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Comparing the Characteristics of Homeless Adults in Poland and the United States

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Abstract This study compared the characteristics of probability samples of homeless adults in Poland ($N = 200$ from two cities) and the United States ($N = 219$ from one city), using measures with established reliability and validity in homeless populations. The same measures were used across nations and a systemic translation procedure assured comparability of measurement. The two samples were similar on some measures: In both nations, most homeless adults were male, many reported having dependent children and experiencing out-of-home placements when they themselves were children, and high levels of physical health problems were observed. Significant national differences were also found: Those in Poland were older, had been homeless for longer, showed lower rates on all psychiatric diagnoses assessed (including severe mental and substance abuse disorders), reported less contact with family and supportive network members, were less satisfied when they sought support from their networks, and reported fewer recent stressful life events and fewer risky sexual behaviors. Culturally-informed interpretations of these findings and their implications are presented.

Keywords Homelessness; international comparison; Poland; social support; stress; mental health; substance abuse; baby-boom cohort

INTRODUCTION

Over the past three decades, homelessness has emerged as a major social issue in most developed nations of the world. Although the problem is now recognized in many nations, most of the research on homelessness has been conducted in the United States (US), with some research done in a few other nations such as the United Kingdom (UK), Canada, France, and Australia (Toro, 2007). Homelessness in Eastern European nations has only recently been acknowledged as a social problem and there is little existing research on the topic (Hradecky & Hladikova, 2007). Such research in the former communist nations of Eastern Europe could yield especially interesting results because homelessness appears to have been very rare prior to the fall of communism in the 1990s and has shown a rapid increase in the past 20 years (Przyemeński, 2008).

A number of authors have recently suggested that research on homelessness that compares nations could lead to a richer understanding of the causes of and solutions to homelessness (e.g., Shinn, 2007; Toro, 2007). To date, however, there have been very few published reports that attempt such comparisons. Early comparative publications generally failed to use sound research methods, often rely-

ing on anecdotal evidence (e.g., Avramov, 1998; Cohen, 1994; Daly, 1990; Helvie & Kunstmann, 1999; Marpsat, 1999; Slegers, 2000). A few recent publications have used more sophisticated methods, carefully replicated across nations, to help us understand differences between nations on the prevalence of homelessness, the characteristics of homeless people, and policy and cultural differences influencing the development and resolution of homelessness.

For example, Milburn et al. (2006) compared large samples of homeless youth from Melbourne, Australia ($N=673$) and Los Angeles ($N=618$). Compared to the Australians, the US homeless youth were younger, and more likely to be in school and to have spent time in jail. They showed less substance use and fewer suicidal attempts. In another paper based on the same two-nation sample, Milburn et al. (2007) used structural equation modeling to examine predictors of HIV risk behaviors. They found that the predictors of HIV risk behaviors were similar across nations, even though the overall level of such behaviors was higher among the Australians. The predictors included high levels of delinquent behaviors and substance use, associating with delinquent peers, and experience with victimization on the streets. Having positive peer relationships and better quality housing predicted fewer HIV risk behaviors in both nations. This study highlights how homeless populations may have different prob-

lems and needs across nations but, at the same time, there may be some common predictors of success.

Based on her review of various studies, including ones explicitly comparing the prevalence of homelessness across nations, Shinn (2007) suggested that the breadth and efficiency of health and human services across nations could help explain the variation in rates of homelessness observed. Germany and France, for example, seem to have relatively low rates of homelessness and have a strong array of services, including a “guaranteed minimum income,” readily available national health care, and generous unemployment benefits (Helvie & Kuntzmann, 1999). Shinn (2007) and others (e.g., Adams, 1986; references deleted to protect blind review) have offered further explanations for higher rates of homelessness observed among some nations (such as the US, Canada, and the UK). These explanations include strong capitalist and individualist national tendencies, intense immigration, an uneven distribution of wealth, relatively weak family and community ties, and levels and patterns of alcohol and other substance abuse.

One common problem with the existing studies on homelessness (mostly from the US) has been poor sampling methods (Robertson, 1992; Toro et al., 1999). Many studies have not documented their sampling methods at all. More recent studies have begun to use sophisticated probability sampling methods to obtain large representative samples of homeless people (e.g., Burnam & Koegel, 1988; Toro et al., 1999; Zlotnick, Robertson, & Lahiff, 1999). Another weakness of existing studies involves the use of measures without documented reliability and validity among homeless populations. The assessment of mental disorders has been especially difficult and early studies produced a wide range of estimates amid considerable controversy (e.g., Snow, Baker, Anderson, & Martin, 1986; Susser et al., 1989). More recent studies have used structured diagnostic interviews with documented psychometric properties (e.g., North & Smith, 1993; Toro et al., 1999).

To our knowledge, there is no existing published empirical study that systematically compares the characteristics of homeless people in an Eastern European nation to homeless people in another nation in or outside of Eastern Europe. The present study used careful sampling and assessment methods, designed specifically for use with homeless adults, to interview homeless adults in both the US and Poland. The study attempted to document the needs of homeless people in each nation so as both to understand the context of homelessness in each nation and to suggest possible ways to reduce and/or prevent homelessness and its harmful consequences across nations.

METHODS

Participants

Participants for the study included 419 adults currently experiencing homelessness, 219 from the county surrounding a major Midwestern city in the US (total 2000 popula-

tion was 2.1 million) and 200 homeless adults from two nearby cities in southwestern Poland (total 2005 populations of 2.9 and 1.0 million). Probability sampling methods, developed in several recent studies of homeless people in the US (e.g., Burnam & Koegel, 1988; Toro et al., 1999; Zlotnick, Robertson, & Lahiff, 1999), were used to obtain representative samples of homeless adults in the targeted regions in both nations. Sampling was conducted at each program site in each region based on the estimated number of homeless people using that program annually, with more participants interviewed at the sites with larger numbers.

In the US, participants were recruited from local homeless shelters and soup kitchens throughout the large urban county in proportion to the number of individuals likely to be at each site, as determined by previously obtained data on service utilization in the prior year. Respondents came from the 29 sites with the largest unique populations of homeless persons served in the prior year. Street sites were not sampled, as it had been estimated in a prior study that less than 1% of the homeless in the county live on the streets but do not come into contact with service providers over the course of a year (reference deleted to protect blind review; see this report for additional details on the sampling methods used).

In Poland, the interviews were conducted at 31 different sites across the two cities. These 31 sites comprised virtually all of the known places where significant numbers of homeless adults could be found in the region. The sites included shelters and other forms of emergency housing. Unlike in the US city, we did not sample from food programs in Poland. This was because relatively few such programs existed in the two cities and because those that did exist served mostly poor, but not homeless, people. Thus, relatively small numbers of homeless people would be found at the soup kitchens, even after considerable time spent screening clients. As in the US, participants were recruited in proportion to the number of individuals likely to be served at each site on an annual basis, as determined by previously obtained service use data. To maintain comparability with the US sampling design, no street sites were sampled in the Polish cities (as in the US, it appeared that most homeless people found on the streets also used shelters, at least on occasion).

In Poland, almost half of the respondents (46.5%) had a vocational or technical education (without a high school degree) and 32.0% more had only an elementary level of education. Only 16.0% graduated from high school and another 5.5% received advanced training (e.g., at a college or university). All but two of the participants were of Polish ethnicity, a fact that is not surprising in a country as ethnically homogenous as Poland (there was one Ukrainian and one Romanian). In the US, with a different educational system, 32.3% failed to complete high school, 38.6% more completed high school, and 29.1% reported taking at least some college courses. Most respondents were African-American (77.6%), with smaller numbers of Caucasians (17.4%), and very small numbers of other or mixed eth-

nicity (5.0%).¹¹ Across the characteristics mentioned above, plus others (e.g., those in Table 1), the US sample was generally similar in composition to earlier samples of homeless adults obtained in the city studied as well as in other US cities (e.g., Shlay & Rossi, 1992; Solarz & Bogat, 1990; Toro et al., 1999; Zlotnick et al., 1999; other references deleted to protect blind review). The Polish sample also appeared similar to samples of homeless adults from a few other existing studies done elsewhere in Poland (e.g., Stankiewicz, 2002).

Measures

Demographic Information. Demographic information was collected on participant age, gender, ethnicity, educational attainment, dependent children, public assistance, time homeless (in current episode), and experience with out-of-home placement (in childhood).

Diagnostic Interview Schedule (DIS). The DIS is a structured diagnostic interview that yields current and lifetime estimates of various psychiatric disorders based on DSM-III-R criteria (Eaton & Kessler, 1985). It has extensive reliability and validity data (e.g., Robins et al., 1981) and has been widely used with homeless populations (Fischer & Breakey, 1991). In the present study, the samples obtained from each nation were compared on diagnoses of schizophrenia, mood disorders (major depression and bipolar disorders), alcohol abuse and dependence, and drug abuse and dependence (across all forms of illicit drugs, including marijuana, stimulants, opioids, and hallucinogens).

Brief Symptom Inventory (BSI). The BSI is a 53-item checklist of current psychological symptoms (Derogatis & Melisaratos, 1983). Participants were asked whether they had been troubled by each symptom during the past two weeks. The BSI, and the full length SCL90R (Derogatis, 1977) from which the BSI was adapted, have found homeless persons to have significantly higher scores than matched and normative samples (e.g., Morse & Calsyn, 1986; other references deleted to protect blind review) and reliability and other validity data also exist based on homeless samples (Calsyn, Allen, Morse, Smith, & Tempelhoff, 1993). The total score was used here.

Physical Health Symptoms Checklist (PHSC). The PHSC is a 78-item list of acute symptoms (e.g., references deleted to protect blind review). In one study, the acute symptom total used had a test-retest reliability coefficient of .85 and internal consistency of .89-.92 (reference deleted).

¹¹ The racial breakdown of the total county population was as follows: 42.2% African-American, 51.7% Caucasian, and 6.1% other or mixed ethnicity (US Census, 2000). Thus, as in most other US cities (Ahmed & Toro, 2004), African-Americans are heavily over-represented among the county's homeless population.

Risky Sexual Behaviors (RSB). The RSB measure assessed the following sexual behaviors, each on a 4-point scale, during the past six months: Frequency of sexual activity (0 = abstinent, 1 = not at all or rarely, 2 = sometimes, 3 = several times a week), number of sexual partners (0 = abstinent, 1 = 1 partner, 2 = 2-3 partners, and 3 = 4 or more partners), and age at first oral, anal, or vaginal intercourse (0 = abstinent, 1 = at or after 15, 2 = between 13 and 14, and 3 = age 12 or before). A 3-point scale was used to assess the following: Condom use (0 = abstinent, 1 = always used condom, 2 = used condom inconsistently) and STD history (0 = abstinent; 1 = no STD history, 2 = at least one STD). Dichotomous items (0 = no, 1 = yes) assessed the presence of other RSBs including drug and/or alcohol use while having sex, sex with intravenous drug users, anal sex, oral sex, and exchanging sex for money or drugs. All self-reported sexual behaviors were summed to derive a total score. A similar total score demonstrated good internal consistency in a prior study of homeless adults (alpha = .86; reference deleted to protect blind review). This study also found evidence for validity of the measure (e.g., those with diagnoses of substance abuse and having been homeless for longer had higher RSB scores). The total score ranged from 0 (for people who did not have sex in the past 6 months) to 18. Sizable numbers received 0 scores (50, 22.8%, in the US sample and 123, 61.5%, in the Polish sample).

Modified Life Events Inventory (MLEI). The MLEI is an interview used to assess stressful life events. As used here it contained 87 items assessing events experienced in the last six months across relationships, housing situations, employment, education and job training, and mental and physical health. It was developed specifically for use with homeless populations and has demonstrated good test-retest reliability in a previous study involving homeless participants ($r=.84$; reference deleted).

Interpersonal Support Evaluation List (ISEL). The ISEL is a 40-item questionnaire in which people are asked to rate the perceived availability of different types of social support. As in recent studies on homeless and poor people (Bates & Toro, 1999; other references deleted to protect blind review), a 4-point rating scale was used on each item, rather than the original dichotomous format. The ISEL consists of four subscales tapping different types of support: tangible, concerning the provision of material aid; appraisal, the belief that one has persons to turn to for advice; self-esteem, the belief that one's status is equal to that of friends; and belonging, concerning having people with whom one can do things. The Polish version of the ISEL was abridged to 39 items, due to cultural differences making translation difficult on one item (the missing item was dropped from the US version in analyses reported here). The four subscales of the ISEL have had test-retest reliabilities of .71-.87 in various community samples (Cohen,

Mermelstein, Kamarck, & Hoberman, 1985) and .62 to .85 in a sample of homeless and poor adults (Bates & Toro, 1999). Bates and Toro (1999) also found that the ISEL subscales were associated with various outcomes (e.g., physical and psychological symptoms).

Social Network Inventory (SNI). The SNI has been used in several recent studies of homeless people (Bates & Toro, 1999; other references deleted to protect blind review). Respondents were asked to answer various questions about people who are important to them and with whom they have interacted within the last six months. Four SNI variables were used: (1) a family contact measure based on the mean frequency of contact across all family members, ranging from 1.00 to 5.00 (with 0s for those with no contact with any family members in the past 6 months; 35 (14.6%) in the US sample and 70 (35.0%) in the Polish sample); (2) a friend contact measure based on the mean frequency of contact across all friends in the network, ranging from 1.00 to 5.00 (with 0s for those having no contact with any friends in the past 6 months; 69 (31.5%) in the US sample and 35 (34.5%) in the Polish sample); (3) a support contact measure based on the mean frequency of contact across all network members who the respondent indicated as having provided emotional, tangible, or other support, ranging from 1.00 to 5.00 (with 0s for those reporting no supporters in the past 6 months; 19 (8.7%) in the US sample and 40 (20%) in the Polish sample); and (4) a support satisfaction measure based on the mean frequency of satisfaction with the support obtained across all supporters, ranging from 1.00 to 5.00 (with 0s for those reporting no supporters in the past 6 months, as for the support contact measure). In their homeless and poor sample, Bates and Toro (1999) found test-retest reliabilities of .74 to .82 for several key SNI variables. They also found that SNI variables were associated with various outcomes and yielded a stress-buffering effect (i.e., those under high stress and with small family networks showed the highest levels of physical health symptoms).

Translation

The interview measures described above were translated in a systematic fashion. First, the measures were translated from English to Polish by a graduate student in psychology who was a native Polish speaker fluent in English. She obtained assistance with the translation, as needed, from other Polish colleagues also fluent in English and from the first author. Next, a second psychology graduate student, also a native Polish-speaker fluent in English, independently translated the Polish version back into English. Finally, the first author (a native English-speaker) compared the original English protocol to the back-translated protocol. Any discrepancies were discussed and the Polish version adjusted so that the intended original meaning came across accurately through the translation process.

Procedure

Interview data on homeless participants were collected over 18 months in both nations (November 2000 through May 2002 in the US, and January 2005 through June 2006 in Poland). The structured interviews were conducted by trained interviewers in both nations. Persons at each site were selected using a method agreed to beforehand that assured random selection, such as approaching every n-th person on the evening's guest list. Few approached refused to be interviewed (less than 5% across all sites in both nations). The interviews were generally conducted in private spaces (usually an office) within the agency, in an area away from other clients. The interviews generally lasted 1.5-3.0 hours. Participants received \$40 for participation in the US and 10 zloty (about \$4 US) in Poland.²²

Interviews in each nation were conducted by trained interviewers (paid full- and part-time staff and graduate students in psychology in the US and graduate students in psychology in Poland). Training included extensive role-playing and practice interviews in both nations. To assure comparability of interview methods, Polish interviewers were trained by one of the key US interviewers who spoke Polish (all Polish interviewers also spoke English to assist the training process). To control for variations in literacy among participants, interviewers in both nations read the whole interview to all respondents, recording their responses. Participation in the research was completely voluntary in both nations. There was written, informed consent obtained from each respondent before the interview.

RESULTS

Chi-square, ANOVA and MANOVA statistics were used to compare the two samples, depending on the type of dependent variable under comparison (categorical or continuous). Rational groupings of characteristics were used in order to facilitate statistical comparisons and data presentation. Categories of characteristics under consideration included demographics (Table 1), psychiatric diagnoses (Table 2), and social support, stress, and symptoms (psychological, physical, and sexual; Table 3). For the continuous variables presented in Table 3, MANOVA was used to screen for overall significance, and follow-up univariate ANOVAs were tested.

Descriptive statistics regarding basic characteristics of the two samples are displayed in Table 1. A majority of the homeless adults found in each nation were male (72.5-

²² The same approach was used in each nation in order to determine the level of compensation: We discussed with agency staff and potential homeless participants what would be the minimum amount we could provide in order to encourage most participants to agree to a 3-hour interview. In Poland, with a much lower standard of living than the US, this amount was determined to be 10 zloty (about \$4 US), while in the US this amount was \$40. The fact that we achieved very similar rates of refusal (less than 5%) in each nation supports the levels set prior to data collection.

74.4%). The samples for the two nations differed significantly on age, with the Polish being on average 4.4 years older than the US homeless adults ($M_s = 46.7$ and 42.3 years). Closer review of the age distributions in Table 1 reveals that the US sample included a much larger proportion of people in their 40s (42.5% vs. only 16.5% in Poland) but much smaller proportions of people older than this

(19.7% in their 50s or older vs. 50.0% in Poland). The Polish sample had also been homeless for much longer, on average, than the US sample. Indeed, a majority (61.0%) of the Polish had been homeless for more than three years, as compared with only 19.6% among the US homeless sample.

Table 1. Background characteristics of homeless adults in Poland and the US.

	US (N=219)		Poland (N=200)		Statistical Test
	n	%	n	%	
Gender					$\chi^2(1) = 0.20$
<i>Male</i>	163	74.4%	145	72.5%	
<i>Female</i>	56	25.6%	55	27.5%	
Age ^a					$F(1,417) = 15.60^{***}$
18-29	19	8.7%	22	11.0%	
30-39	64	29.2%	45	22.5%	
40-49	93	42.5%	33	16.5%	
50-59	35	16.0%	64	32.0%	
60-78	8	3.7%	36	18.0%	
Time Homeless (current episode) ^a					$F(1,417) = 148.77^{***}$
< 6 mos.	105	47.9%	13	6.5%	
6 - 36 mos.	71	0.3%	65	32.5%	
> 36 mos.	43	19.6%	122	61.0%	
Public Assistance (ever)	181	82.7%	149	74.5%	$\chi^2(1) = 4.15^*$
Has Dependent Child(ren)	75	34.7%	57	28.5%	$\chi^2(1) = 1.86$
Out-of-home Placement ^b	30	13.7%	34	17.4%	$\chi^2(1) = 1.10$

^aAlthough presented in categories in this table, the samples were compared in ANOVAs on these two continuous variables. ^bWhen the respondent was a minor. * $p < .05$; ** $p < .01$; *** $p < .001$

Table 2. Psychiatric diagnoses of homeless adults in Poland and the US.

Diagnoses	US (N=219)		Poland (N=200)		Normative	
	n	%	n	%	$\chi^2(1)$	US Rate (%)
Mental Illness	76	34.7%	37	18.8%	13.51 ^{***}	--
<i>Affective disorder</i>	65	29.7%	31	15.7%	11.36 ^{***}	8
<i>Schizophrenic disorder</i>	24	11.1%	7	3.6%	8.48 ^{**}	2
Substance Abuse/Dependence	168	76.7%	92	46.0%	41.87 ^{***}	16
<i>Alcohol</i>	131	59.8%	89	44.5%	9.84 ^{**}	13
<i>Drug</i>	126	57.5%	12	6.0%	126.69 ^{***}	6
Dual Diagnosis	59	27.1%	16	8.1%	25.08 ^{***}	--
Either Diagnosis	185	84.9%	113	57.4%	38.66 ^{***}	--

Note. All diagnoses based on the Diagnostic Interview Schedule (DIS). Those with a dual diagnosis had both a severe mental illness and a substance abuse/dependence disorder. Those with either diagnosis had either of these. Total N_s for the above diagnoses varied from 415 to 419. US national normative rates are based on the total five-site ECA sample ($N = 18,571$; Regier et al., 1988). * $p < .05$; ** $p < .01$; *** $p < .001$

Many of the adults in both nations reported having dependent children (34.7% in the US and 28.5% in Poland), although many of these did not currently have their children with them while homeless (especially for the men in both samples). Many in both national samples also reported having been in some sort of out-of-home placement as

children (13.7% in the US and 17.4% in Poland). In Poland, many of these placements were in orphanages. Most in both samples also reported having received some sort of public assistance at some point, with somewhat more of the US sample reporting such assistance (82.7% vs. 74.5% in Poland, $p < .05$).

Table 2 presents chi-square analyses on DIS diagnoses. Significant ($p < .05$) national differences were found in the rates of all the lifetime diagnoses in the table. Both of the serious mental disorders assessed showed significant and substantial national differences: In the US, 34.7% showed either of the two main disorders assessed, 29.7% showed an affective disorder (mostly major depressive episode), and 11.1% showed a schizophrenic disorder (rates for the Polish sample, were 18.8%, 15.7%, and 3.6%, respectively). For all of these diagnostic rates, the US sample showed nearly or more than double the rate of the Polish sample.

Both of the substance abuse and/or dependence disorders assessed also showed significant national differences: In the US, 76.7% showed either disorder, 59.8% showed an alcohol abuse/dependence disorder, and 57.5% showed a drug abuse/dependence disorder (rates for the Polish sample were 46.0%, 44.5%, and 6.0%, respectively). The rate difference on drug abuse/dependence was particularly large, with the US sample showing almost 10 times the rate seen in the Polish sample. The rate of dual diagnosis (i.e., having both a severe mental illness and substance abuse/dependence disorder) was also much higher in the US sample as compared to the Polish sample (27.1% vs. 8.1%).

There were also many significant differences between the two homeless samples on the various continuous social

support, stress, and symptom variables presented in Table 3. All three MANOVAs were statistically significant ($p < .001$). For the univariate ANOVAs from the SNI, the US sample reported significantly more frequent contact with family and with members of their support network, and they reported more satisfaction with the support received from their network members. This difference was due, in part, to the fact that larger numbers of the Polish sample reported no contact with any family or any supporters in the prior six months (35% and 20% vs. 15% and 9% in the US sample). US respondents also obtained higher scores on the ISEL self-esteem subscale, but less available tangible support on another ISEL subscale. There was a significant and substantial difference in the number of stressful life events reported in the prior 6 months, with the US sample reporting almost twice as many (18.1) events as compared with the Polish sample (9.3). The US sample also obtained significantly higher scores on the measure of risky sexual behaviors (5.8 vs. 2.2 for the Polish sample). This difference was due in large part to the fact that more than half of the Polish sample had been sexually inactive during the prior six months (61.5% vs. 22.8%, for the US sample). Both samples reported large numbers of physical health symptoms (15.9 in the US sample and 15.2 in the Polish). There was no significant national difference found on the level of self-report symptoms on the BSI.

Table 3. Social support, stress, and symptoms among homeless adults in Poland and the US.

	US (N=219)		Poland (N=200)		F	(df)
	M	(SD)	M	(SD)		
Social Network Interview					11.86	*** (4,414)
Family Contact	3.07	(1.54)	2.05	(1.80)	39.42	*** (1,417)
Friend Contact	2.80	(2.04)	2.64	(2.13)	0.59	(1,417)
Support Contact	3.53	(1.34)	3.01	(1.79)	11.49	*** (1,417)
Support Satisfaction	3.67	(1.47)	2.98	(1.82)	18.02	*** (1,417)
ISEL Perceived Support					8.37	*** (4,414)
Tangible	26.81	(7.30)	28.35	(7.48)	4.52	* (1,417)
Self Esteem	27.76	(4.68)	26.46	(6.09)	5.98	* (1,417)
Belonging	28.06	(6.43)	28.59	(6.52)	0.80	(1,417)
Appraisal	27.47	(5.22)	26.40	(6.62)	3.40	(1,417)
Stress and Symptoms					52.45	*** (4,414)
MLEI Stressful Events	18.13	(8.38)	9.31	(7.13)	133.39	*** (1,417)
BSI Symptom Total	0.81	(0.62)	0.79	(0.67)	0.02	(1,417)
Physical Health Symptoms	15.87	(11.42)	15.20	(11.66)	0.35	(1,417)
Risky Sexual Behavior	5.76	(5.39)	2.18	(3.47)	64.38	*** (1,417)

Note. MANOVA *F*s appear opposite the variable group label (e.g., Social Network Interview). All other *F*s are from ANOVAs. * $p < .05$; ** $p < .01$; *** $p < .001$

To assess whether the significant difference between the two samples on age could account for the difference on time homeless (in current episode), age were statistically controlled (by entering it as a covariate) in a post hoc ANCOVA. The nation difference on time homeless remained

statistically significant in this analysis ($F(1,416)=133.01$; $p < .001$). To assess whether the significant differences between the two samples on both age and time homeless could account for other national differences obtained, these two variables were statistically controlled (by entering

them both as covariates) in a set of post hoc (M)ANCOVAs on the continuous variables listed in Table 3. All the multivariate *F*s and all but one of the originally significant univariate *F*s remained significant ($p < .05$) in these (M)ANCOVAs. Only the univariate nation difference on the ISEL self-esteem subscale became nonsignificant after controlling for the two covariates ($F(1,412)=0.81$; $p > .05$).

DISCUSSION

This study identified many differences, but also some similarities, between representative samples of homeless adults obtained in US and Polish cities. The similarities included finding that a clear majority of the adult homeless population was male in both nations (73-74%), and many reported having dependent children (29-35%; even if these children were not homeless with them). Both samples also showed high levels of physical health problems ($M_s=15-16$ symptoms) and many indicated that they had been in some sort of out-of-home placement when they were children (14-17%).

The differences included finding that the Polish sample was considerably older than the US sample (with a mean difference of 4.4 years). This age difference closely parallels the difference in time between data collection for the US and Polish samples (4.2 years on average). This parallel could be the result of a similar birth cohort effect associated with the baby boom generation in both nations. Culhane et al. (2013) recently analyzed the aging of the homeless population in the US based on 22 years of shelter utilization data for single homeless adults in New York City and 20 years of US Census information on the size of the adult male population found in homeless shelters. Similar results were found based on these two different large datasets. Focusing on the Census information, the authors found that, in 1990, “those aged between 34 and 36 had over one and a half times the relative risk for homelessness as the rest of the U.S. population ($RR=1.6$). In subsequent enumerations, the age groups with the highest relative risks for homelessness shifted to 40 to 42 ($RR=1.7$) in 2000, and then to 49 to 51 ($RR=2.0$) in 2010” (p. 4). The authors conclude that the highest risk group for homelessness in the US has come consistently from the tail end of the baby boom generation (i.e., those born in 1959-1964). They cite a variety of factors that might explain this particular risk in the US context, including the fact that this cohort “came of age” during the recessionary period of the late 1970s and early 1980s, rising housing costs for low-income people, the growing prison population, and the crack cocaine epidemic.

Poland also experienced a post-World War II baby boom, though it seems to have begun and ended somewhat earlier than in the US. The peak of the post-war baby boom in Poland is considered to have occurred in 1956, when the birth rate reached a record high of 19.6 percent (Kozłak, 2012). Fertility rates then showed gradual annual declines

in the late 1950s, somewhat quicker declines through 1964 (considered the last year of the baby boom in the US), and continued gradual declines through to 2005 (when our Polish data collection began; GUS, 2008). It is surprising that the same sort of cohort-related high risk for homelessness would be found in Poland, with its very different economic and political history (especially prior to the fall of communism in 1989). But this appears to be the case. While the factors outlined by Culhane et al. (2013) to explain why this cohort has been at risk in the US generally do not seem to apply in the Polish context, there are other important factors that could explain this cohort risk in Poland, as well as across both the US and Poland.

For sure, Poland has experienced dramatic economic and political changes since the fall of communism in 1989, after widespread strikes in Gdansk and other cities by the Solidarity labor movement. The peaceful transformation that followed allowed Poland to move relatively smoothly from the centrally-controlled communist system to the current democratic and capitalist system. The late baby-boom cohort we identify as at-risk in this study, in their late 40s, 50s and early 60s when our data collection occurred in 2005-06, were mostly in their 30s and 40s during the 1990s (15 years earlier) when the new economic and political order began to develop. These age groups, accustomed to the communist system, perhaps were poorly equipped to compete in the new system. They also were, perhaps, less likely to be willing or able (as compared to younger cohorts) to emigrate to nations with better employment opportunities in Western Europe and North America.³³ Their failure to adapt during the 1990s may have put them at a continuing disadvantage in the job and housing markets and led to heightened risk for homelessness, as was the case (for different reasons) in the same cohort in the US.

But what is common in both the US and Polish contexts that might explain the high risk for homelessness among the late baby-boomers? One such common factor is what we will call a “demographic bottle-neck.” Both in terms of the housing and job markets, we can consider the circumstances facing the late baby boom cohort as especially difficult in both nations. The large numbers of young adults coming of age before them (the early baby-boomers) took most of the available housing (especially at lower rent levels) as well as most of the jobs in the economy (especially unskilled positions), leaving only the “crumbs” for the late baby boomers. Many failed to prosper in this competitive job and housing market and many became homeless as a result. As Culhane et al. (2013) note, it was not necessarily the case that the same individuals experienced

³³ The “brain drain” and general loss of young people wishing to work abroad, especially in Western European nations, has become a serious problem for Polish society in recent decades, especially since Poland entered the European Union in 2004. In fact, along with this intense emigration by Poles, there have been many recent reports on the growing numbers of Poles among the homeless populations in many large cities of Europe, including London and Brussels (Mostowska, 2010).

long-term or repeated homelessness throughout the past few decades. Rather, in both nations, the late baby-boomers, as an at-risk cohort, were more likely to show up in the homeless population at any point in time. Homelessness has been described as a “game of musical chairs” (McChesney, 1990). As Shinn (2007) describes it: “In the game children walk around a set of chairs, with fewer chairs than the number of children, while music plays. When the music stops, the children scramble for chairs, but because there are too few chairs, some are left standing, and are “out” of the game. In the analogy, the players are poor households, and the chairs are the housing units they can afford; if there are fewer affordable units than poor households, some will be left homeless when the music stops. The children who fail to nab chairs are those who move more slowly than others. Similarly, individuals and families who fail to obtain housing, under conditions of scarcity, are those who are most vulnerable, by reason of individual factors or social exclusion” (p. 672). Members of the late baby boom cohort in both nations simply seem much more likely to be “without a chair” (i.e., a home) when the “music stops.”

The differences between the Polish and US samples also included the length of time homeless (in the current episode). This difference was not only statistically significant, but quite substantial, with a majority of the Polish homeless adults (61%) having been homeless for more than three years (the comparable figure for the US sample was 20%). The difference could, of course, reflect the age difference discussed above, because older homeless people in the Polish sample could have more opportunity, due to their age, for longer homeless episodes. However, an ANCOVA on time homeless, controlling for age, found the national difference on time homeless remained statistically significant. Perhaps this difference could be a consequence of the particular difficulties that the Polish late baby boomers had in negotiating the new economic system (as described above). Discussions with some Polish service providers also suggested that permanent public housing often takes years to arrange for many homeless people, especially men who seem “able-bodied,” without an obvious physical or mental disability. Without some form of employment, many of the older men in our Polish sample were forced to wait for long periods of time in hope of locating suitable public housing.

The Polish and US samples differed significantly on the full range of psychiatric diagnoses assessed. The largest such difference involved drug abuse and/or dependence: The US sample had a rate of lifetime diagnosis (58%) that was almost 10 times the rate observed in Poland (6%). This is readily explained by the much easier access to, and probably the lower cost of, illicit drugs in the US as compared to Poland. Especially during the communist period, it was very difficult to obtain most illicit drugs in Poland. In fact, systematic study of the use of psychoactive substances, other than alcohol and tobacco, did not occur until the 1990s (after the fall of communism). However, some sur-

veys in the 1980s asked a few questions about experience with drugs, as part of national research on the patterns of drinking alcohol. These surveys consistently found a general lack of such experiences, with the few who had tried drugs typically having done so during visits abroad (Sierosławski & Zielinski, 1998).

After 1989, the use of illicit drugs has likely increased somewhat due to greater availability and to better standards of living (giving more Poles the discretionary funds necessary to purchase drugs). However, it appears that use still continues to be relatively low compared to other developed nations. For example, a nationwide survey conducted in eight different regions of Poland (Sierosławski, 2011) found that only 14.6% of the respondents had tried cannabis at least once in their lives and only 5.4% admitted to frequent use. The second most prevalent drug used was amphetamine, with 2.5% reporting occasional use (no one admitted use in the 30 days before the survey). Third place belonged to ecstasy which was used regularly by 1.4% of the respondents.

The rate of alcohol abuse and/or dependence also showed a difference (58% in the US vs. 45% in Poland), although the size of this difference was much smaller than for drugs. The lower rate of alcohol abuse/dependence in Poland may be related to the fact that, in the Polish shelters sampled, alcohol and inebriation from alcohol consumption were consistently prohibited: If a homeless person was carrying alcohol, it would be confiscated; if drunk, he/she would typically be denied entry into the shelter. In the US such policies are also prevalent, but less consistently so (particularly in soup kitchens). Especially given the long-term stays seen in the Polish shelters sampled in this study, we could expect, over time, less reporting of symptoms of alcohol abuse and dependence in shelters in the context of such firm prohibition. The prohibition seen in the Polish shelters could also explain why our Polish sample showed somewhat lower rates of alcoholism compared to a few other existing studies on homeless adults done in Poland. For example, one study of 40 homeless adults found that, based on clinical interviews by psychiatrists, 60% were alcohol addicted (Sidorowicz, Sanecka, Ślepecka, & Ruciński, 1989).

The Polish and US samples differed significantly on two major psychiatric diagnoses assessing severe forms of mental illness. The US sample had higher rates of both affective disorders (30% vs. 16% in Poland; mostly severe depression in both nations) and schizophrenic disorders (11% vs. 4% in Poland). These differences could be due to the fact that Poland has a national health system that provides basic services for all citizens, including psychiatric care. In the region studied, as elsewhere in Poland, there are several public mental hospitals and many out-patient clinics that serve all citizens, free of charge. On the contrary, in the US mental health services can be difficult to access, especially for poor people without an employer-supported health insurance plan and not enrolled in Medicaid. Because of the lack of access to traditional mental health care, shelters

(and jails) in the US have often become overwhelmed with persons having mental health problems (Daniel, 2007; Koegel, Sullivan, Burnam, Morton, & Wenzel, 1999).

The two samples also differed on many other variables. The US respondents reported significantly more frequent contact with family members and their support networks. While this might seem to be, at least in part, due to the fact that the Polish sample was older and had been homeless for longer, these findings remained significant after statistically controlling for age and time homeless in (M)ANCOVAs. Perhaps there is greater stigma toward homeless people in Poland and, as a result, they are more ashamed of their circumstances. As a result, family and others may avoid contact with the homeless person and the homeless person may similarly avoid social contact. There is some evidence suggesting difficult emotional bonds in the family of origin among homeless people in Poland. Piekut-Brodzka (2003) conducted interviews with 318 homeless people in three large Polish cities (Warsaw, Krakow and Gdansk) in 1997-1999. The study focused on the conditions prevailing in the family of origin of the currently homeless. Almost 80% of the respondents indicated an unfavorable atmosphere in the home of their family of origin. A lack of warm emotional relationships with children was reported by 22%; 20% reported fights, quarrels, and direct threats; 17% indicated an atmosphere of tension and mistrust; and 12% emphasized depressed mood, sadness, and resignation in relation to their families.

However, the Polish respondents reported significantly higher scores on the ISEL tangible support subscale. Perhaps, even despite the stigma that may often operate, Polish people are more charitable in providing basic help to homeless people than US citizens. The vast majority of Poles are Catholics, who have a strong tradition of obligation to help the poor and otherwise disadvantaged. Giving money to homeless beggars on the streets in Poland is a very common practice, as is giving donations to various humanitarian campaigns (especially around the holidays). Supporting this view, a recent nine-nation study involving large random national samples of people called by telephone about their attitudes toward homelessness found that Polish respondents ($N=302$) were more likely than US respondents ($N=462$) to report giving money to homeless panhandlers (57% reporting sometimes or almost always giving in Poland vs. 39% in the US; Toro, Bokszczanin, & Ornelas, 2008).

In aggregate, the differences observed between the characteristics and circumstances of homeless adults in Poland versus the US do not present a consistent pattern suggesting that the experience of homelessness is “worse” in one nation or the other. In the US, homeless adults more often showed a wide range of psychiatric diagnoses, including severe mental and substance abuse disorders, they may have less access to mental health care, and they reported more stressful events and risky sexual behavior and less tangible social support. On the other hand, in Poland, homeless adults are older, experienced longer episodes of

homelessness, had less contact with family and supportive network members, and reported less satisfaction after they seek help from supporters. Certainly, despite these differences, the experience of homelessness is unpleasant, stressful, and often traumatic for people in both nations.

This study had a number of limitations. First, all data were based on self-report from a single interview. Future research would do well to include other data sources. For example, given the social network differences observed here, it could be useful to have the perspective of family members or other important people in the homeless person’s life. Why don’t they offer housing or other assistance to their homeless family or friend? Are resources or attitudes different among family members of homeless people across the nations? A second limitation is that only one specific city was studied in the US and two cities in the same region in Poland. While it is possible that there are city and regional differences within each nation, some studies from the US, at least, suggest more similarities than differences in homeless populations across cities, given the use of similar methodologies (e.g., Toro et al., 1999). Third, only homeless adults were included. Although, in both samples, there were a number of cases of children homeless along with their parents, data were not collected on the children. Finally, the Polish sample was collected about four years later than the US sample. While we don’t believe there were any major political, economic, or social changes in the two nations during these four years (roughly 2001-2005), there could be some changes that may, at least in part, account for the differences observed.

The study also had many strengths. It used careful probability sampling methods, comparable across nations, to obtain representative samples of homeless adults. This allowed some confidence that the characteristics and circumstances experienced by the research participants can be trusted as truly reflecting the reality of life for homeless people across the cities in the two nations. The study also represents the first study to compare the situation of homeless people in an Eastern European nation (Poland) to another nation (the US). Finally, the study assessed a wide array of life domains based on measures with established reliability and validity for use in homeless populations.

In summary, the present study compared the characteristics of homeless adults across two nations, the US and Poland, and found many national differences. Substance abuse and serious mental disorders were more common in the US, perhaps due to less readily available health, mental health, and other social services. Recent health care reforms, such as the Affordable Care Act, may improve this situation in the US. However, as Culhane et al. (2013) note, the health care system in the US is likely to experience some serious stresses due to the aging of the homeless population in the coming decades.

Perhaps just as interesting as the differences, the study also found some striking similarities in the characteristics and contexts of homeless people across these two nations with very difference political, social, and economic histo-

ries. In particular, our findings suggest a high risk for homelessness among people born around the end of the post-war baby boom in both nations. This age cohort seems to have experienced tremendous obstacles in Poland, leading to large numbers with very long-term homelessness in that nation. Poland should also, perhaps, brace for serious challenges in its health care system in the coming decade as this cohort ages.

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