If No, go to Q. 3) No.....0
2. Where have you gone to talk to someone about jobs?  
How many times? Code #T  
Place 1: \_\_\_\_\_ [12,13,14]  
Place 2: \_\_\_\_\_ [15,16,17]
3. During the past 3 months (Date 3 month ago \_\_\_\_\_),  
have you talked to someone outside the shelter about  
finding a home?  
(If Yes, go to Q. 4) Yes.....1 [ 18 ]  
(If No, go to Q. 5) No.....0
4. Where have you gone to talk to someone about finding  
a home? How many times? Code #T  
Place 1: \_\_\_\_\_ [19,20,21]  
Place 2: \_\_\_\_\_ [22,23,24]
5. During the past 3 months (Date 3 month ago \_\_\_\_\_),  
have you talked to someone outside the shelter about  
getting clothing?  
(If Yes, go to Q. 6) Yes.....1 [ 25 ]  
(If No, go to Q. 7) No.....0
6. Where have you gone to talk to someone about getting  
clothing? How many times? CODE #T  
Place 1: \_\_\_\_\_ [26,27,28]  
Place 2: \_\_\_\_\_ [29,30,31]
7. During the past 3 months (Date 3 month ago \_\_\_\_\_),  
have you talked to someone outside the shelter about  
Social Security, Medicaid, SSI, Welfare, other benefits?  
(If Yes, go to Q. 8) Yes.....1 [ 32 ]  
(If No, go to Q. 9) No.....0

pg. 22 [6,96=DNA; 7,97=NA; 8,98=DK; 9,99=MD]

8. Where have you gone to talk to someone about benefits? How many times? Code #T  
Place 1: \_\_\_\_\_ [33,34,35]  
Place 2: \_\_\_\_\_ [36,37,38]
9. During the past 3 months (Date 3 months ago \_\_\_\_\_), have you talked to someone outside the shelter about problems with the police?  
(If Yes, go to Q. 10) Yes.....1 [ 39 ]  
(If No, go to Q. 11) No.....0
10. Where have you gone to talk to someone about problems with the police? How many times? Code #T  
Place 1: \_\_\_\_\_ [40,41,42]  
Place 2: \_\_\_\_\_ [43,44,45]
11. During the past 3 months (Date 3 months ago \_\_\_\_\_), have you talked to someone outside the shelter about getting help with food?  
(If Yes, go to Q. 12) Yes.....1 [ 46 ]  
(If No, go to Q. 13) No.....0
12. Where have you gone to talk to someone about getting food? How many times? Code #T  
Place 1: \_\_\_\_\_ [47,48,49]  
Place 2: \_\_\_\_\_ [50,51,52]
13. During the past 3 months (Date 3 months ago \_\_\_\_\_), have you talked to someone outside the shelter about medical problems?  
(If Yes, go to Q. 14) Yes.....1 [ 53 ]  
(If No, go to Q. 15) No.....0
14. Where have you gone to talk to someone about help with medical problems? How many times? Code #T  
Place 1: \_\_\_\_\_ [54,55,56]  
Place 2: \_\_\_\_\_ [57,58,59]
15. When was the last time you talked to a doctor outside the shelter about a medical problem?
- |  |    |         |
|--|----|---------|
| Never.....   | 00 |         |
| less than 1 month ago.....                           | 01 | [60,61] |
| 1 month ago up to, but not including, 6 months ago.. | 02 |         |
| 6 months ago up to, but not including, 1 year ago..  | 03 |         |
| 1 year ago up to, but not including, 2 years ago...  | 04 |         |
| 2 years ago up to, but not including, 5 years ago..  | 05 |         |
| 5 years ago or more.....                             | 06 |         |

Site R No. 1 0 1  
T Form

16. During the past 3 months (Date 3 months ago \_\_\_\_\_),  
have you talked to someone outside the shelter about  
emotional problems or problems with your nerves?  
(If Yes, go to Q.17) Yes.....1 [ 11 ]  
(If No, go to Q. 18) No.....0
17. Where have you gone to talk to someone about emotional  
problems or problems with your nerves?  
How many times? Code #T  
Place 1: \_\_\_\_\_ [12,13,14]  
Place 2: \_\_\_\_\_ [15,16,17]
18. Have you ever talked to someone about emotional  
problems or problems with your nerves?  
(If yes, go to Q. 19) Yes.....1 [ 18 ]  
No.....0
19. If yes, when was the last time you talked to someone  
about emotional problems or problems with your nerves?  
Never..... 00  
less than 1 month ago..... 01 [19,20]  
1 month ago up to, but not including, 6 months ago. 02  
6 months ago up to, but not including, 1 year ago. 03  
1 year ago up to, but not including, 2 years ago... 04  
2 years ago up to, but not including, 5 years ago.. 05  
5 years ago or more..... 06
20. During the past 3 months (Date 3 months ago \_\_\_\_\_),  
have you talked to someone outside the shelter about a  
drinking problem?  
(If Yes, go to Q. 21) Yes.....1 [ 21 ]  
(If No, go to Q. 22) No.....0
21. Where have you gone to talk to someone about a drinking  
problem? How many times? Code #T  
Place 1: \_\_\_\_\_ [22,23,24]  
Place 2: \_\_\_\_\_ [25,26,27]
22. Have you ever talked to someone about a drinking  
problem?  
(If yes, to to 23) Yes.....1 [ 28 ]  
No.....0
23. If Yes, when was the most recent time you talk to someone  
about a drinking problem?  
Never..... 00  
less than 1 month ago..... 01 [29,30]  
1 month ago up to, but not including, 6 months ago. 02  
6 months ago up to, but not including, 1 year ago.. 03  
1 year ago up to, but not including, 2 years ago... 04  
2 years ago up to, but not including, 5 years ago.. 05  
5 years ago or more..... 06

24. During the past 3 months (Date 3 months ago \_\_\_\_\_),  
have you talked to someone outside the shelter about a  
drug problem?  
(If Yes, go to Q. 25) Yes.....1 [ 31 ]  
(If No, go to Q. 26) No.....0
25. Where have you gone to talk to someone about a drug  
problem? How many times?  
Code #T  
Place 1: \_\_\_\_\_ [32,33,34]  
Place 2: \_\_\_\_\_ [35,36,37]
26. Have you ever talked to someone about a drug  
problem?  
(If Yes, go to Q. 27) Yes.....1 [ 38 ]  
(If No, go to Q. 28) No.....0
27. If Yes, when was the most recent time you talked to  
someone about a drug problem?  
Never..... 00  
less than 1 month ago..... 01 [39,40]  
1 month ago up to, but not including, 6 months ago.. 02  
6 months ago up to, but not including, 1 year ago... 03  
1 year ago up to, but not including, 2 years ago... 04  
2 years ago up to, but not including, 5 years ago... 05  
5 years ago or more..... 06
28. During the past month, how many times have you  
talked to a shelter caseworker?  
Number of times \_\_\_\_\_ [41,42]
29. How many months have you been staying at this shelter?  
Number of months \_\_\_\_\_ [43,44]
30. During the last \_\_\_\_\_ months, how many times  
have you talked to a shelter caseworker about  
jobs, housing, medical services or other problems?  
Number of times \_\_\_\_\_ [45,46]
31. During the past month (Date 1 month ago \_\_\_\_\_),  
have you talked to any of the shelter staff, other than  
a shelter caseworker, about any problems you might have?  
(If Yes, go to Q. 32) Yes.....1 [ 47 ]  
(If No, go to Pg. 26) No.....0
32. If you have talked to other shelter staff, who are they?  
Code  
Person 1: \_\_\_\_\_ [48,49]  
Person 2: \_\_\_\_\_ [50,51]

## PHYSICAL HEALTH

NOW I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT YOUR  
PHYSICAL (BODILY) HEALTH.

1. In general, would you say that your physical health is:
 

|                |   |
|----------------|---|
| poor.....      | 1 |
| fair.....      | 2 |
| good.....      | 3 |
| excellent..... | 4 |

[52]
  
2. Would you say that you have a disease, injury or handicap that restricts your daily life or makes your daily life difficult?
 

|          |   |
|----------|---|
| Yes..... | 1 |
| No.....  | 0 |

[53]
  
3. If YES TO Q 2, SPECIFY \_\_\_\_\_ CODE ..... [54,55]
  
4. Do you take any other medications, such as pills, tablets, injections, sprays or ointments on a regular basis, that is 3 or more times a week?
 

|          |   |
|----------|---|
| Yes..... | 1 |
| No.....  | 0 |

[56]
  
5. If YES to Q 4, please specify particular medication: \_\_\_\_\_ Code..... [57,58]
  
6. Are you currently taking any medication that was prescribed to you by a medical doctor?
 

|          |   |
|----------|---|
| Yes..... | 1 |
| No.....  | 0 |

[59]
  
7. If YES to Q 6, what condition or disease is the medication for? Code..... [60,61]
  
8. Have you had any of the following injuries during the past 3 years? [Yes=1; No=0]
 

|  |       |      |
|--|-------|------|
| 1. A concussion (severe blow to head, etc....) | _____ | [62] |
| 2. The fracture of a limb.....                 | _____ | [63] |
| 3. A burn - 1st, 2nd or 3rd degree.....        | _____ | [64] |
| 4. A fracture of your skull.....               | _____ | [65] |
| 5. Other injury: _____                         | _____ | [66] |
  
9. Would you say that your hearing is:
 

|           |   |
|-----------|---|
| good..... | 1 |
| fair..... | 2 |
| poor..... | 3 |

[67]

10. When was the last time you had it checked?  
     During the past year or less.....1  
     During the past 3 years.....2 [68]  
     During the past 5 years.....3
11. Would you say that your vision is:  
     good.....1  
     fair.....2 [69]  
     poor.....3
12. When was the last time you had your vision checked?  
     During the past year or less.....1  
     During the past 3 years.....2 [70]  
     During the past 5 years.....3
13. Do you use glasses or contact lenses?  
     Yes.....1 [71]  
     No.....0
14. Would you say the condition of your teeth is:  
     good.....1  
     fair.....2 [72]  
     poor.....3
15. When was the last time you had your teeth checked by a dentist?  
     During the past year or less.....1  
     During the past three years.....2 [73]  
     During the past five years.....3
16. Would you say that your memory (your ability to remember dates, names, etc.) is:  
     good.....1  
     fair.....2 [74]  
     poor.....3
17. Would you say that over the past three years your memory has  
     Not changed.....1  
     Gotten worse.....2 [75]  
     Gotten better.....3
18. Has there been any change in your general health over the last year?  
     No, it hasn't changed.....1  
     Yes, it has gotten better.....2 [76]  
     Yes, it has gotten worse.....3

19. If it has gotten worse (3 to Q 18) why has it  
gotten worse? [probe for explanation]

\_\_\_An accident.....1  
\_\_\_A disease.....2  
\_\_\_Your living conditions...3  
\_\_\_Other.....4

[77]

20. Do you smoke cigarettes almost every day?

Yes.....1  
No.....0

[78]

21. On the average, how many cigarettes do  
you smoke each day?

Between 1 and 10.....1  
Between 10 and 20 (pack).....2  
More than a pack (20).....3  
More than 2 packs (40).....4  
Don't smoke.....0

[79]

Site R No. T Form

### MEDICATIONS

1. Has a doctor or nurse ever told you that you had any of the following disease/disorders?
2. Did a doctor prescribe medication for disorders 1 through 8?
3. Have you taken the prescribed medications over the past month?

**CIRCLE 1 UNDER Q1, Q2, Q3 TO INDICATE YES**

| <u>Disease/Disorder</u> |                            | <u>Q 1</u> | <u>Q 2</u> | <u>Q 3</u> | <u>CODE:</u>      |            |
|-------------------------|----------------------------|------------|------------|------------|-------------------|------------|
|                         |                            | <u>Yes</u> | <u>Yes</u> | <u>Yes</u> | <u>Yes=1: N=0</u> |            |
| 1                       | High blood pressure/Hyper. | 1          | 1          | 1          | —                 | [11,12,13] |
| 2                       | Asthma                     | 1          | 1          | 1          | —                 | [14,15,16] |
| 3                       | Heart                      | 1          | 1          | 1          | —                 | [17,18,19] |
| 4                       | Cancer                     | 1          | 1          | 1          | —                 | [20,21,22] |
| 5                       | Epilepsy                   | 1          | 1          | 1          | —                 | [23,24,25] |
| 6                       | Diabetes                   | 1          | 1          | 1          | —                 | [26,27,28] |
| 7                       | TB                         | 1          | 1          | 1          | —                 | [29,30,31] |
| 8                       | Other                      | 1          | 1          | 1          | —                 | [32,33,34] |

4. Has a doctor told you that you had a problem with your nerves (or emotional problems)? Yes.....1 [35]  
No.....0

5. Has a doctor ever prescribed a medication for your nerves (or for your emotional problems)? (ASK Q. 6) Yes.....1 [36]  
No.....0

6. Has a doctor ever prescribed any of these pills for you?  
(READ NAMES AND CIRCLE PILLS PRESCRIBED)
- |           |                  |
|-----------|------------------|
| Thorazine | Prolixin         |
| Haldol    | Trilafon         |
| Stelazine | Serentil         |
| Navane    | Loxitane         |
| Mellaril  | Trilavil/Etrafon |
- (IF ANY ARE CIRCLED, CODE YES)
- |                |           |
|----------------|-----------|
| (ASK Q. 7)     | Yes.....1 |
| (SKIP TO Q.10) | No.....0  |
- [37]

7. When was the last time that a doctor prescribed this/one of these medication(s) for you?
- less than 6 months ago .....01  
6 months ago up to, but not including, 1 year ago...02  
1 year ago ...2 years ago.....03  
2 years ago ..5 years ago .....04  
5 years ago ..10 years ago.....05  
10 years ago or more.....06
- [38,39]



8. Have you taken this/any of these medication(s) in the past week? Yes.....1 [40]  
No.....0
9. Before you were homeless the first time had a doctor prescribed any of these medications for you? Yes.....1 [41]  
No.....0
10. Has a doctor ever prescribed Lithium for you? (ASK Q. 11) Yes.....1 [42]  
(SKIP TO Q. 14) No.....0
11. When was the last time that a doctor prescribed Lithium for you? less than 6 months ago.....01 [43,44]  
6 months ago up to 1 year ago.....02  
1 year ago ... 2 years ago.....03  
2 years ago ... 5 years ago.....04  
5 years ago ... 10 years ago.....05  
10 years ago or more.....06
12. Have you taken Lithium in the past week? Yes.....1 [45]  
No.....0
13. Before you were homeless the first time had a doctor ever prescribed Lithium? Yes.....1 [46]  
No.....0
14. Has a doctor ever prescribed Methadone for you? (ASK Q. 15) Yes.....1 [47]  
(ASK Q. 17) No.....0
15. When was the last time that a doctor prescribed Methadone for you? less than 6 months ago..... 1 [48]  
6 months ago up to 1 year ago..... 2  
1 year ago ... 2 years ago..... 3  
2 years ago ... 5 years ago..... 4  
5 years ago ... 10 years ago..... 5  
10 years ago or more..... 6
16. Have you taken Methadone in the past week? Yes.....1 [49]  
No.....0
17. Has a doctor ever prescribed Antabuse for you? (ASK Q. 18) Yes.....1 [50]  
(ASK Q. 20) No.....0

18. When was the last time that a doctor prescribed Antabuse for you?

less than 6 months ago.....01  
 6 months ago up to 1 year ago.....02  
 1 year ago ... 2 years ago.....03  
 2 years ago ... 5 years ago.....04  
 5 years ago ... 10 years ago.....05  
 10 years ago or more.....06

[51,52]

19. Have you taken Antabuse in the past week?

Yes.....1  
 No.....0

[53]

20. Have you ever been given an injection for your nerves that you were supposed to get every week or every few weeks?

(ASK Q. 21 and 22) Yes.....1  
 No.....0

[54]

21. Was this Prolixin?

Yes.....1  
 No.....0

[55]

22. Before you were homeless the first time had a doctor ever prescribed an injection/Prolixin?

Yes.....1  
 No.....0

[56]

Site R No. T Form 1 0 1

### OTHER DRUGS

NOW I WOULD LIKE TO ASK YOU A FEW QUESTIONS ABOUT OTHER KINDS OF DRUGS.  
(NOTE: USE STREET NAMES UNDER QUESTION FOUR TO CLARIFY DRUG FOR R).

1. Have you ever used the following drugs? (SEE DRUG LIST)
2. Of those used, ask if R has used them more than 20 and more than 50 times. [Code: YES = 1, NO = 0]

| DRUG LIST     |             | EVER  | >20   | >50   |            |
|---------------|-------------|-------|-------|-------|------------|
| Marijuana     | (USE STREET | _____ | _____ | _____ | [11,12,13] |
| Barbiturates  |             | _____ | _____ | _____ | [14,15,16] |
| Amphetamines  | NAMES       | _____ | _____ | _____ | [17,18,19] |
| Opiates       |             | _____ | _____ | _____ | [20,21,22] |
| Cocaine       | UNDER Q. 4) | _____ | _____ | _____ | [23,24,25] |
| Hallucinogens |             | _____ | _____ | _____ | [26,27,28] |
| Other _____   |             | _____ | _____ | _____ | [29,30,31] |

3. Before the first time you were homeless, how many times had you taken \_\_\_\_\_? [1: Please read those drugs that R indicated s/he had used in Q 1 and 2. Code YES = 1; NO = 0]

| DRUG          |             | EVER  | >20   | >50   |            |
|---------------|-------------|-------|-------|-------|------------|
| Marijuana     | (USE STREET | _____ | _____ | _____ | [32,33,34] |
| Barbiturates  |             | _____ | _____ | _____ | [35,36,37] |
| Amphetamines  | NAMES       | _____ | _____ | _____ | [38,39,40] |
| Opiates       |             | _____ | _____ | _____ | [41,42,43] |
| Cocaine       | UNDER Q. 4) | _____ | _____ | _____ | [44,45,46] |
| Hallucinogens |             | _____ | _____ | _____ | [47,48,49] |
| Other _____   |             | _____ | _____ | _____ | [50,51,52] |

4. When was the last time you used any of the above drugs? [1: Again name the drugs which R had used and code USE according to the CODING PROCEDURE indicated below]

| DRUG          | STREET NAME                          | CODE  |      |
|---------------|--------------------------------------|-------|------|
| Marijuana     | (pot, grass, herbs, ganja)           | _____ | [53] |
| Barbiturates  | (downers, sleeping pills, quaaludes) | _____ | [54] |
| Amphetamines  | (uppers, speed)                      | _____ | [55] |
| Opiates       | (heroin, horse, smack, demoral)      | _____ | [56] |
| Cocaine       | (coke)                               | _____ | [57] |
| Hallucinogens | (LSD, peyote, PCP, angel dust)       | _____ | [58] |
| Other _____   | (glue, amylinitrate, etc.)           | _____ | [59] |

### CODING PROCEDURE

During the last month .....1  
 During the last three months.....2  
 During the last year.....3  
 During the last three years.....4  
 During the last five years.....5

NEXT I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT  
DRINKING ALCOHOL. (YES = 1, NO = 0)

1. Does your family or close relatives complain or  
worry about how much alcohol you drink? \_\_\_\_\_ [60 ]
2. Do you drink less than or about the same amount  
as most other people your age?..... \_\_\_\_\_ [61 ]
3. Do you ever feel guilty about your drinking? \_\_\_\_\_ [62 ]
4. Do your friends or relatives think you are  
a normal drinker? ..... \_\_\_\_\_ [63 ]
5. Are you able to stop drinking when you want to? \_\_\_\_\_ [64 ]
6. Have you ever attended a meeting of Alcoholics  
Anonymous? ..... \_\_\_\_\_ [65 ]
7. Has your drinking ever caused problems between  
you and your family or other close relatives? \_\_\_\_\_ [66 ]
8. Have you ever gotten into trouble at work  
because of your drinking? ..... \_\_\_\_\_ [67 ]
9. Have you ever missed work for two or three  
days in a row because you were drinking? \_\_\_\_\_ [68 ]
10. Have you ever gone to anyone for help about  
your drinking? ..... \_\_\_\_\_ [69 ]
11. Have you ever been in a hospital because  
of your drinking? ..... \_\_\_\_\_ [70 ]
12. Have you ever been arrested because of your  
drinking? ..... \_\_\_\_\_ [71 ]
13. Did you ever get in trouble in a shelter  
because you were drinking? ..... \_\_\_\_\_ [72 ]
14. Do your friends in the shelter think that  
you drink too much? ..... \_\_\_\_\_ [73 ]

Site R No. T Form

## HOSPITALIZATIONS

NOW I AM GOING TO ASK YOU ABOUT TIMES YOU HAVE BEEN HOSPITALIZED. FIRST, I WILL ASK YOU ABOUT HOSPITALIZATIONS FOR MEDICAL PROBLEMS. THEN I WILL ASK YOU ABOUT HOSPITALIZATIONS FOR NERVOUS PROBLEMS, DRINKING PROBLEMS, AND DRUG PROBLEMS.

## 1. HAVE YOU EVER BEEN HOSPITALIZED FOR A MEDICAL PROBLEM?

Yes.....1 [11]

(SKIP TO Q. 4) No.....0

## 2. WHEN WAS THE MOST RECENT TIME? GIVE ME THE DATE THAT YOU WERE DISCHARGED.

Date:....Month \_\_\_\_ [12,13]  
Day \_\_\_\_ [14,15]  
Year \_\_\_\_ [16,17]

(ASK Q. 3) less than 6 months ago.....01  
6 months ago up to, but not including, 1 year ago..02  
1 year ago up to, but not including, 2 years ago...03 [18,19]  
2 years ago up to, but not including, 5 years ago..04  
(SKIP TO Q. 4) 5 years ago up to, but not including, 10 years ago.05  
10 years ago or more.....06  
Reason (DO NOT CODE) \_\_\_\_\_

## 3. HOW MANY TIMES IN THE PAST 2 YEARS?

(CODE DIRECTLY: 00=NONE, 01=ONE, ETC.) ..... [20,21]

## 4. HAVE YOU EVER BEEN HOSPITALIZED FOR A PROBLEM WITH YOUR NERVES OR FOR EMOTIONAL PROBLEMS?

(ASK Q. 5) Yes.....1 [22]

(SKIP TO Q.10) No.....0

## 5. HOW MANY TIMES?

Once.....1  
2-5 times.....2 [23]  
6-10 times.....3  
More than 10 times.....4

## 6. WHEN WAS THE MOST RECENT TIME? GIVE ME THE DATE THAT YOU WERE DISCHARGED.

Date:.... Month \_\_\_\_ [24,25]  
Day \_\_\_\_ [26,27]  
Year \_\_\_\_ [28,29]

(ASK Q. 7) less than 6 months ago .....01  
6 months ago up to, but not including, 1 year ago..02  
1 year ago up to, but not including, 2 years ago...03 [30,31]  
2 years ago up to, but not including, 5 years ago..04  
(SKIP TO Q. 8) 5 years ago up to, but not including, 10 years ago.05  
10 years ago or more.....06  
Reason (DO NOT CODE) \_\_\_\_\_

## 7. HOW MANY TIMES IN THE PAST 2 YEARS?

(CODE DIRECTLY: 00=none, 01=one, etc.)..... [32,33]

## 8. BEFORE YOU WERE HOMELESS FOR THE FIRST TIME HAD YOU BEEN HOSPITALIZED FOR A PROBLEM WITH YOUR NERVES OR FOR EMOTIONAL PROBLEMS?

Yes.....1  
No.....0 [34]

9. HAVE YOU EVER BEEN IN A STATE HOSPITAL FOR A PROBLEM  
WITH YOUR NERVES OR EMOTIONAL PROBLEMS?

(ASK Q. 10) Yes.....1 [35]  
(SKIP TO Q.11) No.....0

10. WHEN WAS THE MOST RECENT TIME?

less than 6 months ago.....01  
6 months ago up to, but not including, 1 year ago.....02  
1 year ago up to, but not including, 2 years ago.....03 [36,37]  
2 years ago up to, but not including, 5 years ago.....04  
5 years ago up to, but not including, 10 years ago.....05  
10 years ago or more.....06

11. HAVE YOU EVER BEEN HOSPITALIZED FOR A DRINKING PROBLEM?

(ASK Q. 12) Yes.....1 [38]  
(SKIP TO Q.16) No.....0

12. HOW MANY TIMES?

Once.....1  
2-5.....2 [39]  
6-10.....3  
More than 10 times....4

13. WHEN WAS THE MOST RECENT TIME? GIVE ME THE DATE  
THAT YOU WERE DISCHARGED.

DATE:....Month \_\_\_\_ [40,41]  
Day \_\_\_\_ [42,43]  
Year \_\_\_\_ [44,45]

(ASK Q.14) less than 6 months ago ..... 01  
6 months ago up to, but not including, 1 year ago. 02  
1 year ago up to, but not including, 2 years ago.. 03 [46,47]  
2 years ago up to, but not including, 5 years ago. 04  
(SKIP TO Q.15) 5 years ago up to, but not including, 10 years ago 05  
10 years ago or more ..... 06  
Reason (DO NOT CODE) \_\_\_\_\_

14. HOW MANY TIMES IN THE PAST 2 YEARS?

(CODE DIRECTLY: 00=NONE, 01=once, etc.)..... [48,49]

15. BEFORE YOU WERE HOMELESS FOR THE FIRST TIME HAD YOU  
BEEN HOSPITALIZED FOR A DRINKING PROBLEM?

Yes.....1  
No.....0 [50]

16. HAVE YOU EVER BEEN IN A STATE HOSPITAL FOR A  
DRINKING PROBLEM?

(ASK Q. 17) Yes.....1 [51]  
(ASK Q. 18) No.....0

17. WHEN WAS THE MOST RECENT TIME?

less than 6 months ago.....01  
6 months ago up to, but not including, 1 year ago...02  
1 year ago up to, but not including, 2 years ago....03 [52,53]  
2 years ago up to, but not including, 5 years ago...04  
5 years ago up to, but not including, 10 years ago..05  
10 years ago or more.....06

18. HAVE YOU EVER BEEN IN A PROGRAM FOR PEOPLE WITH DRINKING PROBLEMS WHERE YOU STAYED OVERNIGHT, BUT NOT IN A HOSPITAL?  
 (SKIP TO 21) Yes..... 1 [54]  
 \_\_\_\_\_ (Specify) (ASK Q. 19) No..... 0
19. WHEN WAS THE MOST RECENT TIME? GIVE ME THE DATE THAT YOU WERE DISCHARGED.  
 Date:..... Mo \_\_\_\_\_ [55,56]  
 Day \_\_\_\_\_ [57,58]  
 Yr. \_\_\_\_\_ [59,60]
- (ASK Q.20) less than 6 months ago .....01  
 6 months ago up to, but not including, 1 year ago..02  
 1 year ago up to, but not including, 2 years ago...03 [61,62]  
 2 years ago up to, but not including, 5 years ago..04  
 5 years ago up to, but not including, 10 years ago..05  
 (SKIP TO Q.21) 10 years ago or more .....06  
 Reason (DO NOT CODE) \_\_\_\_\_
20. HOW MANY TIMES IN THE PAST 2 YEARS?  
 (CODE DIRECTLY: 00=NONE, 01=once, etc.) ..... [63,64]
21. HAVE YOU EVER BEEN HOSPITALIZED FOR A DRUG PROBLEM?  
 (ASK Q. 22) Yes.....1 [65]  
 (SKIP TO Q.26) No.....0
22. HOW MANY TIMES?  
 Once.....1  
 2-5.....2 [56]  
 6-10.....3  
 More than 10 times.....4
23. WHEN WAS THE MOST RECENT TIME? GIVE ME THE DATE THAT YOU WERE DISCHARGED.  
 Date:.....Month \_\_\_\_\_ [57,68]  
 Day \_\_\_\_\_ [59,70]  
 Year \_\_\_\_\_ [71,72]
- (ASK Q.24) less than 6 months ago .....01  
 6 months ago up to, but not including, 1 year ago..02  
 1 year ago up to, but not including, 2 years ago...03 [73,74]  
 2 years ago up to, but not including, 5 years ago..04  
 5 years ago up to, but not including, 10 years ago..05  
 (SKIP TO Q.25) 10 years ago or more .....06  
 Reason (DO NOT CODE) \_\_\_\_\_
24. HOW MANY TIMES IN THE PAST 2 YEARS?  
 (CODE DIRECTLY: 00=NONE, 01=ONCE, etc.) ..... [75,76]
25. BEFORE YOU WERE HOMELESS FOR THE FIRST TIME HAD YOU BEEN HOSPITALIZED FOR A DRUG PROBLEM?  
 Yes.....1 [77]  
 No.....0
26. HAVE YOU EVER BEEN IN A STATE HOSPITAL FOR A DRUG PROBLEM?  
 (ASK Q. 27) Yes.....1 [78]  
 (SKIP TO Q. 28) No.....0

|      |   |     |   |      |   |
|------|---|-----|---|------|---|
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27. WHEN WAS THE MOST RECENT TIME?  
less than 6 months ago .....01  
6 months ago up to, but not including, 1 year ago...02  
1 year ago up to, but not including, 2 years ago...03  
2 years ago up to, but not including, 5 years ago...04  
5 years ago up to, but not including, 10 years ago...05  
10 years ago or more .....06 [ 11,12 ]
28. HAVE YOU EVER BEEN IN A PROGRAM FOR PEOPLE WITH  
DRUG PROBLEMS WHERE YOU STAYED OVERNIGHT, BUT NOT  
IN A HOSPITAL? (PROBE: LIKE PHOENIX HOUSE)  
(Go to Q 29) Yes.....1 [ 13 ]  
(Go to Q 31) No.....0
29. WHEN WAS THE MOST RECENT TIME? GIVE ME THE DATE  
THAT YOU LEFT. DATE:....Month \_\_\_\_ [ 14,15 ]  
Year \_\_\_\_ [ 16,17 ]
- ASK less than 6 months ago.....01  
Q 30 6 months ago up to, but not including, 1 year ago...02  
1 year ago up to, but not including, 2 years ago...03 [ 18,19 ]  
SKIP 2 years ago up to, but not including, 5 years ago...04  
Q 31 5 years ago up to, but not including, 10 years ago...05  
10 years ago or more.....06
30. HOW MANY TIMES IN THE PAST 2 YEARS?  
(CODE DIRECTLY: 00=NONE, 01=ONCE, ETC. \_\_\_\_ [ 20,21 ]
31. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY OTHER REASON?  
No.....0  
(reason \_\_\_\_\_ and date\_\_\_\_\_) Yes.....1 [ 22 ]
32. HAVE YOU EVER STAYED IN THE HOSPITAL FOR LONGER THAN  
3 MONTHS IN A ROW?  
(ASK Q 33) .....Yes.....1 [ 23 ]  
No.....0
33. (FOR EACH HOSPITALIZATION, RECORD PRIMARY REASON, YEAR  
ADMITTED, AND DURATION)
- | Adm. | Reason | Date<br>Admitted | How<br>Long stayed | State Hosp. |
|------|--------|------------------|--------------------|-------------|
| 1    | _____  | _____            | _____              | _____       |
| 2    | _____  | _____            | _____              | _____       |
| 3    | _____  | _____            | _____              | _____       |
| 4    | _____  | _____            | _____              | _____       |
| 5    | _____  | _____            | _____              | _____       |
| 6    | _____  | _____            | _____              | _____       |
| 7    | _____  | _____            | _____              | _____       |
- ANY PSYCHIATRIC HOSPITALIZATIONS  
ABOVE?.....Yes.....1 [ 24 ]  
No.....0



I WOULD LIKE TO ASK YOU ABOUT THE TIMES THAT YOU WERE HOSPITALIZED FOR ANY REASON DURING THE PAST 6 MONTHS.

34. SINCE (DATE 6 MONTHS AGO) HAVE YOU BEEN ADMITTED TO A HOSPITAL? [IF R. WAS STAYING IN A HOSPITAL WITHIN THE PAST 6 MONTHS, BUT WAS ADMITTED PRIOR TO 6 MONTHS AGO, DO NOT INCLUDE.]

(Go to Q 35) yes.....1  
No.....0

[ 25]

35. HOW MANY TIMES HAVE YOU BEEN ADMITTED TO A HOSPITAL SINCE (DATE 6 MONTHS AGO)?

(CODE DIRECTLY: 01=ONCE, 02=TWICE, ETC.) CODE \_\_\_\_\_

[ 26, 27]

36. (THINKING OF THE MOST RECENT TIME) WHY WERE YOU ADMITTED TO THE HOSPITAL? SOMETIMES PEOPLE GO INTO THE HOSPITAL FOR MORE THAN ONE REASON. FOR EXAMPLE, FOR A MEDICAL PROBLEM AND A DRINKING PROBLEM AT THE SAME TIME. IF THERE WAS MORE THAN ONE REASON, PLEASE TELL ME ALL OF THEM.

| Adm. | Reason(s) | Date<br>Admitted<br>(Do not include if prior<br>to 6 months) | How<br>long stayed | State Hosp.<br>(Don't ask if reason for adm. was<br>a medical reason) |
|------|-----------|--|--------------------|---|
| 1.   | _____     | _____  | _____              | _____   |
| 2.   | _____     | _____  | _____              | _____   |
| 3.   | _____     | _____  | _____              | _____   |
| 4.   | _____     | _____  | _____              | _____   |
| 5.   | _____     | _____  | _____              | _____   |
| 6.   | _____     | _____  | _____              | _____   |
| 7.   | _____     | _____  | _____              | _____   |

COMMENTS ON REASONS: (TO HELP YOU DISTINGUISH THE ACTUAL REASONS) FOR ADMISSION FROM A CONDITION R WAS TREATED FOR IN THE HOSPITAL).

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

7. \_\_\_\_\_

## THE QUEENS MEN'S SHELTER

1. Did you ever stay at the Queens Men's Shelter?

(If Yes, Skip to Q. 2) Yes.....1  
(If No, Skip to Q. 9)..No.....0

[28]

2.\* When did you go to Queens Men's Shelter for the FIRST  
and LAST time? How long did you stay each time?

Date of First Time.....Month \_\_\_\_  
Year \_\_\_\_  
Length of Stay in weeks..... \_\_\_\_

[29,30]  
[31,32]  
[33,34]

Date of Last Time.....Month \_\_\_\_  
Year \_\_\_\_  
Length of Stay in weeks..... \_\_\_\_

[35,36]  
[37,38]  
[39,40]

3. How did you go to the QM Shelter?

FIRST LAST

[41][42]

a. By bus from 3rd Street.....1 1  
b. Referred/sent there from  
\_\_\_\_ Shelter  
by Social Service Team.....2 2  
c. Referred/sent there from  
\_\_\_\_ Shelter  
by OMH Team.....3 3  
d. Other.....4 4  
e. Does not apply (didn't go to QS).....6 6

FIRST TIME

4. Code shelter for 3b and 3c..... \_\_\_\_  
5. Code for 3d..... \_\_\_\_

[43,44]  
[45,46]  
[47,48]

LAST TIME

6. Code shelter for 3b Last Time and 3c Last Time... \_\_\_\_  
7. Code for 3d Last Time..... \_\_\_\_

[49,50]  
[51,52]  
[53,54]

8. While at QMS, were you referred to the  
New Directions Mental Health Clinic?

No.....1  
Yes, but refused to be screened .....2  
Yes, screened, not accepted into program.....3  
Yes, accepted, but did not participate.....4  
Yes, accepted, participated for.....5  
If 5, Number of Weeks.....

[55]

[56]

\*[IF R DID NOT GO TO QUEENS MEN'S SHELTER, CODE -  
Month=96, year=96, Length of Stay=96...DNA]

7. Compared to other shelters, QMS was:
- |                     |   |      |
|---------------------|---|------|
| Overall better..... | 1 |      |
| About the same..... | 2 | [57] |
| Not as good.....    | 3 |      |
8. Compared to other shelters services at QMS  
(Mental health, social services, medical) were:
- |                     |   |      |
|---------------------|---|------|
| Better.....         | 1 |      |
| About the same..... | 2 | [58] |
| Not as good.....    | 3 |      |
9. Compared to other shelters, personal  
safety at QMS was:
- |                     |   |      |
|---------------------|---|------|
| Better.....         | 1 |      |
| About the same..... | 2 | [59] |
| Not as good.....    | 3 |      |
10. Why did you leave the QMS Shelter?

|         |
|---------|
| Comment |
|---------|

|       |      |
|-------|------|
| Code: | [60] |
|-------|------|

11. If NO to Q.1, were you ever referred to or told  
to go to the QMS shelter?
- |                               |   |      |
|-------------------------------|---|------|
| No.....                       | 1 |      |
| Yes, by Shelter Soc. Services |   | [61] |
| at .....                      | 2 |      |
| Yes, by OMH team              |   |      |
| at .....                      | 3 |      |
| Yes, by other .....           | 4 |      |
12. If Yes to Q. 11, why didn't you go to Queens Men's  
Shelter?
- |   |   |      |
|---|---|------|
| Only for mentally ill, "I'm not crazy"..... | 1 |      |
| Too far away from friends, family or        |   |      |
| other social supports.....                  | 2 | [62] |
| Too far away from street-level resources    |   |      |
| and opportunities.....                      | 3 |      |
| Negative/Hostile community.....             | 4 |      |
| Other: .....                                | 5 |      |

## VICTIMIZATION

NOW I WOULD LIKE TO ASK SOME QUESTIONS ABOUT EVENTS THAT MIGHT HAVE HAPPENED TO YOU DURING THE PAST YEAR?

1. Did anyone rob you by using force or threatening to harm you?  
 Yes.....1 [ 63]  
 No.....0
2. Did anyone steal some of your property, such as a radio, your clothing, or money?  
 Yes.....1 [ 64]  
 No.....0
3. Did anyone threaten you with a gun, knife or some other weapon?  
 Yes.....1 [ 65]  
 No.....0
4. Did anyone beat you up with their fists, a club or some other heavy object?  
 Yes.....1 [ 66]  
 No.....0
5. Are you afraid that someone is going to try to hurt you?  
 Most of the time.....4  
 About half of the time...3 [ 67]  
 Part of the time.....2  
 A little of the time.....1  
 Never.....0

|      |   |     |   |      |   |
|------|---|-----|---|------|---|
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# PROBLEMS WITH THE POLICE

NOW I'M GOING TO ASK YOU SOME QUESTIONS ABOUT PROBLEMS YOU MIGHT HAVE HAD WITH THE POLICE AND THE LAW. THIS INFORMATION IS CONFIDENTIAL AND WILL NOT BE PASSED ON TO ANYONE.

1. Have you ever been arrested?  
 Yes.....1 [11]  
 No.....0
2. If yes to Q 1, how many times have you been arrested in the past 3 years?  
 Number of times \_\_\_\_ [12,13]
3. Have you ever been convicted of a crime?  
 Yes.....1 [14]  
 No.....0
4. If yes to Q. 3, how many times have you been convicted in the past 3 years.  
 Number of Times \_\_\_\_ [15,16]
5. If yes to Q 4, how much of the past 3 years did you spend in prison or jail?  
 Number of Months \_\_\_\_ [17,18]
6. Were you ever arrested for buying, selling or dealing with drugs?  
 Yes.....1 [19]  
 No.....0
7. Were you ever arrested for robbery to support a drug habit?  
 Yes.....1 [20]  
 No.....2
8. Were you sent to jail or reform school before the age of 18?  
 Yes.....1 [21]  
 No.....0
9. If yes to Q. 8, how old were you when you were sent to jail or reform school for the first time?  
 Age. \_\_\_\_ [22,23]
10. Were you ever expelled from school?  
 Yes.....1 [24]  
 No.....0
11. If yes to Q. 10, how old were you when you were first expelled from school?  
 Age.. \_\_\_\_ [25,26]

## DEMOGRAPHIC INFORMATION

NOW I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT YOU AND YOUR FAMILY BACKGROUND. (CIRCLE # OR CODE IN SPACE PROVIDED)

1. How old are you?..... [27,28]
2. What is your date of birth?.....Month [29,30]  
Day [31,32]  
Year [33,34]
3. What is your sex/gender?.....  
Female .....1 [35]  
Male.....0
4. In which country were you born? (Code)  
Country [36,37]
5. If United States, were you born in New York City?  
(DNA for others).....Yes.....1 [38]  
No.....0  
DNA.....6
6. What is your current legal marital  
status?.....Married.....1 [39]  
Separated.....2  
Divorced.....3  
Widowed.....4  
Never Married.....5
7. How many times have you been married?  
(Code 0 if 5 in Q. 6)..... [40]
8. What is your ethnic background?  
Asian or Pacific Islander.....0  
Black, Non-Hispanic.....1 [41]  
Hispanic.....2  
Native American.....3  
White, non-Hispanic.....4  
Other.....5
9. In which country were your mother and father born?  
Code:.....Mother [42,43]  
Code:.....Father [44,45]
10. Which language was generally spoken in your home?...  
English.....1 [46]  
Spanish.....2  
Other.....3
11. How well do you read English ?  
Very Well.....1 [47]  
Average.....2  
Marginal.....3  
I can't read English...4

12. What is your religious preference?...  
 Baptist.....01  
 Catholic.....02  
 Islamic.....03  
 Jewish .....04  
 Muslim.....05 [48,49]  
 Protestant.....06  
 Pentecostal.....07  
 Other.....08
- 
13. Do you attend religious services? Yes.....1  
 No.....0 [50]
14. How many living children do you have? (CODE: Number of children ..... [51,52]
15. How old is your youngest child? Age..... [53,54]
16. How old is your oldest child? Age..... [55,56]
17. With whom do (most of) your children now live? (Code..... [57,58]
18. What was the highest grade in school that you completed?  
 None.....01  
 Some grade school (G 1-7).....02  
 Completed grade school (G-8).....03  
 Some high school (G9-11).....04  
 Completed High School (GED or 12).....05 [59,60]  
 Some college (G13-15).....06  
 Completed college(16).....07  
 Graduate School (>16).....08  
 Graduate Degree (MA/MS, Ph.D).....09
- 
19. When you were 12 years old, were you living with your natural mother?  
 (IF YES go to Q 21).....Yes.....1 [61]  
 (IF NO Ask Q. 20).....No.....0
20. Who was the person that you considered to be your mother when you were 12 years old?  
 None.....01  
 Natural mother.....02  
 Step mother.....03  
 Foster mother.....04 [62,63]  
 Grandmother.....05  
 Aunt.....06  
 Other, specify:.....07  
 (Q.21-24 Refer to this person)

21. Did your mother learn how to read and write? Yes.....1 [64]  
No.....0
22. What was your mother's occupation when you were 12 years old? \_\_\_\_\_ [65,66]
23. Did your mother go to school in the United States? Yes.....1 [67]  
No.....0
24. What was the highest grade in school (or degree) that your mother completed?  
None.....01  
Some grade school (G 1-7).....02  
Completed grade school (G-8).....03  
Some high school (G9-11).....04  
Completed High School (GED or 12).05 [68,69]  
Some college (G13-15).....06  
Completed college(16).....07  
Graduate School (>16).....08  
\_\_\_\_\_  
Graduate Degree (MA/MS, Ph.D.....09
25. When you were 12 years old, were you living with your natural father?  
(Yes Skip to 27).....Yes.....1 [70]  
(No Ask Q. 26).....No.....0
26. Who was the person that you considered to be your father when you were 12 years old?  
None.....01  
Natural father.....02  
Step father.....03  
Foster father.....04 [71,72]  
Grandfather.....05  
Uncle.....06  
\_\_\_\_\_  
Other, Specify:.....07  
(Q. 27-30 Refer to this person)
27. Did your father learn how to read and write? yes.....1 [73]  
no.....0
28. What was your father's occupation when you were 12 years old? \_\_\_\_\_ [74,75]
29. Did your father go to school in the United States? yes.....1 [76]  
no.....0



30. What was the highest grade in school or degree that your father completed?

None.....01  
Some grade school (G 1-7).....02  
Completed grade school (G-8).....03  
Some high school (G9-11).....04  
Completed High School (GED or 12).05  
Some college (G13-15).....06  
Completed college(16).....07  
Graduate School (>16).....08  
\_\_\_\_ Graduate Degree (MA/MS, Ph.D.).....09

[77,78]

|      |   |     |   |      |   |
|------|---|-----|---|------|---|
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VETERAN

1. Were you in the armed services? Yes.....1 [11]  
No.....0
2. If YES to Q 1, In which branch of the service did you serve? (Circle appropriate number).....  
Army.....01  
Navy.....02  
Air Force.....03 [12,13]  
Marines.....04  
Coast Guard.....05  
Merchant Marine.....06  
Other.....07  
Did not serve.....96
3. What was the highest rank that you achieved? Code rank..... [14,15]
4. How many years did you serve? Number of years [16,17]
5. Which years did you serve? Years..... 19 [18,19]  
to 19 [20,21]
6. Was your active-duty military service during:  
May 1975 or later.....01  
Vietnam Era (8/64-4/75).....02  
2/55 - 7/64.....03 [22,23]  
Korean Conflict (6/50-1/55).....04  
World War II (8/40-7/47).....05  
World War I (4/17-11/18).....06  
Any other time.....07  
Did not serve.....96
7. If YES to Q1, were you in combat? Yes.....1 [24]  
No.....0  
DNA.....6
8. If YES to Q7, were you wounded? Yes.....1 [25]  
No.....0  
DNA.....6

## REVISED CES-D SCALE

NOW I AM GOING TO READ YOU A LIST OF QUESTIONS ABOUT HOW YOU FELT OVER THE PAST WEEK. I WOULD LIKE YOU TO TELL ME HOW MUCH OF THE TIME YOU FELT A CERTAIN WAY. THIS CARD INDICATES THE FOUR POSSIBLE RESPONSES TO EACH QUESTION. GIVE CARD TO R. PLEASE TELL ME HOW MUCH OF THE TIME DURING THE PAST WEEK.....

| A LITTLE<br>OF THE TIME<br>NEVER | SOME<br>OF THE TIME | ABOUT HALF<br>OF THE TIME | MOST<br>OF THE TIME<br>ALWAYS |
|----------------------------------|---------------------|---------------------------|-------------------------------|
|                                  | 1                   | 2                         | 3                             |

Were you bothered by things that usually don't bother you?....01 [26]  
 Was your appetite poor, you did not feel like eating?.....02 [27]  
 Did you feel so tired and worn out that you couldn't  
 enjoy anything?.....03 [28]  
 Did you feel that you were just as good as other people?.....04 [29]  
 Did you have trouble keeping your mind on what you were  
 doing?.....05 [30]  
 Did you feel depressed?.....06 [31]  
 Did you feel that everything you did was an effort, was hard  
 to do?.....07 [32]  
 Did you feel hopeful about the future?.....08 [33]  
 Did you feel unhappy about the way your life is going?.....09 [34]  
 Did you feel fearful?.....10 [35]  
 Did you feel discouraged and worried about your future?.....11 [36]  
 Were you happy?.....12 [37]  
 Did you talk less than usual?.....13 [38]  
 Did you feel lonely?.....14 [39]  
 Were you worried about your health?.....15 [40]  
 Did you enjoy life?.....16 [41]  
 Were you bothered by nervousness and your nerves?.....17 [42]  
 Did you feel sad?.....18 [43]  
 Did you feel that you don't have enough friends?.....19 [44]  
 Did you feel that you could not get going?.....20 [45]  
 Were you feeling in good spirits?.....21 [46]

## HARD TIMES

I WOULD LIKE TO KNOW IF THERE HAVE BEEN TIMES IN YOUR LIFE THAT HAVE BEEN VERY HARD FOR YOU. FOR EXAMPLE.....

1. Was there any time in your life when you felt so yes....1 [47]  
 bad that you made a suicide attempt?..... no.....0  
 2. How many times in your life did you make a suicide  
 attempt (Code # times, ..... [48,49]  
 3. When was the last time you made a suicide attempt?  
 (Code approximate # months ago)..... [50,51]  
 4. Do you have any thoughts about suicide now?..... yes....1 [52]  
 no.....0  
 5. Was the first time you made a suicide attempt  
 before the first time you were homeless?..... yes....1 [53]  
 no.....0

## BELIEFS AND FEELINGS

NOW I AM GOING TO ASK YOU ABOUT SOME BELIEFS AND FEELINGS THAT SOME PEOPLE HAVE HAD DURING THEIR LIFETIME. SOME PEOPLE HAVE THESE FEELINGS AND BELIEFS AFTER THEY HAVE BEEN DRINKING ALCOHOL OR TAKING DRUGS. I WOULD LIKE TO KNOW IF YOU HAVE EVER HAD SOME OF THESE BELIEFS OR FEELINGS WHEN YOU HAVE NOT BEEN DRINKING ALCOHOL OR TAKING DRUGS. HOW OFTEN DURING THE PAST YEAR:

- |  | Code | Qual-<br>ifier |           |
|--|------|----------------|-----------|
| 1. Have you ever heard noises or voices that other people say they can't hear.....                   | ___  | ___            | [ 54, 55] |
| 2. Have you ever felt that there were people who wanted to harm or hurt you?.....                    | ___  | ___            | [ 56, 57] |
| 3. Have you ever felt that there was something odd or unusual going on around you?.....              | ___  | ___            | [ 58, 59] |
| 4. Have you ever had visions or seen things that other people say they can't see?.....               | ___  | ___            | [ 60, 61] |
| 5. Have you ever felt that you had special powers that other people don't have?.....                 | ___  | ___            | [ 62, 63] |
| 6. Have you ever thought that you were possessed by a spirit or the devil?.....                      | ___  | ___            | [ 64, 65] |
| 7. Have you ever felt that your thoughts were taken from you by some outside or external force?..... | ___  | ___            | [ 66, 67] |
| 8. Have you ever had ideas or thoughts that nobody else could understand?.....                       | ___  | ___            | [ 68, 69] |
| 9. Have you ever felt that thoughts were put into your head that were not your own?.....             | ___  | ___            | [ 70, 71] |
| 10. Have you ever felt that your mind was taken over by forces you couldn't control?.....            | ___  | ___            | [ 72, 73] |

NOTE: CONSIDER CULTURAL OR SITUATIONAL NORMS IN JUDGING THE IMPLICATIONS OF ANSWERING THE ABOVE QUESTIONS. FOR EXAMPLE, IF IT IS NORMATIVE OR TYPICAL TO HEAR VOICES OR FEEL THAT YOU ARE POSSESSED BY A SPIRIT WITHIN A GIVEN CULTURAL OR RELIGIOUS GROUP, THEN SUCH BELIEFS OR FEELINGS SHOULD BE INDICATED- CULTURAL OR SITUATIONAL.

| CODE             | QUALIFIER       |
|------------------|-----------------|
| 0 = NEVER        | 0 = NONE        |
| 1 = ALMOST NEVER | 1 = CULTURAL    |
| 2 = SOMETIMES    | 2 = SITUATIONAL |
| 3 = FAIRLY OFTEN | 3 = UNTRUTHFUL  |
| 4 = VERY OFTEN   | 4 = OTHER       |

Site R No. T Form

## SERVICE NEEDS

WHAT KINDS OF SERVICES DOES R NEED TO IMPROVE HER/HIS [QUALITY OF] LIFE [HEALTH, MENTAL HEALTH, INCOME, STABLE HOUSING, CONTROL OF ADDICTIONS, ETC.] AND MOVE TOWARD A MORE STABLE LIVING SITUATION. PROBE FOR 3.

RECORD R'S SPONTANEOUS RESPONSE:

1. \_\_\_\_\_ CODE 1..... [11 , 12]  
 2. \_\_\_\_\_ CODE 2..... [13 , 14]  
 3. \_\_\_\_\_ CODE 3..... [15 , 16]

THEN GO THROUGH THE FOLLOWING LIST WITH R AND SEE IF S/HE WOULD LIKE HELP IN SOME OF THE AREAS NOT INDICATED ABOVE. THEN INDICATE THE KINDS OF HELP OR SERVICES WHICH YOU JUDGE THAT R NEEDS TO IMPROVE HER/HIS QUALITY OF LIFE AND MOVE TOWARD A MORE STABLE LIVING SITUATION. [YES=1, NO=0]

DO YOU NEED HELP WITH:

|  | R's<br>Rating | I's<br>Rating |           |
|--|---------------|---------------|-----------|
| Health and medical problems.....                               | 01            | _____         | [17 , 18] |
| Nerves and emotional problems.....                             | 02            | _____         | [19 , 20] |
| Getting along with your family.....                            | 03            | _____         | [21 , 22] |
| Finding a place to live.....                                   | 04            | _____         | [23 , 24] |
| Getting on public assistance.....                              | 05            | _____         | [25 , 26] |
| Learning how to (handle or) manage<br>money.....               | 06            | _____         | [27 , 28] |
| Finding a job.....   | 07            | _____         | [29 , 30] |
| Getting on SSI/SSDI.....                                       | 08            | _____         | [31 , 32] |
| Getting your veteran's benefits.....                           | 09            | _____         | [33 , 34] |
| Improving your job skills.....                                 | 10            | _____         | [35 , 36] |
| Drinking problems.....   | 11            | _____         | [37 , 38] |
| Learning how to get what you have<br>coming from agencies..... | 12            | _____         | [39 , 40] |
| Problems with drugs.....                                       | 13            | _____         | [41 , 42] |
| Legal problems.....  | 14            | _____         | [43 , 44] |
| Learning to get along better<br>with other people.....         | 15            | _____         | [45 , 46] |
| Getting around town on buses and<br>subways.....               | 16            | _____         | [47 , 48] |
| Learning how to read and fill out<br>forms.....                | 17            | _____         | [49 , 50] |
| Learning how to protect yourself.....                          | 18            | _____         | [51 , 52] |
| Having a steady income.....                                    | 19            | _____         | [53 , 54] |
| Problems with the police.....                                  | 20            | _____         | [55 , 56] |

END OF INTERVIEW 1 \_\_\_\_\_ 1 \_\_\_\_\_ 1 \_\_\_\_\_  
 AM=1 PM=0 HOUR MIN [57,58 , 59 ]

LENGTH OF INTERVIEW \_\_\_\_\_

# RATING OF R BY INTERVIEWER

BASED ON WHAT YOU HAVE LEARNED ABOUT R FROM THE INTERVIEW PLEASE ANSWER THE FOLLOWING QUESTIONS WITH THE RATING SCALE PROVIDED BELOW. USE MEN AND WOMEN OF APPROXIMATELY THE SAME AGE AND FROM THE SHELTER POPULATION AS YOUR COMPARISON OR REFERENCE GROUP. INDICATE YOUR CONCLUSION ABOUT R BY PLACING THE NUMBER REPRESENTING YOUR CHOICE POINT FROM THE RATING SCALE IN THE SPACE PROVIDED.

## RATING SCALE

|                     |                        |                        |                        |                        |
|---------------------|------------------------|------------------------|------------------------|------------------------|
| <u>NOT AT</u>       | <u>TO A SLIGHT</u>     | <u>TO A MODEST</u>     | <u>TO A MODERATE</u>   | <u>TO A LARGE</u>      |
| <u>ALL</u> <u>1</u> | <u>EXTENT</u> <u>2</u> | <u>EXTENT</u> <u>3</u> | <u>EXTENT</u> <u>4</u> | <u>EXTENT</u> <u>5</u> |

TO WHAT EXTENT:

1. Did you feel that R gave accurate answers to your questions?..... [60]
2. Was R very nervous and tense during the interview?..... [61]
3. Was R very discouraged or depressed about his/her current life situation?..... [62]
4. Did you feel that R gave accurate answers to your questions on the use of illegal drugs?..... [63]
5. Was R hostile toward you during the interview?..... [64]
6. Was R under the influence of alcohol during the interview?..... [65]
7. Will R be able to live a more stable life if reasonable opportunities for change are made available to her/him?..... [66]
8. Did you feel that R gave accurate answers to your questions on hospitalization for mental disorders?..... [67]
9. Did you feel that R would accept help from agencies and other services?..... [68]
10. Is R impaired in function by the effects of mental disorder(s)?..... [69]
11. Did you feel that R gave accurate answers to your questions on the use of alcohol?..... [70]
12. Does R have a serious drug problem?..... [71]
13. Will R be able to move directly into a form of unsupervised housing without the help of extensive transitional and supportive services?..... [72]

Pg. 51 [6,96=DNA; 7,97=NA; 8,98=DK; 9,99=MD]

14. Did R manifest an inappropriate affect during parts of the interview?..... [73]
15. Was R unusually unkempt or bizarre in appearance?..... [74]
16. Was R so withdrawn into his/her own world that he/she found it very difficult to answer your questions?..... [75]
17. Did R indicate the ability to size up a situation and make judgements and conclusions which are constructive and to her/his benefit?..... [76]
18. Did R manifest unusual ways of thinking and reasoning about past and current experiences?..... [77]
19. Was R apathetic or flat in affect during the interview?..... [78]
20. Did R manifest extreme attitudes of distrust and suspicion during the interview?..... [79]
21. Based upon your observations about R's capacities, as well as what R has told you about his/her preferences, which of the following best indicates the most appropriate residential setting for this individual at this time?..... [80]

| <u>INDEPENDENT LIVING COMM.</u> |                   | <u>SUPERVISED LIVING COMM.</u> |                         | <u>INPATIENT CARE</u>    |
|---------------------------------|-------------------|--------------------------------|-------------------------|--------------------------|
| 1                               | 2                 | 3                              | 4                       | 5                        |
| Completely Independent          | With some Support | With some Supervision          | With 24 hr. Supervision | Needs Psych. Inpat. Care |