Homeless Women and Health Care in an Urban Setting: Portland, Oregon

by

Amy Pujanauski

A Thesis

Presented to

Oregon Health Sciences University

School of Nursing

in partial fulfillment

of the requirements for the degree of

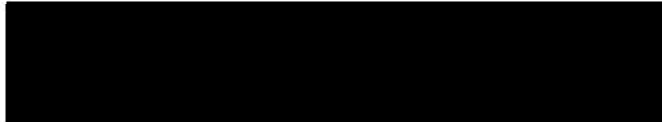
Master of Science

June, 1989

Running head: Homeless Women

APPROVED:

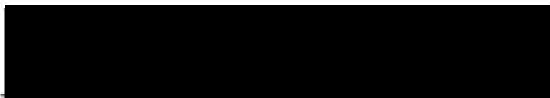
Mary Ann Curry, R.N., D.N.Sc., Thesis Advisor



Barbara Limandri, R.N., D.N.Sc., First Reader

Donna Jenson, R.N., Ph.D., Second Reader

Sheryl T. Boyd, R.N., Ph.D., Assoc. Dean for Grad. Studies



Carol A. Lindeman, R.N., Ph.D., Dean, School of Nursing

This study was supported in part by
Federal Nurse Traineeship Grants

2 A 11 NU 00250-12
2 A 11 NU 00240-13

Acknowledgements

I would like to thank the people at the West Women's Hotel, Sisters of the Road Cafe, and Baloney Joe's, staff and clients, whose cooperation made this project possible.

I would like to acknowledge the valuable contributions made by my committee, for sharing their knowledge, ideas, enthusiasm, and time for multiple readings of my work through its various stages. I would like to thank Mary Ann Curry for her professional and personal availability, and for her inspiration, guidance and ability to see a broad picture and offer an organizational structure to my work. I would also like to thank Barbara Limandri for her critical reading, and expertise in mental health and management of qualitative data. And thanks to Donna Jensen for her support and community health perspective.

TABLE OF CONTENTS

CHAPTER		PAGE
I	Introduction	2
	Review of the Literature	5-29
	Precipitants of Homelessness	5-8
	Mixed Sample Studies	8-20
	Studies on Homeless Women	21-26
	Portland Data	27-29
	Conceptual Framework	30-32
	Research Questions	32
II	Methods	33-35
	Design	33
	Sample and Setting	33-34
	Data Collection Methods	34-35
	Instrument	35-36
	Procedures	36-38
	Analysis	38
III	Results and Discussion	39-90
	Sample Characteristics	39-47
	Research Question One	47-77
	Nutrition	48-50
	Physical Health Status and Needs	51-59
	Mental Health Status and Needs	60-77
	Research Question Two	77-83
	Access to Health Care	77-78
	Interpersonal Aspects of Care	78-81
	Continuity of Care	81-82
	Source of Care	82-83
	Additional Findings	83-90
	Daily Unmet Needs	83-86
	Children	86-88
	Safety	88-90
IV	Summary, Limitations, and Implications	91-98
	Summary	91-93
	Limitations	93-95
	Implications for Research	95-97
	Implications for Practice	97-98
	Appendices	99-116
	Appendix II (Interview Schedule)	100-113
	Appendix II (Consent Form)	115-116
	References	117-118
	Abstract	119-121

LIST OF TABLES

TABLE		PAGE
1	Marital Status	40
2	History of Homelessness	42
3	Precipitants of Homelessness	43
4	Potential Interventions in Homelessness	46
5	Meal Location and Frequency	49
6	Reproductive Health Experience	59
7	Depression Attribution	63
8	Counseling Issues	71
9	Problems Accessing Health Care	79
10	Custody Status of Dependent Children	87

CHAPTER I

Introduction

Homelessness is a social condition with serious health consequences. It is a state of vulnerability wherein the homeless are exposed to and demonstrate conditions similar to the general population that are exacerbated by additional risk factors unique to their lifestyle. They have been found to have higher incidences of morbidity than domiciled people on almost every health indicator except cancer, obesity and stroke (Wright, 1987). Sebastian (1985) emphasized that the stresses of homelessness make people more vulnerable to exacerabation of chronic mental health problems, substance abuse, loneliness, depression, fear, and low self-esteem.

There are at least one-half million homeless people in the United States (United States Department of Housing and Urban Development, 1984 in Wright et al, 1985). Other estimates range between one to four million (Cuomo, 1986, and United States Department of Health Services in Wright et al., 1987). Much has been written about the health of homeless men as they have been a significant population for many years. Less is known about the emerging and more vulnerable population of homeless women whose health status, needs and experiences are different than those of men. Physical care needs include preventative reproductive health care as well as perinatal care. Some data suggest a

higher incidence of mental health problems in women than men (Wright, 1987). Domestic violence, sexual assault, and substance abuse are also significant mental health issues of homeless women (Brickner, Scharer, Conanan, Elvy, and Savarese, 1985).

The purpose of this study was to explore the health status and practices, and health care needs and experiences of homeless women in Portland, Oregon. Circumstances precipitating homelessness in their lives were also described.

Historically, homeless women were assumed to be an isolated insignificant population who were primarily alcoholic or mentally ill. Several authors have described the new homeless as a heterogeneous group who have become homeless primarily due to family confict and/or economic crisis. Slavinsky and Cousins' (1982) review of the literature countered prevalent beliefs that there were few homeless women, that most were alcoholics, and that they had no contact with the health care system. Homeless women described in that review were primarily the deinstitutionalized or uninstitutionalized mentally ill.

Based on a later analysis, Stoner (1984) described a more heterogeneous population. She added domestic violence as a significant precipitating factor and alcohol as a coping mechanism. She noted the specific vulnerabilities

of homeless women to crime, sexual assault, and other elements of life on the streets as well as some becoming dependent upon panhandling, drug dealing, shoplifting and prostitution for survival. Stoner (1984) described homeless women as victims of the economy, of landlords, of a depleted mental health system, and of their partners. She related this to the feminization of poverty and family breakdown resulting from divorce, desertion, and abuse leading to mortgage foreclosures or evictions. Stoner (1984) stressed that these women have not chosen their circumstances but are victims of forces over which they have lost control.

Most recently, Roth, Toomey & First (1987) emphasized that much research had focused on homeless women who are alcoholic, mentally ill, or who have been battered. These authors noted that there is little information on homeless women without these characteristics but who, lacking a support system and job skills in the face of family conflict and financial crisis, have no place to go.

Many of the physical and mental health issues of homeless women though relevant to nursing practice have not been a specific focus of research and need to be described (Sullivan & Damrosch in Bingham, Green, & White, 1987). Health care providers for low income women need more information about the health status, needs and experiences

of homeless women. Only then can the quality and specificity of care be improved and changes made in health care policy and delivery systems.

Review of the Literature

Homelessness has not been consistently defined in the literature. Most usually it has meant anyone without a permanent address including people living in temporary housing like shelters or short-stay hotels as well as those actually living on the street. Women, especially those with children, have tended to use shelters and hotels. Thus, a broad definition of homelessness is used in this review which includes both women who are temporarily sheltered and those living on the street.

The first group of studies addresses factors precipitating homelessness. Because so little has been written specifically about homeless women, the second group includes studies of both men and women that analyzed physical and mental health findings by gender. The third area of literature describes problems unique to homeless women. Because the target population is Portland's homeless, local studies and background information conclude the review.

Precipitants of Homelessness

A 1981 survey of 27 Baltimore social services organizations working with the homeless cited the primary

reasons for homelessness among women as family dysfunction, deinstitutionalization and psychological disorder, and eviction (Walsh & Davenport, 1981). Responses were solicited via mailed questionnaires to key informants in the social services system. Although homelessness had commonly been attributed to mental illness and deinstitutionalization, those responding to the questionnaire indicated family dysfunction as the most prevalent cause, which subsequently received some support in the literature (Bassuk, Rubin & Lauriat, 1986; Crystal, 1984; Roth et al., 1987).

Crystal (1984), and Sullivan and Damrosch (in Bingham et al., 1987), reviewed the literature describing causes of homelessness among women. Crystal (1984) reported that the most prevalent type of homelessness was situational and caused by economic problems. The leading causes according to Sullivan and Damrosch (in Bingham et al., 1987) included deinstitutionalization and mental illness; no-fault divorce, unemployment and difficult economic circumstances; and family violence.

Massachusetts psychiatrists used a single, semi-structured clinical interview and a structured questionnaire, the modified Social Support Network Inventory, to assess the mental health status and social and psychological factors contributing to homelessness of

80 homeless women with their families in shelter care (Bassuk et al. 1986). While the authors were denied access to one-third of Massachusetts' shelters, they suggested that those they had accessed were representative of all Massachusetts' shelters. Based on their assessments homelessness was attributed to family breakdown amidst difficult economic circumstances, subsistence living, psychological deprivation, and impoverished self-esteem.

Thirty-one homeless alcoholic women on Skid Row in New York were compared to 151 women receiving treatment for alcoholism in a study that explored whether these women were homeless because of their alcoholism, or because of lifelong patterns of marginal existence (Corrigan & Anderson, 1984). The homeless women were characterized as having experienced a transient, downward social course precipitated by a specific loss. In comparison to the women in treatment, they lacked both emotional and social resources, had less formal education and occupational skills, and were less likely to come from intact families. Based on this sample of homeless alcoholic women, the researchers concluded that, if their study was a representative sample, homeless alcoholic women are not a homogenous group with a life-long pattern of marginality.

In an Ohio survey of 979 homeless people in 19

counties across the state, 186 women were personally interviewed by a team of university researchers (Roth et al., 1987). All interviewers were college educated, most had social science training, and all were extensively trained in interviewing and administration of the psychiatric assessment tool. The interview schedule assessed mobility, reasons for homelessness, prior work history, current work and sources of income, use of social services, psychiatric hospitalizations, social support, physical and mental health, substance abuse problems, general well-being and demographics. The direct questions in the structured schedule standardized as much as possible interactions between multiple interviewers and subjects. Family conflict, and economic factors including unemployment, problems paying rent, eviction or termination of benefits, were cited equally (40%) as the women's major reasons for homelessness. Only 18% of men cited family problems as their reason for homelessness, though an equal percentage (40%) related it to economics.

Mixed Sample Studies

Common health problems of homeless people were described in an edited text of primarily descriptive data based on authors' personal experiences and local surveys (Brickner et al., 1985). Health problems included lice and scabies, thermoregulatory disorders, trauma, inadequate

nutrition, tuberculosis, peripheral vascular disorders (especially varicose veins in women), alcoholism, and mental health problems. Limited access to health care due to delivery system barriers, such as documentation of permanent residence along with attitudes of providers towards the homeless and their special needs, were also cited as major problems.

The Johnson-Pew Memorial Trust allocated $25 million to fund health care projects for the homeless in 19 cities (Wright, 1987). A preliminary report describing the programs summarized initial data from 80,000 contacts with 30,000 people in 15 cities between March 1986 and June, 1987. Health information from contact forms completed at the study sites were later coded by nurses at the research center using a modified version of the International Classification of Diseases. Data collection methods were otherwise not described.

Twenty-six percent of the clients were women, and one in four had a child or children in her care. Forty-two percent of the women were between the ages of 16 and 29. The document reported some gender differences in morbidity that were largely attributed to men's higher incidence of alcoholism (48% vs 16% for women). As compared to men, women had less tuberculosis, hypertension and trauma, and more nutritional disorders including deficiencies, obesity,

anemia. They also had more endocrinological disorders, diabetes and genito-urinary disorders. Although Wright (1987) described the women as having higher rates of mental illness (40% vs 20%), these incidences were based upon practitioners' judgments while seeing clients for physical complaints and not mental health clinicians' diagnostic assessments. Mental illness suggests a severity of disease and dysfunction where mental health problem might be more appropriate.

Over 11% of the women seen were pregnant. Wright (1987) suggested this was a high incidence based upon the nation's birth rate of 3%. If the national pregnancy rate is considered to be twice the birth rate, almost certainly a high estimate, these women's pregnancy rate is twice the national average. The youngest age cohort, 16 to 19 year olds, had the highest pregnancy rate--25%. The next highest were the 20 to 24 year olds, with an incidence of 20%, which declined to just over 10% for 25 to 29 year olds and less with increasing age. If this high incidence of pregnancy were due to promiscuity, the expected incidence of sexually transmitted diseases would also be increased, however, this was not shown by the data in Wright's study. It is also possible that data based upon one contact is not adequate to estimate the true incidence of sexually transmitted diseases, unless they were the reason for which

care was sought. Rape, prostitution and incest might also be considered possible causes of pregnancy in this vulnerable population, although data were not collected to suggest such a relationship.

This document was not a complete research report but a preliminary description of findings. As such it was the best data available on the largest probability sample of homeless people. The data on physical health problems were presumably objective, based upon physical examinations and lab tests, and therefore fairly reliable. The reported incidences of alcoholism and mental illness were based more upon the subjective judgement of the practitioner and self-report of the client than diagnostic tools with established validity and reliability. Assuming that some women withheld information and that accuracy of practitioners' judgements varied, it is unlikely that the reported incidences were accurate

This report lacked a variety of information that would have offered more complete description and opportunity for comparison with other studies. Background demographics on education and patterns and factors precipitating homelessness, and data on women's experience with domestic violence and sexual assault would have strengthened the study.

The following authors' data supports descriptions

provided by Brickner (et al., 1985) and is consistent with some of the findings of Wright (1987). Wright et al. (1987) reviewed charts of 6235 New York homeless people attending clinics sponsored by St. Vincent's Hospital to compare their incidences of morbidity to epidemiological data from the 1979 National Ambulatory Medical Care Survey (NAMCS). Wright's (et al., 1987) methods selected for men attending shelters' clinics. The National Ambulatory Medical Care Survey was based on a nationwide probability sample of over 7000 patients in 3000 physicians' practices seen during one week in 1979. The NAMCS data was compiled from questionnaires that solicited social and background information, as well as an account of clients' principal health problems. Because the NAMCS sample was different from the study sample in regard to age, race and sex, the authors weighted the NAMCS sample and presented both weighted and unweighted results for comparison. The authors were not specific about other differences between the NAMCS and their sample, and invited requests for more information on the weighting procedures.

Health problems found two to three times as often in homeless people as in the weighted NAMCS sample included infectious and parasitic diseases, venereal diseases, blood diseases, eye and ear diseases, gastrointestinal disorders, skin ailments, and trauma. Heart disease and hypertension

were 30 to 60 percent higher. The estimated minimal incidence of alcoholism in the homeless sample was 30%, and was the suggested precursor to many of the above listed health conditions.

Wright's (et al., 1987) design may have contributed to their finding a higher incidence of sexually transmitted diseases than Wright (1987). Their data were not necessarily based on one contact, and allowed for some retrospective data collection. Patients' three main problems were entered on the data collection tool. The authors noted that in the NAMCS sample frequently only one problem was listed. The number of multiple contacts per patient and length of patient follow up in both Wright's (et al., 1987) and Wright's (1987) are unknown. It is possible that diagnoses in Wright's (1987) data were limited by fewer contacts per patient.

Wright (et al., 1987) surveyed 810 women who comprised 13% of their total sample. Half were white, 38% black and 9% hispanic; their mean age was 48.3. The overrepresentation of both older women and those of ethnic minorities make this sample neither representative of homeless women in general nor of those living in New York. Though the sample size is large, results can only be generalized to a population of similar composition. Their morbidity as compared to the men showed that the women had

a higher incidence of hypertension, endocrinological disorders and diabetes. Older white women had neoplasms three times more frequently than any other group. The minimum incidence of mental health disorders in all the women sampled was estimated at 34%, while for the younger white women it was over 50%.

A high incidence of pregnancy was not a problem for these women because of age. The authors did not specify different incidences of alcoholism for men and women as has been suggested by other data (Wright, 1987). The incidence of mental health disorders is consistent with other studies in that it is high and higher than found in the men sampled (Robertson, Ropers, & Boyer, 1985; Wright, 1987). As in the other studies, these incidences are only estimates based upon primary care practioners' subjective judgements rather than mental health professionals' clinical diagnoses. The authors suggested, however, that their error had more likely been in underreporting. They also acknowledged their lack of attention to social factors, and did not have data to describe these women's experience with precipitating factors, such as domestic violence and sexual assault.

Roth (et al., 1987) compared characteristics of the 793 men and 186 women in their sample. Subjects were accessed in a variety of homeless conditions including

shelters, hotels, the street and other short-stay arrangements. As compared to homeless men, the women were both younger (median age 28 vs. 35) and less educated (62% vs. 53% were high school dropouts). Nearly 40% of the women stated they had a problem needing medical attention. Eight women were pregnant. Nearly half the women reported taking medication or drugs, 82% of whom said the substance had been prescribed. The researchers reported that the women had substantially higher incidences of both physical health and substance abuse problems than did the men. Based upon a single interview using the Psychiatric Status Schedule, a tool commonly used in psychiatric epidemiological research, 35% of both the men and women were psychiatrically impaired. Only 10% of the women were judged to be alcoholic, which the authors stated was much lower than that for men in the sample.

The authors suggested that one-third to one-half of homeless women could potentially support themselves and live independently. They recommended interventions focused on increasing the women's economic independence through job training and education, and counseling directed toward resolving family conflict.

Robertson (et al., 1985) described the Basic Shelter Research Project of the UCLA School of Public Health. A convenience sample of 238 homeless adults one quarter of

whom were female were personally interviewed by one of a team of 24 trained interviewers using a structured interview tool. Six shelter or meal sites in the two areas with the most concentrated populations of homeless persons in Los Angeles County were used. The authors discussed the bias in their sample as being toward sheltered people in central Los Angeles, while at least half of Los Angeles' homeless live in other areas and many do not use shelters.

The Basic Shelter Index (BSI) tool used in the study was adapted from a variety of sources and extensively pretested and revised. It was read to subjects and covered the following areas: demographics, welfare status and utilization, economic and employment history and status, physical and mental health status and care utilization, drug and alcohol use and abuse, criminal history and status, and crime victimization. The BSI's reliability was found to be 92% when data obtained from it were compared with intake forms at one of the shelters. Areas of disagreement were related to arrest records and psychiatric hospitalizations indicating clients had wanted to give intake workers more socially desirable responses.

The majority of the 55 women interviewed were white with Blacks, Hispanics and Native Americans disproportionately represented. One third of the women had been victims of crime in the last 6 months, mostly robbery

or assault, with one sexual assault. Two of 24 women's homelessness was precipitated by domestic violence.

The results are not generalizable due to the small nonrepresentative sample although the women's health status and access problems are consistent with other descriptive studies. Missing physical and mental health data led to some inconclusive findings. Although 36 of the 55 women were under 40 years old, the interviews did not address reproductive health needs. Over half the women had had an acute illness or injury within the past two months. Almost half described their health as only fair to poor with two-thirds having chronic health problems, most commonly high blood pressure, asthma or arthritis.

Fifteen of the 45 women responding said that their health prevented employment. Lack of money and transportation were cited as main obstacles to care with none of the sample reporting a usual source of medical care.

More women than men reported feelings of depression, suicide attempts, untreated mental health problems, and psychiatric hospitalizations. Out of a subset of 26 women who were sampled concerning depression, 13 were assessed as depressed. Their depression was mostly attributed to separation from family, a death in their family or of a friend, or other reasons. Six women (13.3%) had attempted

suicide in the past 12 months. Ten (28.8%) reported having a mental health problem which has not been treated, and 15 of the 55 (27.3%) had been hospitalized for a mental health condition--six within the last year.

No significant differences were found between genders in substance use and treatment history. One quarter reported having sought counseling for alcohol or drug problems. Subjects were not questioned regarding current use patterns, which did not allow for inferences about dependency and addiction.

Crystal (1984) described the growing population of homeless women and how they differed significantly from homeless men on marital status, presence of and relationships with children, and psychiatric history. He based his conclusions on psychosocial assessments of 1800 women newly admitted to the New York shelter system (compared to 6000 men) as well as 213 in-depth interviews with homeless women. He described women as being more likely than men to be or have been married, more likely to have a psychiatric problem (especially women in their 30s and 40s), more likely to have grown up in an institutional or foster care setting, less likely to have been incarcerated, and more likely to have never been employed. Most had at least one child who was likely to be in foster care. These women often attempted to maintain a

parental relationship. He recommended that services address these women's needs and concerns regarding their children.

Lenehan, McInnis, O'Donnell and Hennessey (1985) described the 15 year history of a clinic located at a Boston shelter for the homeless. The shelter housed 110 to 120 men and 35 women nightly. According to the authors, many of those served by the shelter considered its clinic their primary source of health care. The authors estimated that 50% of the men were alcoholic compared to 5% of the women, 40% of the men vs. 90% of the women were mentally ill, and 70% of the men and 60% of the women were physically ill. Their rough estimates were consistent with Wright's (1987) generalization that homeless women have more mental health problems, and men have more problems with alcoholism though neither estimates were reported to be based upon clinical diagnoses and were more likely subjective observations.

<u>Summary</u>

The literature suggests that homelessness in women is generally precipitated by family dysfunction and economic problems. Domestic violence was a commonly cited precursor. The interplay of the preceding factors with drug and alcohol abuse was not specifically addressed.

The lifestyle of homelessness increases women's

vulnerability to a variety of physical and mental health problems, as well as exacerbating preexisting conditions. Exposure to the elements, being on their feet, and the lack of opportunities to maintain personal hygiene put them at risk for hypothermia, varicose veins, inadequate nutrition and dermatologic problems. Homeless women have been found to have higher incidences than both homeless men and domiciled people of several conditions including nutritional, endocrinological, and genito-urinary disorders. Many women reported health problems for which they were not receiving care and having problems accessing care.

The incidence of mental health problems are reportedly higher among homeless women than men. Depression and recurrence of chronic mental health problems are common. Alcoholism is likely higher among both homeless women and men than the general population, and considered to be higher in men. The incidences of both drug and alcohol abuse and mental health problems were based largely upon subjective judgements from a single encounter rather than clinical assessments. The use of mental health terminology, such as mental health problems, psychiatric disorder, and mental illness was inconsistent, usually undefined and may have been inappropriate.

Studies/Problems Unique to Women

Women are especially vulnerable to assault. Kelly (in Brickner, et al., 1985) cited San Francisco's Sexual Trauma Service records' review to describe the incidence of sexual assault among the homeless. It was 20 times that of the rest of the population. Seventy-six percent of the victims were women, although women comprise only 22% of San Francisco's homeless.

Appropriate nutrition during pregnancy is also a sex specific problem (Winick in Brickner, et al. 1985). Winick noticed the number of pregnant women at a shelter, leading him to emphasize the importance of vitamin and mineral supplements for this population, and eating foods rich in calcium and iron. Winick went as far as recommending hospitalization of these women during pregnancy to insure adequate nutrition.

In a qualitative study, Strasser (1979) observed homeless women at a men's shelter that also offered meals and services to women. The author recorded observations twice daily on 34 of the 56 women using the shelter during the six week study period. The women's ages ranged from 15 to 78, with the majority (28) being over 40. Twenty-seven were white and seven were black. Strasser (1979) assisted with greeting women at the door, served meals, waited in line, responded to requests, and listened to interactions.

She described in detail the physical appearances of these women as well as personal hygiene, daily schedules, ethnicity, health conditions, and their perceptions of their health and health care providers.

Strasser (1979) recommended that health care providers assess these clients' perceptions of providers, and be aware of their present health practices and beliefs and tendency toward inappropriate compliance with official directives. She described the women's strenuous daily existence beginning very early in the morning after a night of intermittent sleep, and both the difficulty they have with and the importance they placed upon maintaining personal hygiene. Strasser (1979) suggested that contrary to beliefs at that time, these women were predominantly nonalcoholic, although nutritional aberrations, as well as multiple and severe health problems, were prevalent. They feared men as well as dependence, and expressed a strong desire for autonomy.

Sullivan & Damrosch (in Bingham et al., 1987) cited their own research in presenting profiles of homeless women from a residential rehabilitation program. Data were presented on the first 105 women (mean age 28.4) admitted to the program during its first three years. One third of these women reported being pregnant at least once while homeless. Nearly all rated their health as good (65%) or

fair (31%). Almost half acknowledged having received psychiatric care. Twenty-four percent admitted alcohol dependence; staff estimated the incidence of substance abuse problems among these women at 50%.

Chavkin, Kristal, Seabron and Guigli (1987) attempted to establish a relationship between the stressful circumstances of living in a hotel for the homeless with an increased incidence of low birth weight. They controlled for numbers of prenatal care visits as well as other factors known to influence birth weight to see if the women in the homeless hotel group still had a higher incidence of low birth weight babies. Such findings would illustrate the effects of the stressful circumstances of these women's lives on reproductive outcome. This is the first/only study attempting such a correlation with homeless women.

The authors compared birth certificate information of 401 children born to mothers living in New York's hotels for the homeless to 13,247 women living in low-income housing projects, and all other New York City residents (241,548) between January, 1982 and June, 1984. Women living in shelters and housing projects were predominantly Black (two-thirds) or Hispanic (one-quarter) and under age 25 (50%). The highest proportion of births were to teenagers in the projects' group (30%). Women from the city-wide group were more evenly distributed among ethnic

groups, and the highest proportion of their births (30%) were to women over 30.

The women in the hotel group received significantly less prenatal care. More than half received between zero and three visits compared to 22% of the project mothers, and 15% of the city-wide group. Sixty-eight percent of the city group had seven or more visits whereas only 30% of the hotel mothers received this level of care. Mean birth weights of the hotel group were 149 grams lower than the project group, and 276 grams less than the city-wide group.

When multiple regression analysis was used to control for numbers of prenatal care visits, birth weights in the hotel group were still 125 grams less than the city-wide group. Controlling for other influencing factors continued to show lower birth weights in the hotel infants. When controlling for race, hotel infants' birth weights averaged 49 grams less than projects' infants and 181 grams less than the city infants. When controlling for age and infant sex, hotel infants weighed 98 grams and 233 grams less than the two other groups, and when controlling for parity, 49 grams and 182 grams less.

Both the incidence of low birth weight ($\leq$2500g) and the infant mortality rate were twice as high in hotel infants as in city-wide infants. The incidence of low birth weight was 16% in the hotel group, 11.4 in the project group, and 7.4% in the city-wide group. The infant

mortality rate was 24.9 for the children of hotel mothers, 16.6 for the project infants, and 12.0 in the city-wide group. Multiple regression analysis similar to that used with birthweight would have been useful with this data as well.

This study illustrates the need for further attention to the reproductive health experience of homeless women. Birth weights were lower and infant mortality higher for homeless sheltered women when compared to housing project women also experiencing stressful socioeconomic circumstances. This data and the multiple regression analysis suggest a relationship between these women's stressful lifestyles and birth outcome. While the reliability of birth certificate information is questionable, it is the best source of data available. The number of births to women who had been homeless and lived in a shelter for some time during their pregnancies was also likely much higher, but could not be traced via birth certificates.

Massachusetts mental health professionals interviewed 80 homeless women and their families in shelter care and determined that only nine of the mothers did not have mental health problems (Bassuk et al., 1986). The women's median age was 27 with 40% having less than high school educations. Based upon a single interview and questionnaire, 71% were labeled with Axis II diagnoses, or

personality disorders. The authors also described the women's histories of employment, incarceration, relationships, health/mental health status, early family disruptions and income maintenance/housing history.

The women had poor or absent social support, unstable employment histories, and had been on welfare longer than two years. They had moved frequently and most often they were from disrupted families including unknown fathers, divorce, death, mental illness, alcoholism, and abuse.

Summary

Health care problems of homeless people in general have been described, although reproductive and other health care needs of women have not been specifically addressed. Much of the limited research on homeless women is based on small convenience samples from large metropolitan areas. The Johnson-Pew data are beginning to fill the gaps related to health status, although it lacks depth in psychosocial characteristics. Mental health and substance abuse are consistently cited as problems in this population, although accurate assessment of their incidence and significance has not been possible. Domestic violence, family conflict and breakdown, and economic dependence have all been supported as factors contributing to women's homelessness as well as areas appropriate for intervention.

<u>Portland Data</u>

According to a report describing the shelter needs of Portland's homeless, there were at least 960 individual women, 190 women in couples and 4750 people in families, homeless and requiring shelter between July of 1985 and June of 1986 (Shelter Advisory Committee, 1986). These estimates were based on completed emergency shelter vouchers submitted to Multnomah County's Shelter Advisory Committee. Assuming that not all homeless women requested shelter, these estimates are minimal numbers. The vouchers also specified reasons for homelessness, although they did not distinguish between men and women.

Among reasons for homelessness, the following were the most common. Unemployment was stated as the main reason (32%), alcohol and drug problems were second (20%), domestic violence third (18%) and chronic mental illness fourth (6%).

The Wallace Medical Concern, a volunteer agency in Portland born of the urban poor's identified need for access to care, provided clinical services and house calls to single-room occupancy and short-stay hotels and shelters over a period of 18 months (Reuler, Bax & Sampson, 1986). Their analysis of the 1,184 recorded visits neither distinguished between the needs of men and women nor mentioned reproductive care. For the 76 women and 500 men

under 45 years old comprising the majority of the sample, reasons for seeking care were primarily dermatologic, respiratory, or gastrointestinal.

One hundred and ninety homeless women in Portland were surveyed by 18 trained Portland State University social work graduate students using a structured interview schedule (Multnomah County, 1984). The tool had been previously used with homeless people in Phoenix, Arizona. It had been pretested and revised for local use. In addition to demographics the tool covered residency/shelter history, income/employment history, physical and mental health, law violations, physical/sexual abuse, relationships and needs. Interviews averaged 40 minutes and took place in a variety of settings including hotels, meal sites, clinics, the welfare office, shelters and the street.

The average age of the sample was 32 with two-thirds under 36. The representativeness of the sample is unknown. Sixty percent described their health as being fair to poor, with reproductive problems being one of the three most commonly cited, the others being vision and mental health. One-third stated that they had had difficulty accessing health care, and nearly half had had difficulty accessing dental care. Most (59%) had also received counseling at some time in their lives. The interviewers suggested that

10% of the women had chronic mental illnesses although this was a personal subjective judgement and not based on a clinically diagnostic assessment.

In response to questions exploring alcohol use, 42% of the women stated that they did not drink at all. Fifteen percent reported they were recovering alcoholics, 12% said that they had over six drinks a day, and 10% had less than five drinks per day (Multnomah County, 1984).

Over two-thirds of the women reported having been physically abused at some time in their lives, 19% as children, 36% as adults, 14% both. Almost half the women had been sexually abused at some time in their lives, one-fourth as children, 12% as adults and 6% both. The women in this sample who had been sexually abused as children were more likely to have attempted suicide (statistics not included). Nearly half of the women who had histories of psychiatric hospitalization had been physically abused. One-third of the women stated that they were now homeless because they had left an abusive relationship.

The major factors identified in the literature regarding causes of homelessness and the health needs of homeless women will be summarized in the conceptual framework.

Conceptual Framework

Homelessness among women is generally attributed to poverty; unemployment; decreased social services; insufficient low income housing; and family breakdown including crisis, battering or eviction (Multnomah County, 1984; Stoner, 1984; Walsh & Davenport, 1981; Roth, et al., 1987; Crystal, 1984). The emerging body of research suggests that homeless women have significant physical and mental health problems as well as difficulty accessing services (Bassuk et al., 1984; Brickner et al., 1985; Wright, 1987;) When compared to the domiciled population, homeless people have been shown to exhibit substantially higher incidences of many physical and mental health problems (Wright, et al., 1987). The physical health hazards of the homeless lifestyle include lack of consistent shelter, poor nutrition, difficulty maintaining personal hygiene, exposure to weather and the street environment, communal sleeping and bathing when shelters are used, and limited access to health care.

Homeless women have been shown to be more vulnerable than both homeless men and other people to a variety of physical health problems. Nutritional deficiences, varicosities, endocrinological and genital-urinary problems and neoplasms have all been described (Brickner, et al.; Wright, 1987; Wright et al, 1987).) Their lifestyles also

put them at risk for assault from which they may suffer traumatic injuries, stress or rape (Kelly in Brickner et al., 1985). Initial research suggests that homeless women are also likely to have been abused by their partners or other family members (Multnomah County, 1984).

Mental health problems common to homeless women include chronic illness, depression, anxiety, low self-esteem and others associated with stress (Sebastian, 1985; Bassuk, et al., 1986; Multnomah County, 1984). Although homelessness does not cause chronic mental illness it may contribute to or precipitate its recurrence or exacerbation.

Substance abuse and alcoholism among homeless women is difficult to estimate and has probably been underreported (Wright, 1987; Wright et al., 1987; Sullivan and Damrosch in Bingham et al., 19875). Whether coping mechanisms or addictions they are significant and likely concealed problems.

The reproductive health of this population is just beginning to be reported. Along with being at risk for unwanted pregnancies, accessing prenatal care is difficult, compounding the likelihood of low birthweight (Chavkin et al., 1987; Wright, 1987). Recognition of and followup care for sexually transmitted diseases are also likely areas of neglect. Homeless women could also be considered vulnerable to AIDS as their lifestyle may be predisposing

to rape, prostitution, and IV drug abuse. Preventive care such as Pap smears and mammograms, if not unthought of, may be nearly unattainable.

The problems of homeless women are multiple and complex. Circumstances precipitating homelessness are generally related to family conflict or economics. Women without resources who become homeless are vulnerable to a variety of physical and mental health conditions. Health care is likely both difficult to access and unavailable for some needs, such as counseling and preventative care.

Because the literature describes a variety of health problems and access problems, these factors provided the conceptual organizing framework for a descriptive study that asked the two following questions:

1. What are the perceived health status, practices and health care needs of homeless women?
2. What has been the experience of homeless women in the health care system regarding accessing care and with health care professionals?

The operational definition of homeless women for the purpose of this study is women who do not have predictable domiciles and consistent means of support to sustain daily needs. They may be housed at shelters, hotels, or temporarily with friends or family. This definition is consistent with the literature which usually considers sheltered women to be homeless.

CHAPTER II

Methods

This chapter will describe the design, settings subjects, and data collection methods, procedures, and analysis used to answer the research questions:

1. What are the perceived health status, practices and health care needs of homeless women?
2. What has been the experience of homeless women in the health care system regarding accessing care and with health care professionals?

Design

An exploratory design was used. Homeless women were interviewed to describe factors precipitating their current circumstances, their health status and practices, and health care needs and experiences. These areas have not previously been a focus of nursing research, and therefore, an exploratory study broad in focus was appropriate to meet the goals of this research.

Settings

This study was conducted in a variety of settings serving homeless women in Portland. Settings included the West Women's Hotel, a women's shelter offering transitional housing for women and their children for up to 18 months; Baloney Joe's Shelter and the East Side Clinic, a men's shelter offering meals and clinical services to both men

and women; and Sister's of the Road Cafe, a restaurant offering low cost meals to low or no income people.

Subjects

The criteria for inclusion in this study were: a) homeless female, b) age over 18 and c) consent to participate. Eighteen women were interviewed over the data collection period of four months. Subjects were a nonprobability purposive sample of temporarily sheltered or otherwise homeless women over the age of 18 meeting this study's operational definition of homeless. Because subjects were accessed via community agencies, the sampling bias was toward those who understood how to access social services systems.

Data Collection Methods

The researcher interviewed the subjects using a structured interview guide (Appendix A). Data were collected on the following variables: the women's history of homelessness and its precipitating factors; physical and mental health, and perceptions of experiences and needs; substance use; physical and sexual abuse; and relationships with children and partners. In-depth interviews provided breadth and depth not possible on a self-administered survey where literacy, educational preparation, and motivation were factors. The interviewer was able to ask questions less superficial than those on surveys, and could

clarify any related confusion. Some of the questions were open-ended, and the interviewer used probes for more information. The additional data produced via the researcher's observations helped interpret subjects' responses and direct probes (Polit and Hungler, 1987). The researcher was also able to offer subjects referrals to sources of care for problem areas discussed during the course of the interview.

Interview Schedule. A tool was adapted from several sources that had already been tested with the homeless (see Appendix I). These included the Basic Shelter Index (Robertson, et al., 1985) and the interview schedule used in the Multnomah County study (Multnomah County, 1985). Specific areas explored included the woman's history of homelessness, demographics, physical and mental health, substance abuse, physical and sexual abuse, relationships with significant others and children, and perceptions of health care experiences and needs. Both direct and open-ended questions were asked.

The first research question was answered by interview questions related to the perceived health status, needs and practices of subjects in the following areas: nutrition (12-14), physical (17-22) and mental health (61-72), reproductive health care (34-35b, 38-41, 42-46, 47), substance use (48-58), and domestic violence and abuse

(74-77). Questions related to needs in each category were: homelessness (10-11), nutrition (15-16), physical (20d, 21b) and mental health (73), reproductive health care (35c-37), substances (59-60), and domestic violence and abuse (78-80).

The second research question was answered by questions related to subjects' experiences and needs regarding accessing health care and with health care professionals. These questions were in the following categories: health care access and experience (20d, 23-33), needs (24-25, 31).

Additional findings in the areas of basic needs, children and safety were related to questions 81-91, and 35b-c. Responses to demographic questions (1-7), were used to compare other categories according to age, ethnicity, education and marital status.

Procedures

The researcher arranged access to settings by contacting representatives from the above mentioned agencies. Interviews were conducted only when a location ensuring privacy was available, such as an empty exam room, office or other room. The researcher relied on clinic and shelter staff to refer potential subjects when she was present for on-site interviewing. Clinic staff were asked not to refer women who were seriously ill, or who appeared emotionally vulnerable, suicidal or potentially violent.

Women willing to be interviewed were introduced to the researcher who described the study and obtained informed consent. Subjects were assured that their participation was voluntary, that they had the right to refuse to participate or to withdraw at any time, and that their decision would not affect their eligibility for services received at that site. Women were informed that the researcher was required by law to report knowledge of child abuse, and some diseases, such as gonorrhea. Women were also told that the confidentiality of any illegal activities witnessed by the researcher could not be protected in court.

Subjects were assured that all other information obtained was confidential. Risks to participants were minimal although the emotional nature of some participants' self-disclosure may have been psychologically stressful. The potential benefits of the study to participants were also minimal, and only if the interview process was experienced as therapeutic and the researcher was able to offer useful referrals. The informed consent form approved by the Oregon Health Sciences' Committee on Human Subjects was read to subjects by the researcher, and a consent to participate was obtained, thereby bypassing potential reading comprehension problems. See Appendix B for the informed consent information which was read to subjects.

The duration of the interviews ranged from one half hour to two hours. Five women were interviewed at the West Women's Hotel, three at Sisters of the Road Cafe, and 10 at Baloney Joe's.

Analysis

The first six taped interviews were transcribed verbatim. Content analysis of interview responses was based upon codes and categories that emerged from these first interviews. Responses to the interview questions were then transcribed from the remainder of the interviews. These were coded into categories created by the first interviews when possible. Some new codes and categories were added. Responses to questions were combined and tabulated when possible. Broader themes, such as the experience of teenage homelessness and alcoholism, stigma, and losses related to children, also became evident. The research questions were then answered based upon responses to specific questions as described in the Interview Schedule section.

CHAPTER III

Results and Discussion

This section will first describe and discuss the demographic characteristics of the sample, the historical circumstances of the women's homelessness, and the research questions. This section will conclude with additional findings related to general needs, safety and children. Exerpts from transcripts of the taped interviews will be used to illustrate the results.

Demographic Characteristics

The age of the 18 women ranged from 18 to 54 with a mean age of 30. Most (15) were under 35. Except for two women who were part Native American, all were Caucasian. Refer to Table 1 for a description of the sample's marital status. Over one half of the women (10) had never finished high school, two of whom had less than an eighth grade education, and one had completed a GED. Three women were high school graduates, an additional 4 had some college, and one woman had completed a master's degree.

The sample's representativeness of homeless women in Portland cannot be known, as their demographic characteristics have not been determined. The relatively young mean age of the sample, 30, is similar

Table 1

Marital Status

Marital status	*n*
Single/Never Married	
Has male partner	1
Has female partner	1
Does not have partner	2
Divorced	
Has male partner	5
Has no partner	5
Married	2
Widowed/No male partner	2

to a larger study of 10 homeless women in the Portland area who had a mean age of 32 (Multnomah County, 1985).

History of Homelessness

Nearly one half of the women (8) had lived on the street most of the time they had been homeless, the duration ranging from 6 months to seven years (see Table 2). Four women had usually been sheltered, with short periods of time, days to weeks, spent on the street. Six women had never lived on the street.

Nearly one half (7) of the women had been essentially homeless or without a permanent residence since they were teens. For the others, it was usually a combination of factors precipitating homelessness, especially loss of work and eviction, coupled with involvement in an abusive relationship and/or substance abuse. Table 3 summarized these factors.

The multiple factors precipitating homelessness in these women's lives were consistent with local studies (Multnomah County, 1985; Oregon Shelter Network, 1988; Technical Assistance for Community Services, 1989) and others (Walsh & Davenport, 1981; Bassuk, et al., 1986; Crystal, 1984; Roth et al., 1987). The following exerpt was typical of circumstances precipitating homelessness.

Table 2

History of Homelessness

Years living in Portland		Duration of homelessness		Living arrangement shelter vs. street	
Years	n	Months	n	Location	n
<2	9	<6	3	Temporary Shelter	
2-5	1	6-11	1	Hotel	3
>5	5	Years		With Friends	2
Native	3	1-2	2	Shelter	6
		2-5	3	Apt/House	4
		>5	9	Street	3

Table 3

Multiple Precipitants of Homelessness

Subject	Homeless since teen Left or made to leave family	Left abusive relationship	Job loss	Eviction	Alcohol &/or drugs	Loss of health Physical	 Mental	Total
1	X							1
2	X							1
3		X			X			2
4			X	X				2
5		X	X	X				3
6			X	X	X			3
7			X	X		X	X	4
8		X					X	2
9			X	X				2
10	X							1
11	X							1
12		X						1
13	X							1
14			X	X	X			3
15			X	X	X			3
16	X						X	2
17							X	1
18	X				X			2
Total	7	4	7	7	5	1	4	

One subject was a 34 year old woman interviewed at the West Women's Hotel who had a Master's degree. She had become homeless as a result of unemployment and eviction. She had previously left her partner after a severe beating resulted in a head injury which may have precipitated the development of a Parkinsonian tremor that limited her from some types of employment.

> There are some things I can't do because of my tremor. I ran out of money, and got a court order to evict me from my last apartment in June of '87. I had been out of work since Sept. '86. I walked the streets looking for money. I've been without a permanent residence for one year. It was real hard.

Homeless Since Teenage Years. Seven of the women had become homeless as teenagers, a phenomenon noted by Robertson (personal communication, 1988) as increasingly evident. Dysfunction and abuse in their families of origin were significant precipitants of homelessness in this sample.

According to Crystal (1984), foster care or institutionalization is a common experience among homeless women. A 30 year old woman sheltered at the West described how she had been institutionalized then put in foster care after having been molested by her father. She has lived in 23 places in the last 7 years, and said that she had never learned the skills

necessary to develop a successful life and maintain a permanent residence.

> I think a lot it (being homeless) was because of what happened to me when I was younger, plus being in an institution. It's like all my life I've been going from here to there, I've never stayed in one place.

One 19 year old who lived under the Burnside Bridge, related her story as the survivor of a dysfunctional family and incest.

> My mom kicked me out (after 10th grade). I went through a lot of emotional stress. And I started living on the streets, taking care of myself. ...The reason why I am homeless is because Number One you have to have a job to get a house. In order to get a job you have to have a house.

Potential preventive/interventive factors. Women were asked what might have helped prevent or intervene in the circumstances of their homelessness. They cited a variety of factors, most commonly related to employment (Table 4). Only two of the women were unable to suggest what might have made a difference, one of whom stated that she had actively chosen her lifestyle.

Potential interventions described by the women were similar to those suggested by Roth (et al., 1987), and

Table 4

Factors Cited by Subjects as Preventive or Interventive in Their Experience of Homelessness

Subject	Available/Supportive Family	Job Skills/ Employment	Nonabusive Partner	No Involvement with Drugs/Alcohol	Socialization with Mainstream Peers	Social Services	Total
1	X	X					2
3			X				1
4		X					1
5		X	X				2
6				X	X		2
7						X	1
8			X				1
9		X					1
10	X	X			X		2
11	X	X					2
12			X				1
13	X	X					2
14		X	X	X			3
15	X	X		X			3
17		X					1
18	X		X	X			3
Total	6	10	6	4	2	1	

focused on increased job training and education, counseling directed toward resolving family conflict, and increased availability of low income housing. Over half of the women had not finished high school, and most had no job skills.

Substance abuse was a common experience for over one half of the women and was an obstacle to employment and successful living. Yet, as reported under Substance Abuse in a later section, only two women of the 10 with substance abuse problems had participated in treatment programs. This may have indicated that they were unwilling to participate in treatment, and/or that appropriate treatment was not available to them.

Research Questions

Question One

To answer research question one, "What are the perceived health status, practices and needs of homeless women?", subjects were asked questions addressing: nutrition, health status, reproductive health, mental health, substance use, and violence against women.

The sample was predominantly young, which may have been an advantage regarding their experience of health. The women reported a range of health status descriptors which considered along with their health needs appeared to have been overstated. Their health status should be

considered at best below what is average for middle class women and may have been overestimated because of their adaptation over time to a lower baseline level of wellness.

The four oldest women each described multiple, and often serious, health problems, such as mental illness or not feeling mentally well, pneumonia, needing dental implants to facilitate eating, and an untreated seizure disorder. Three of these women appeared too ill, both physically and mentally, to be employed. Although increasing age is not necessarily accompanied by health problems, as the body ages and begins to require more care, the stresses of homelessness may be more severe for older women whose lives had been progressively depleted of the resources necessary to do this.

Nutrition

Perceived Adequacy and Needs

One half of the women responded that their diets were sometimes inadequate, while the others felt that their diets were adequate. Four of the nine who stated their diets were adequate lived at the West, while two others had food stamps.

Women depending upon meal sites usually depended upon one meal per day, which may or not have been adequate, or available every day (Table 5). One woman

Table 5

Nutrition: Location and Frequency

Meals Per Day		Location	
Meals	n	Place	n
1	6	Meal site	8
1-2	6	Shelter	5
>2	6	Other	5

said she usually did not eat two or three days a week, and another said she got enough to eat about every two to three days. Except for women living at the West, all women were able to mention food from at least one of the four food groups missing in their diets, most commonly fresh vegetables, and a protein source such as milk or meat.

For those women living on the street, obtaining food would sometimes occupy the greatest part of their days. One 23 year old woman had been homeless since she was 16 and depended mostly upon one meal a day at meal sites for food. She described what she felt was lacking in her diet, and in that of others sustained by meal sites.

> More protein. Eggs or cheese or meat. Some decent green vegetables. Raw vegetables is what I'm getting cravings for. I need the Vitamin A in it. We need milk. (A dinner at Baloney Joe's doesn't have those things?) To a certain extent it does...I can hold out on one meal a day.

Perceived Health Status and Needs

Health Status

In response to the question asking women to describe their health, nearly one half (8) the women described their health as pretty good or good, 2 as excellent, 4 as fair and 4 as poor. One of the 2 women who described their health as excellent was a chronic IV drug user, the other had developed a Parkinsonian tremor after a head injury from her abusive husband. The two oldest women in the sample (45 and 54) both described their health as poor, as did another woman, for problems related to both physical and mental health. All but two smoked cigarettes, but this was not considered by any to be a health issue.

Health Care Needs

All but 2 women had some health related concerns. Mental health, dental, and chronic respiratory infections were problems most frequently mentioned. Six women described mental health problems such as depression, deteriorated mental health, and chronic mental illness. Five also complained of persistent colds, especially during winter, and five also mentioned their need for dentistry, which ranged from caries to implants. The woman needing implants was limited to eating only soft foods until she could find a way to

afford the care.

Three women thought they were pregnant. Another had a positive pregnancy test and was especially concerned about getting enough to eat. Other reproductive health concerns will be detailed under Reproductive Health.

Dermatologic, ocular, orthopedic and neurologic problems were also described by women in the sample. Dermatologic problems reported by three women included acne, recent history of scabies, and a neck lesion requiring excision. Two women needed eye care, one for glasses, and one for a growth on her eyelid. Two women had orthopedic concerns including chronic hip and knee pain, and one had never had follow-up hip surgery to remove pins. Two women had neurologic problems, one of whom was under care for a Parkinsonian tremor, the other had a seizure disorder for which she was not currently under care.

Obtaining adequate nutrition was a basic health related concern for the women sampled. As stated earlier, half reported that their diets were inadequate. Other health needs most commonly reported were related to mental health, dentistry, and upper respiratory infections. The high incidence of mental health problems, infectious disease and nutritional needs among the homeless is well documented (Brickner

(et al., 1985; Robertson, et al., 1985; Wright, 1987; Wright et al., 1987). Dentistry was also a significant need among women previously sampled in Portland (Multnomah County, 1985).

Although not identified by the women, reproductive health care appeared to be an important area of need. Seven women had been pregnant at some time while homeless, and nearly all fertile sexually active women were not using contraceptives. Reproductive health care had also been identified by women in the Multnomah County study (1985). The following exerpt describes one of the subjects' needs in her own words.

A 43 year old woman who had lost her job, health insurance, and home after being beaten by her partner and made to leave town, described her need for dentistry.

> I need some dental work. I need implants. My mouth's in pretty bad shape. That's one of the reasons I can't eat. (It's painful?) Yes...If it's hard, I can't chew it, I don't care what it is. Because the whole side of my head goes beserk...I have to find a way to do that. I don't know how I'm going to do it yet. I went up to the Oregon Health Sciences, and there's nothing they can do for me. (Because you don't have money?) Yes. And that's really got me down. Because the only thing they can

do for me is the implants, which is $6,000, he said.

Medication. Although only two women were currently on medication, one for her Parkinsonian tremor and the other for estrogen replacement; two others were unable to afford their medications that included oral contraceptives and estrogen replacement. Another woman was not on her previously prescribed medications for a seizure disorder and depression because she had not sought care for these problems in Portland.

Reproductive Health Needs

Seven women had been pregnant while homeless, yet for over half of the women birth control and reproductive health were not identified issues. Nine women were menopausal or had had tubal ligations, one woman was not sexually active and the other was in a lesbian relationship.

Contraception. Of the seven fertile women currently sexually active with men, only one was using contraception. Although one sexually active woman who did not use contraceptives described herself as "not mentally or emotionally ready," she said she would have a child if she got pregnant. Another woman "didn't think it could happen" despite the fact she had a child within the last two years.

Pregnancy. Of the 3 women who thought they were pregnant, one wanted to be pregnant, one would accept the pregnancy because she "didn't believe in" contraception, and one planned to abort. The woman who had a positive pregnancy test was unsure whether she would abort or have the child. The woman who planned to abort had wanted to be on oral contraceptives but had been unable to afford them. In addition, one woman who was not pregnant was trying to get pregnant.

Reproductive health care was not a stated concern of the women interviewed. Yet, there had been 7 pregnancies among them while homeless, and 6 of 7 fertile sexually active women were not using contraception. Two of the women, despite their lack of housing, desired pregnancies. While much of reproductive health care is anticipatory and preventive, these women were oriented toward seeking care for acute problems.

One woman, homeless for 5 years and still a teenager, had a fatalistic attitude toward pregnancy, and expressed both her lack of concern, prevention, and readiness for it. She also may have imagined it as a way of getting off the street. She said,

> I figure it this way, if it happens, it happens, it it don't, it don't. (What would you do if you got pregnant?) I'd make the guy I'm going out with get a decent job. He already made me a promise, if I do get you pregnant, you are definitely getting off the streets. (So, you aren't interested in birth control?) Well, I am but I'm not. To tell you the truth, at this particular moment, I'm not emotionally or mentally ready (for pregnancy).

Sexually transmitted diseases. With some exceptions, women reported few STDs. Although all appeared to be aware of the risks of STDs, only two women stated that they would use condoms when sexually active and only two women were in monogomous relationships of three years or more. Four women had had gonorrhea, and one woman had herpes. One woman who continued to share needles with her partner said she had tested both positive and negative for HIV.

Sexually transmitted diseases, that have been reported both at an increased and average incidence among homeless persons (Wright, 1987; Wright et al., 1987), were not frequently reported by these women. All women denied ever having prostituted. Both having had a sexually transmitted disease and having prostituted may

have been socially undesirable experiences the women were not willing to acknowledge during the interview.

None of the sample reported using condoms. The lack of use of condoms may be attributed to as many factors as there are individuals. Among those possible reasons may have been the men's unwillingness to use them; women's lack of assertiveness and habituation to exploitation by men, their physical (safety) and emotional dependence on men, and their fear of abuse and wanting desperately to be wanted. Probably neither sex had been socialized to use condoms nor were they fully knowledgeable about STDs. Their thought processes may have lacked the sophistication necessary to anticipate consequences (STDs, pregnancy) and they also may have been more fatalistic. Finally, pregnancy may offer secondary gain to some women, including partnership and family.

Prostitution. No women admitted to having prosititututed, however, this seemed to have been a semantical difference. One woman alluded to a common occurrence among women of having to "barter with sex" for safety, and ally themselves for protection with men whom they did not necessarily know well. Along with the potential physical danger would also seem to be an increased risk for infection from casual sex.

Other. In response to questions about gynecologic

surgeries and pregnancies, women reported a total of 12 reproductive surgical procedures, and 57 pregnancies resulting in 30 living children (Table 6). Only one woman had never been pregnant nor had surgery.

Table 6

Reproductive Health Experience

Reproductive health experience	n
Gynecologic surgeries	6
Tubal sterilization	6
Pregnancies	57
Complications	3
Preterm	3
Neonatal deaths	2
Stillbirth	1
TAB	5
SAB	16 (5 >1)
Childhood deaths[a]	3
Women with living children	9
Living children	30

[a]all were car accidents

Perceived Mental Health Status and Mental Health History

Perception of Mental Health

Mental health was a frequently mentioned area of concern for the women interviewed. Although the literature reported a high incidence of mental illness among homeless women, those numbers were not usually based upon diagnostic assessment but providers' judgements (Brickner, et al. 1985; Robertson, et al., 1985; Roth, et al., 1987; Wright, 1987; Wright, et al, 1987).

When asked to describe their mental health, only one woman described hers as excellent, one third (6) as good or pretty good, nearly one half (8) as fair or ok, and three as poor. These were subjective self descriptions. The "excellent" came from a woman living at the West recently separated from an abusive and drug abusing relationship. This may have been relative to the contrast of her prior suicidal despair felt while being abused and using drugs. The woman who described her mental health as "good" had 3 children in foster care, used IV crank, and admittedly got drunk and smoked marijuana to escape. At least four of the women with "fair" mental health also described themselves as being chronically depressed.

Of the women with "poor" mental health, two were on SSI for mental health reasons, and the other complained of deteriorating mental health due to the stress of recent circumstances and homelessness.

While the women used a range of mental health descriptors, as in physical health, the range might be restricted among people who are relatively deprived, beginning below what is average for the domiciled population. Most women were in the middle range of below average, and chronically depressed. In overstating their mental health, some women may have accepted psychological trauma as a way of life, and have lowered expectations of life in general.

Hospitalization. Although nearly one-half of the women had been hospitalized in a psychiatric facility, only four made specific reference to having had a psychiatric diagnosis, three of which were chronic mental illnesses. Two women had been hospitalized after attempting suicide with drug overdoses. The others included alcohol detoxification, post partum depression, chronic mental illness and psychotic breaks, and "post traumatic stress disorder."

Depression

Depression among the women was a universal though varied experience, from very transient and lasting

only hours, to days, weeks and months. Most attributed it to their current difficult circumstances, though their relationships with their families, or children, were also problematic. Table 7 offers a rank ordering of circumstances identified as contributing to depression. Some women named more than one circumstance.

One woman had not lived with her 2 youngest children for over three years. Her 17 year old son who also was homeless had not finished high school and was in the Job Corps. Thoughts of her children, impending eviction and her husband's urge to resume drug use were overwhelming.

> I've been really depressed the last couple weeks about Christmas season coming on, the kids aren't with me, we're getting evicted...(Have you felt suicidal?) Yes, and I can't say not lately. For a fleeting moment I said to myself I'd rather be dead than go through this bullshit again...(pending) eviction and the possibility of starting on drugs again, which luckily didn't happen. Just kind of a bad time. My old man was just wanting to get (drugs), and I told him if he did I'd leave him. And I would have. He chose not to, it was kind of a hard lesson but it worked.

Table 7

Depression Attribution

Attribution	n
Current life circumstances	9
Partner's abuse	4
Drugs/Alcohol	3
Loss of children	2
Lack of family	2
Endogeneous depression/bipolar illness	2
Stigma	1
Family death	1
Loss of relationship	1
Premenstrual syndrome	1

Suicide: Attempts and Ideation

Over half of the women (10) had contemplated suicide at some time in the past, and all of those had attempted it. Two had gestured or attempted within the last three months, the others over a year ago. Of the four women currently having at least occasional suicidal thoughts, three did not consider themselves to be actively suicidal, while the other had recently attempted suicide with over the counter sinus medication.

Influence of Homelessness on Mental Health

What the literature has not addressed is the influence of the stressful circumstances of homelessness on women's mental health. The following characteristics in combination with the stresses of homelessness could also have precipitated more moderate and limited mental health problems leading to hospitalization but not chronic mental illness. These include: having been children of dysfunctional, abusive and sometimes alcoholic families; socioeconomic and educational disadvantages; victims of partners' and random violence; and alcohol and/or drug abuse.

The influence of homelessness on their mental health status was described by nearly all women as negative,

depressing or stigmatizing. Included below are some of thewomen's descriptions of their mental health status, experience of depression and attribution for it, suicidal ideation, and in general the effects of homelessness on their mental health.

A 33 year old woman described her struggle with hopelessness, frustration, and trying to succeed amidst overwhelming circumstances.

> I feel suicidal occasionally, but not right now. If I keep going at the rate I'm going, and I don't see a bright future somewhere, I'm liable to say, "Hey, it's not worth it, there's got to be something better than this." No, I'm fine now though, I'm still a fighter.
>
> Everybody likes to feel good about themselves and say, "I've accomplished. I'm capable." And then when you find yourself where you can't, but have all the abilities to, it's tough to accept. You scream and yell and then they want to send you up to the funny house, where you have no decisions or no freedom whatsoever. You just got to cope and say, "Hey, it'll get better."
>
> It seems like these last few years, things just haven't been working out. Things that I've planned and set up, and try and do and they don't turn out. So, we're trying to figure that out in counseling.

The following comprehensive quote is from a 54 year old woman who stated that she had always been a working person, and the circumstances of declining physical and mental health precipitated her unemployment and eviction. She found herself to be ineligible for some social services and felt cheated by the system she had always supported. She also described homelessness as a mentally stressful and stigmatizing condition. Her story offers a graphic illustration of a woman's entry into and experience of homelessness.

> I have been through hell for about... months. I keep a lot of it inside, I go to counseling. I went to mental health and was told I couldn't plug into their system because I wasn't psychotic, "You've just been through a lot of crises, and you're very depressed."
>
> This is terrible because I've been a working person all my life, I've worked for the government, for people, I've done so many things, and I've been through a lot with my son, and I can't tell you how my personal feelings are on the inside for the last year. It's like I've been screwed to the max. That's all I've got to say. Sometimes I've lost myself.
>
> I'm working on my self-esteem. People treat me like some kind of dirty sheet sometimes, it hurts. Somebody once approached me downtown that knew me from the other side of the river. He said, "What in the

hell are you doing down here in Old Towne. You're like a fish out of water." Well, this is where the city has put me. Physically, mentally, morally, I'm stuck with it. It is a first class royal screw...I've been terribly mistreated.

It used to be I had all kinds of money. Now I have to be so conservative. I just feel funny all the time. I keep checking my things. I'm scared to death somebody's going to steal something from me, watching my pennies like there's no tomorrow. I just don't feel like myself at all. I can't do anymore than take one day at a time, that's all I can do.

Tomorrow I'm going to have to leave where I'm at unless I come up with some more money. I'm going to have to sell some clothes or make some t-shirts or something to make some rent money. And I've never in my life had a problem coming up with rent money. Usually my rent is paid in advance. Never before in my life have I had to worry about paying rent, paying for anything. When Jack died, I had money up the yin yang. The first of this year I didn't owe one penny. I figured here I almost 55 years old and I don't owe the world anything. Now I've got almost $7000 in medical bills. I've been threatened in court, threatened with attorneys, threatened to move. "You're a victim and you're exposed," that's what the attorney

said, "You're out and you're gullible."

> We're homeless, we're down here in Old Towne, so most of the time they look at me and say, "Do you prostitute." I'm serious. I applied for three jobs this last week and that's exactly what was said to me. "How are you surviving down there, do you prostitute? Are you doing drugs, or what?" Sure makes you feel bad when you're trying as hard as you're trying.

Summary. Mental health problems in this sample were a combination of preexisting mental illness, as well as more limited and moderate responses to stressful circumstances, such as chronic situational depression and frustration. As the experience of these women indicated, homelessness is a threat to mental health.

Current Coping and Counseling

Coping. The women tended to use individual or internal coping mechanisms rather than other people such as friends or counselors. Five women mentioned sleeping and crying. Three said that exercise or walking helped, 2 turned to diversional activities (cards, pool, videogames, TV) or introspection, and two each mentioned reading or some creative ativity.

Street drugs and alcohol were also used as an escape, or as a way to alleviate anxiety or depression. Three women specifically described smoking marijuana as being helpful, two mentioned religion, and one woman had used

crisis lines. Only three women said they turned to friends or family for help.

The women's tendencies to use internal coping mechanisms when they were already feeling depleted seemed unlikely to be successful, as described by some women in the following exerpts. They also tended not to use friends as resources, perhaps because peers were often in no better condition, they were socially isolated and/or their transience precluded intimate, supportive relationships.

Except at the West Women's Hotel, counseling was not named as an option for coping. Women at the West were encouraged to enter into counseling, and therapy was arranged for them. Services for unsheltered or low income women continued to be limited, as one subject discovered when she was unable to get counseling because she was not psychotic. Some women's past negative experiences with counseling or with the social welfare system, as children in dysfunctional families, or mothers dealing with custody issues, may also have prevented them from seeking help.

One woman who lived at the West described how her separation from her children was a problem for which she initiated counseling when other coping mechanisms, primarily sleep, were not working.

> I can pinpoint most of it (depression) down to my children. There's a child that looked just like my

daughter that was here. She looked just like her at the age the last I'd seen her. Now she's 12. And that kind of depressed me... And then I couldn't get to sleep because I'm on to my kids...Lately it seems like I've been sleeping. I've set my alarm for meeting with Donna (caseworker) in the morning and I'll sleep through it. When I'm sleeping I try and work out my problems, and it's one of my escapes from reality... But with my kids, there's nothing I can do about them. I'd need money to go back to court, to get the judge's order, and I don't have the money.

Counseling experience and needs. None of the women were currently involved in or had ever been in long term psychotherapy or counseling, but most had had some experience with short term therapy. One half had had short term individual counseling at some time in the past and 4 had had intermittent counseling over a period of years. Most responded that counseling had been a positive experience. Of the five women currently in counseling, four were sheltered at the West Women's Hotel. Three women not currently in counseling expressed interest in seeing a counselor. Table 8 rank orders the focus of these women's counseling experiences. Some women named more than one.

Substances

Over half of the women (10) described themselves as

Table 8

Counseling Issues

Focus	n
Substances/alcohol	6
Coping/Managing difficult life circumstances	5
Individual issues	4
Parenting/child related	3
Abuse (as child or adult)	3
Mental health/depression	3
Career issues/employment	2

alcoholics, two of whom were currently drinking at least occasionally. Only one woman acknowledged current drug use (IV crank) although four others described themselves as recovering addicts. Four women described a history of both alcohol and drug dependence.

These women's incidence of alcoholism and drug addiction, over 50%, was in the high range of previously reported incidences (Multnomah County, 1985; Roth et al., 1987; Sullivan & Damrosch, 1987; Wright et al., 1987; Wright, 1987). Several described the onset of their addictions during their teenage years. Some women also seemed to be using alcohol and pot as an escape from or to cope with their current physical and psychological environments.

History of Alcoholism as a Teen

One woman described being on her own as a teen, her use of alcohol at that time, and her current tendency toward binge drinking. She stated that her parents were prescription drug addicts, but did not drink. She said,

> When I was a teenager I used to drink a fifth of Southern Comfort a day. I was emancipated when I was 15. And I worked, I was going through school and I worked 40 hours a week. I used to pop 5 black beauties a day, smoke a couple joints at night to go to sleep, but to keep me running through the day I'd drink my

Southern Comfort...I got pneumonia when I was 17 and when I was in the hospital with that I went through the DTs...By the time I went through my DTs, they didn't have to tell me about alcohol treatment, that cured me...Every time I think of that, when I wake up with little shakes in the morning, I go, "Oh no, that's it". And I don't touch it again for another six months or a year. (When you do start drinking again, what is it like?) I go on different binges. If I go out and drink at night for like two weeks straight in a row, then I start feeling a little shakey in the morning, then it's time to tell myself there's no more drinking for awhile.

Family history. Most women identified some family history of alcoholism. Over one third (7) of the women had had at least one alcoholic or substance dependent parent, two of whom also thought they had at least one alcoholic grandparent. Five other women had alcoholic siblings. Only five women thought they had no family history of alcoholism, and one woman's family of origin was unknown to her.

Counseling/treatment experience and needs. Although most women (10) had not had counseling or treatment related to substance abuse and none were currently interested in it, it was the most common reason for having had

counseling (Table 8). Of the 6 women who had been counseled about drugs or alcohol, most of them (5) considered it a positive experience.

Violence Against Women

Almost all women interviewed had been physically and/or sexually abused as children or adults, consistent with the literature, and more specifically addressed by Bassuk (et al., 1986) and Multnomah County (1985). In response to questions regarding their experience of physical or sexual abuse, only 4 women had been neither physically nor sexually abused. Five women reported having been physically abused in their families of origin, 6 were sexually abused, and 3 were both physically and sexually abused. Almost all women (14) had been physically abused by at least one male partner, and two were also sexually abused. No women admitted to being currently involved in an abusive relationship. Nearly half of the women (8) had been raped, five by men known to them.

A 45 year old woman who had been put on a Greyhound bus by the Las Vegas police and made to leave her home and job after her partner beat and threatened to kill her described the impact of that experience.

> I was so unsure of everything. I mean, I was from a family where men didn't beat up on their women. I

> had a good marriage. If my husband was alive I'd still be married. That's how good it was you know. And then to have someone beat the living hell out of you and threaten you, and you can't even go back to your job, it's so scary. And then I started questioning me, what's wrong with me, why did he do this to me...
> And I sure as hell didn't expect him to have a gun. And that I think scared me. He told me, there was a crowd of people there, when he told me this. He threw me up against the wall and told me he had a bullet with my name on it. And it didn't phase him that there were 30 people standing around. So there's no way you could convince me that he wouldn't shoot me if he had a chance. And then I kept asking myself, why me? Why did I have to leave my home, because of some psycho. Now I'm glad I did.

Some women who were abused as children were also abused by their male partners as adults. One woman related her experience of her father's attempt to molest her that finally made her leave home, and subsequent male partners' devastating effect on her mental health.

> My father, even though he's a strong Christian type, he and my step moms, they beat us, me and my little brother, because we were the only two at home.

> He tried to sexually assault me when I was 16, I ran away from home. All the men I've gone out with, including my ex-husband, have beaten me, for one reason or another, they've done mental and emotional abuse, to the point where I thought I was nothing but a little scum on earth.

Summary. Abuse as a major precipitant of homelessness is well known. It also occurs concurrently with homelessness, as described by women in this sample. With even fewer resources and choices than domiciled abused women, homeless women may be forced into risky alliances with men paradoxically for safety reasons, as well as in a desperate attempt to create some sense of family and belonging. With an inadequate shelter and social services network unable to offer them more than their abusive partners, along with a lower level of physical and mental wellness, they learned to accept the threat and experience of physical violence and trauma as a way of life.

Counseling experience and needs. Four women had been counseled regarding their experience of abuse and were not interested in continuing. Five women were currently addressing this issue in counseling and two women expressed interest in talking to a counselor about their experience.

Although the women at the West have counseling readily available to them, for other women services are limited and

may require transportation to evening groups. Although all women denied being in abusive relationships at the time of the interview, of the 8 women with male partners, only two were relationships of longer than one year. The potential for violence in such short term and tenuous relationships cannot be known but likely exists. One woman described having been hit by her current partner and said she would not tolerate it again. This same man had abused his former wife, who was also interviewed.

Research Question Two

The following section presents data related to research question two, "What has been the experience of homeless women with the health care system, i.e., accessing health care and with health care professionals?" Subjects were asked to describe their access and interpersonal experiences.

Access to Health Care

Homeless persons' access to health care has been consistently reported as limited (Brickner, et al., 1985; Multnomah County, 1984; Reuler, et al., 1986; Robertson, et al., 1985). Inability to pay for care was the primary barrier to care in this sample. It also prevented continuing with a regular source of care after unemployment and loss of health insurance. Although most women were able to access primary care, specialty care such as

dentistry, dermatology, or opthamology was either unavailable to them, or not known to be available through Portland's volunteer agencies.

Nearly all women reported that they rarely sought health care, but most (14) were able to describe a problem related to accessing health care. In addition, almost all described having experienced interpersonal problems with providers, such as feeling stigmatized.

Table 9 summarized the women's responses to problems encountered accessing care. Although the majority described financial barriers, difficulty with other aspects such as quality and continuity were frequently cited.

<u>Interpersonal</u>

Providers' attitudes were identified as both the most helpful as well as the most difficult aspect of the health care experience. Three women specifically mentioned providers' abilities to communicate and listen as being especially helpful. Other women described the experience of feeling stigmatized or judged negatively because of their poverty in the eyes of their providers.

Perhaps as significant as accessing care was the experience women had once they entered the system. Both Brickner (et al., 1985, and Strasser, 1979) addressed health care providers' potentially negative attitudes toward the homeless. Several women clearly articulated

Table 9

Problems Encountered Accessing Care

Problems
Unable to access due to inability to pay for services (6)
Became unable to afford regular source of care (4)
Poor continuity of care (2)
Inadequate quality of free care (2)
Unable to access specialty care with Medicaid (1)
MD not available at regular source of care (BJs) (1)
Long wait for appointment for emergent problem (1)
Refused care by ER when identified as junkie (1)
Refused care because of lack of identification (1)
Lack of transportation (1)
Lack of childcare (1)
Dislikes social environment at most convenient clinic (1)

their experience of stigmatization by the health care system.

For a woman who lived at the West Women's Hotel and had a chronic health problem, her stigmatizing and depersonalizing experiences in the health care system were a frequent and major source of difficulty. Her caseworker, also identified with the West, was unable to successfully advocate for her.

> I feel like I've been looked at differently because of where I live, that my care has been determined more by where I live than who I am. I was having a lot of pelvic pain from January until April. I was hospitalized for 10 days in March. It was awful. I was still in pain when I left. I was told there was nothing more that could be done, that the pain was "all in my head." "She's just one of those people who live down at the West."
>
> Psychologically it's been a real burn. I'm an educated person, I've worked at the University, I consider myself to be a good person. I don't like the idea that wherever I live has to preclude who I am as a person. But it's been very painful. At that time I wasn't in any kind of sexual situation and that really got 'em too. He said, "Well, you live down there, you

should have all kinds of contacts."

It's funny how if I had my own apartment number I would have been treated totally different. I can really say that because I know that the many times I've been up there for other problems as well. The minute they find out where I am that's it. I'll be treated just fine until they find out where I live. And I can compare that to the way it used to be and it's changed a lot. They look at you as "she's just down there at the West, she's just trying to get in here so she can have a meal or something".

Summary. This woman described the need to feel respected and treated with compassion by her health care provider. She, and others like her, were sensitive to providers' attitudes and could not afford further loss of dignity from an already fragile sense of self-esteem. This woman's experience was an illustration of why some women avoided contact with the health care system.

Continuity

Only a couple women specifically mentioned continuity of care as a problem. One responded that she "couldn't afford it" and had not known it was possible to have a regular provider in a free clinic. Another woman who had recently had pneumonia and was depending upon free care remarked that, "The clinics are so busy they have neither

the time nor capacity to treat medical problems adequately." It was likely that having a regular provider was difficult for a population depending upon free care in community or county clinics. Even if a woman were to request one provider, a busy clinic with some staff turnover would not be able to provide it. Some of these women had strong needs for medical case management or for advocacy within the system.

Seeking emergent care. Most women could not recall a recent accident and did not have an emergent care experience to consider. Two women had sought care for illnesses, one for a miscarriage and one for pneumonia. The woman who had miscarried described the experience as stigmatizing, and felt she had been made to feel at fault for the miscarriage. Although the woman with pneumonia had been initially treated at an ER, she had difficulty finding follow-up care.

Source of Care

Regular source. Most women could name a regular source of care. Inability to pay for care was the reason given by 3 women for not having a regular source of care. Inability to pay also prevented some from seeking specialty care and caused 4 women to discontinue their longstanding source of care. Most women went to free community or county clinics. One woman was a patient at Oregon Health Sciences

and only one woman said that she regularly used emergency rooms and did not need a regular source of care, despite feeling that she was in poor health.

Payment. The majority had no source of payment. One woman had VA benefits, two had medical cards and one mentioned selling her food stamps to afford care.

Additional Findings

The following are additional findings in the areas of daily needs, children and safety. Women were asked to name three daily unmet needs, as well as to describe their concerns regarding their children and personal safety.

Daily Needs

Women's daily unmet needs ranged from "nothing" or simple, incidental items to complex and abstract personal and social needs. Despite their childhood experiences of dysfunctional and abusive families, several women expressed the desire to be closer to their families, perhaps thinking it would be different, or this was an unresolved desire for what was not available to them as children. Many of the women's needs could only be met through the increased availability of low income housing, education and job training, and an array of social and health services. Needs were grouped into five categories: health, basic, personal, family, and social.

Health needs did not appear as a priority when asked about needs in general. Only two women mentioned health related needs, one for better health in general, the other for a doctor for her children, and glasses and dentistry for herself.

The most common basic need stated was food, followed by home and showers, employment/career, money, clothing and sleep. A 27 year old woman recently sheltered in a hotel had been living primarily on the street and was intermittently employed. Her description of her needs were basic.

> I think the main thing is hygiene, you know. Especially when you're struggling and you show up to work and you've got a backpack and you're not even clean. It's just very bad.
>
> And sleep. Sleep is very important. Sometimes you can't even sleep in the hotel, it's just too loud, the floor vibrates. It's very hard.

Personal needs were for "a better life," more time for self, self esteem, and the return of former professional status (2 each). Two women named leisure activities, one a fishing trip, the other, sex. One woman wanted incidental items like cigarettes and soda, while another specified a more abstract personal growth goal of wanting to "learn how to get what I want."

One woman who lived at the West described her basic needs as met. She was beginning to address serious issues in her life, of regaining her former status, having a relationship with her children, and experiencing a pleasurable leisure activity. She said,

> I want my supplies, office and business back, but those aren't things I can get on a daily basis. I can get all the clothes I want, and the food I want and the sleep I want. I'd love to have my kids and I'd love to have my business back and other than that I don't really...I'd like to go fishing. I would love to go fishing.

In response to the question regarding daily unmet needs, only two women mentioned their desire for family, one for her children and the other for her family of origin. During the course of the interview however, three other women had stated their desire to be with their children, and three others expressed wanting a closer relationship with their families of origin.

Some women described unmet social needs. Two would have liked the opportunity for more communication with others, and another wanted someone to talk with about her current relationship. One woman stated that what she wanted was, "caring, understanding and emotional support."

A 54 year old woman who had been homeless for about 8 months and was experiencing declining physical and mental health, was only recently able to get into a shelter. Her needs varied from basic, food and a permanent home, to health and self-esteem.

> I need healthy food. I don't eat that much right now, I have no appetite. The doctor said the protein and calcium content in my system are depleted...I would like my health back together. A comfortable place that is warm, without the threat of being evicted or moved or bounced around. And I'd like good foods, without worrying about where I'm going to do it at, worrying about having enough money or food stamps. I'd like to have self esteem back and professional status back.

Children

Of the 9 women with living children, only two did not have child-related concerns. For some, the lack of relationship with and/or custody of their children was a significant issue. Four women were being followed by the Oregon Children's Services Division. Several women (4) desired to regain custody of their children and two women needed legal assistance to reestablish relationships with their children. One of these women did not even know where they and her ex-husband were living. Table 10 summarized the custody status of the 20 children age 18 or younger.

Table 10

Custody Status of Dependent Children

Status	n
Mother's custody at the West	3
Mother's custody in temporary living situation	2
Living with other family members	7
Foster care	5
Relinquished for adoption	3

As a group the women had suffered tremendous losses regarding children. Three had had children who had died, 3 had relinquished children for adoption, and 4 desired relationships with children of whom they had lost custody. Several women mentioned their concerns about their children as a factor contributing to depression.

Homeless women with children confronted severe emotional, psychological and physical deprivation. The culture that socialized them into identifying themselves primarily as mothers, or offered limited alternatives, also victimized them with socioeconomic forces, depleting them to the point where they were judged to be inadequate parents. The same system that facilitated their childbearing, did little to support childrearing, but offered sanctions and a sense of failure. As recommended by Crystal (1984), critical social services needed by homeless women were those that support establishing and maintaining relationships with their children.

Safety

Homeless women have been described as particularly vulnerable to sexual assualt (Kelly in Brickner, et al., 1985) and crime victimization (Robertson, et al., 1985). Although safety was not currently an issue for women at the West, it was for most other women, including those who

were also sheltered but felt they were in unsafe neighborhoods. Some women, perhaps in denial out of necessity, attempted to downplay the danger of living on the street. However, most women both with and without male partners who had or were currently living on the street, acknowledged their feelings of vulnerability. One woman explained how she felt both safe and unsafe because of the high male to female ratio on the street. Many had been raped, assaulted or robbed, but did not seem to feel the police were available to them, and rarely had sought their intervention.

Nearly half of the women were currently concerned about personal safety, four of whom felt they lived in unsafe neighborhoods. Half expressed feelings of vulnerability while living or having lived on the street. Of those that usually felt safe, six were sheltered (five at the West), and three named the presence of their male partners as contributing to their safety.

Nearly half of the women had been raped, most by men known to them. Four women had been assaulted within the past year, and five had been the victims of theft.

One woman who at 23 was a seven year veteran of living on the street, shared her experience of feeling less safe at her place of employment than living under the Burnside

Bridge. Although she denied being concerned about living on the street, she described the precautions taken for sleeping and having to be alert during the night. She has worked at an AM/PM market at 28th and Broadway, "right on the edge of Saigon," for 3 weeks.

> They got me on the graveyard shift where I'm the only one working. I've been held up twice by a knife. (Have you felt more vulnerable without a male partner?) Not really. Because even though I was alone and homeless, I still had bodyguards. When we'd roll out at night I'd have a guy on this side and a guy on this side, so I wasn't alone. And if anything happened I was usually awake and tapping one of them on the shoulder saying, "Hey, wake up, something's going on here" because I'm a light sleeper. So I wasn't really alone.

Police involvement. Both women who had sought help from the police regarding theft of their property were not satisfied with the help they had received. One woman described witnessing an instance of what she labeled police brutality toward street people, and said she would personally be reluctant to seek their assistance.

These findings and others related to the research questions will be summarized in the next chapter.

CHAPTER IV

Summary

A sample of 18 primarily young, Caucasian women were interviewed to explore their health status, needs and experiences. Nearly half had become homeless as teenagers, while for others it was a combination of circumstances, most prominently job loss, eviction, physical abuse, and use of substances.

In answer to the first research question, "What are the perceived health status, practices and health care needs of homeless women?", the women tended to overestimate their health status, as indicated by their multiple health needs. Although mental health, dental and chronic respiratory infections were the most frequently named health needs, reproductive health care was also area of significant need as evidenced by the women's pregnancies while homeless, and lack of use of condoms and other contraception. All but women were smokers, and except for those sheltered at the West, the women survived on chronically inadequate diets.

The women's mental health problems tended to be of a more moderate and limited nature, such as frequent depression due to the stressful circumstances of homelessness, than chronic mental illness. Most had also been abused either or both in their families of origins and by male partners and were addicted to drugs and/or alcohol. They tended to use more internal than interpersonal methods of coping, as well as seeking relief through substances.

In answer to the second research question, "What has been the experience of homeless women in the health care system regarding accessing care and with health care professionals?", most women had a source of primary care, but not a regular provider. Access to specialty care was more of a problem. Providers' attitudes were described as both the most difficult and most helpful aspects of receiving health care. For some it had been a distinctly stigmatizing experience.

Additional Findings

The women described a variety of unmet daily needs, generally categorized as health, basic, personal, family or social. Health needs were not a priority, and many of the women's needs went beyond basic (food, clothing, shelter) to needs which could only be met through a variety of

social services, and increased availability of low income housing, and adult education and job training.

Most women with children were concerned about them, which some described as contributing to their chronic depression. Desiring custody and/or more of a relationship were the most commonly expressed desires.

Many women acknowledged feeling vulnerable living on the street or being sheltered in unsafe neighborhoods. They also did not feel that police protection was readily available to them and tended to rely more on alliances with men.

Limitations

There were several limitations to this study. They included the small convenience sample, and the coding and analysis of qualitative data. A strength of the study is the researcher's emphasis on recording the women's lived experiences, and giving them a voice through this research. Despite questions addressing many sensitive areas, no women had become emotionally destabilized, and many stated that the interview had been a positive experience for them, and that they appreciated the researcher's time, attention and interest.

Although the researcher had access to women at a variety of settings offering services to the homeless, this

biased the sample toward women accessing services. The sample was also predominantly under 35 years old. While the young mean age was consistent with a larger sample of homeless women in Portland (Multnomah County, 1985), it is possible older women were not using the same services as were the younger women sampled. The researcher did not attempt to approach and interview women on the street, but was usually referred to subjects through agency personnel. It is possible that the health status, needs and experiences of older women are different.

A variety of limitations are associated with taped interviews. Anonymity cannot be maintained and the accuracy of any self report measure is uncertain. Women were questioned about potentially sensitive areas, like substance abuse and prostitution, and their answers may have been biased toward being more socially acceptable than what their experience truly was. However, the researcher did have the sense that these women were being truthful. The fact that half acknowledged problems with substance abuse, a socially undesirable behavior, and many admitted to having been molested, lends credibility to the data.

The interaction between researcher and subjects is both a potential bias of the data and strength of the study. Although similar questions were asked, interaction and

rapport varied. The conditions under which the interviews were done also varied, from an office in a clinic or shelter, to a corner in a busy restaurant/meal site. Some subjects also had more time to spend with the interviewer; a couple were distracted by their children.

The interviews were transcribed verbatim, as shown by the exerpted material. The coding of the qualitative data into quantitative categories required the judgement of the researcher, who was assisted by her thesis committee members in achieving some consistency of interpretation.

For reasons discussed above, the generalizability of the findings are therefore limited. They are however consistent with previous studies, especially that from Multnomah County (1985).

Implications for Research

This study offers a variety directions for nursing research. The complexity of the women's multiple physical and mental health needs suggests the need for case management, advocacy, and referral into specialty care, especially with pregnant women or those with chronic health problems. Research into the most expedient and accessible way to offer this would be a service to these women.

The demographic characteristics of homeless women in Portland have not been determined. The largest sample

study of 190 individuals showed a mean age of 32 (Multnomah County, 1985). If this were to be done, perhaps during an annual survey like that done by the Shelter Network (1988), nursing research could address planning age appropriate services. Preliminary research suggests a need for reproductive and preventive health care and education.

Nursing research could also address the needs of homeless teens, and those vulnerable to becoming homeless. As indicated by this and other preliminary research (Robertson, et al., 1985; Crystal, 1985) many homeless or transient adults were homeless as teens, or in institutions or foster care. What are the needs of this population that are not being met by current interventions or social services?

This research and the Multnomah County study (1985) suggests that homeless women were not able to access adequately nourishing meals or more than one meal a day. This is particularly a problem for pregnant women, as suggested by Winnick (in Brickner, et al., 1985). This study suggests a need for examining the nutritional adequacy of meals provided by meal sites and mechanisms for the planning and provision of multiple meals per day for homeless persons, especially if pregnant.

Mental health was another strong area of need. Some

women said that they were interested in counseling, another mentioned the lack of services for other than the chronically mentally ill. Exploration into the types of services that would be best utilized by women (and couples) with more moderate and limited mental health problems, due to the severe deprivation of their current circumstances, is another potential area of nursing research. The ability of mental health services, offered on a brief, crisis basis, to alter homelessness should be explored. These women have many issues that might be productively addressed within therapeutic relationships, including coping, children, history of abuse, addiction to substances and creating a more successful life.

Providers in settings which currently serve this population could be surveyed to assess their attitudes toward their clients. They could also be asked what they need to improve their services.

Implications for Practice

Perhaps the most significant implication for practice is the perception of some women that their experience with health care providers was stigmatizing. Providers must project a nonjudgemental attitude and make the experience as positive as possible. Unless a positive rapport is established, women may be less likely to followup on a

treatment regimen, as emphasized by Strasser (1979). Along with the woman's immediate subjective experience, this creates the potential for future bias against seeking care, presenting for care on an urgent or emergent basis only, and projecting a negative attitude toward a new provider based on previous experience.

Providers must be aware of and take the time to, or plan to, address the women's multiple and complex needs, physical and mental health, histories of abuse, substance addiction, and child related concerns. Women need to be educated regarding reproductive and preventive health care, STDs, and their intentions regarding pregnancy explored. Multiple appointments and familiarity with the community's referral system may be necessary. Women may be best served by advocacy within the health care system, as the failure of the case manager at the West shows, there may have been some carryover stigma to a person in her position.

APPENDIX I

INTERVIEW SCHEDULE

DEMOGRAPHICS

1. How old are you now?

2. What is your race?
    1. Caucasian
    2. Black
    3. Hispanic
    4. American Indian
    5. Southeast Asian
    6. Other:

3. What was the last grade in school that you finished? (Code years)

4. What is your marital status?
    1. never married
    2. married
    3. married, but separated
    4. widowed
    5. divorced

5. How many times have you been married?

6. How many times have you been involved with someone but not married?

7. Are you currently involved in a relationship with someone (not legal husband)?
    1. yes 2. no
    if yes, please explain.
    Are you living with this person?

HOMELESSNESS

8. How long have you been without a permanent place to stay?
    1. less than 1 month
    2. 1-2 months
    3. 3-5 months
    4. 6-12 months
    5. Over one year (how many years).

9. Where are you staying now?

10. In reviewing the past what particular events or circumstances contributed to the situation you're in today?

When did they occur?

11. What do you think would have helped prevent you from becoming homeless?

NUTRITION

12. Please describe your eating habits to me?

13. What do you usually eat?

14. Where do you usually eat?

15. Do you usually get enough to eat?

16. What do you need that you're not getting?

HEALTH STATUS

17. How would you describe your health?
1. poor 2. fair 3. good 4. excellent

18. What are your major health concerns?

19. Do your have a chronic or recurring illness, I mean a problem that you have all of the time, or one that makes you sick occasionally? (for example, high blood pressure or diabetes)
1. yes 2. no

20a. (If yes) What is the illness?
Code by name(s) of illness(es):
If more than two, indicate which two are most serious
high blood pressure
cancer
diabetes
heart conditions
emphyzema
bronchitis
asthma
chronic cough
herpes
headaches
arthritis
pneumonia
epilepsy
other: specify

20b. How long ago did you first notice the problem?
Indicate time: Years: Months:
One month or less

20c. When was the last time you saw a health provider about this?
1. Within the last year
2. Over a year
3. Never seen anyone about this problem

20d. Why haven't you sought care more recently?
<u>Potential codes</u>:
Not enough money
Problem not serious
Don't know a doctor where I can go
No transportation
Thought it would go away by itself
Don't have medical insurance
Couldn't get a medical appointment
Would have to wait too long
Lost insurance and stopped going
Knew how to treat the condition without medical help
Can't be treated
Other: specify
DK or NA

21. Are you seeing a health care provider, taking medicine, or receiving any medical treatment now?
1. yes 2. no

21a. (If yes) Please tell me who you're seeing, and describe your treatment or medicine to me.:

21b. If you are not now taking medicine, should you be taking any?
1. yes 2. no 3. DNA (currently taking medicine)

21c. If yes, what type(s) of medicine should you be taking?

22. Does your health keep you from working at a job or going to school?
1. yes 2. no 3. some jobs

<u>HEALTH CARE ACCESS AND EXPERIENCE</u>

23. Please describe your experience seeking health care and with health care professionals?

24. What has been difficult for you?

25. What has been helpful?

26. How do you generally pay for health care?

27. Do you have a medical card?
1. yes 2. no

28. Have you ever had a medical card before?
1. yes 2. no

28a. (If applicable) How many months ago and how did you lose your benefits?

29. Where do you or would you go for health care?
1. ER 2. Free clinic 3. Public health dept. 4. Other

30. Do you have one person you usually see there?
1. yes 2. no

31. Tell me why you don't have a regular person or place to go?

<u>Potential codes</u>:

Never get sick/don't need
dissatisfied with care
too expensive/no insurance
don't know where to go
none available close by
doctors won't take medicaid
doctors want money only
move around too much
have to wait too long
have to take time off from my job
other

32. Thinking back over the past two months, were you sick or did you have any accidents?
1. yes 2. no

32a. What was the matter?

<u>Potential codes</u>:

broken bones
cuts
other accidents
flu
colds
cough
backaches/trouble
headaches
hearing problems
burns
falls
colds
weak, dizzy
mononucleosis
cancer
pregnancy related

eye trouble	high blood pressure
bronchitis	ankle/foot/leg problems
skin	intesitinal
cardiac	mental health
other: specify	

32b. Did you contact a health professional about this problem?

1. yes 2. no

<u>If yes</u>:

32c. Where did you go for care?

<u>Potential codes</u>:

1. ER
2. County clinic
3. Free community clinic
4. private physician
5. private hospital
6. other: specify

32d. How long did you wait before you sought care?

Number of days:
Less than 1 day:
Doesn't remember:

32e. How many days did you have to wait for an appointment?

Indicate number of days
Less than one day
Don't remember

33f. Once you arrived at ___________, how long did you have to wait before you saw a provider?

Indicate number of hours
Less than one hour
DK or NA

33g. If no, can you tell me why not?

<u>Potential codes</u>:

Problem not serious enough
couldn't find the time
couldn't afford to go to the doctor
no transportation
doctor couldn't help
would have to wait too long to see the doctor
other: specify

REPRODUCTIVE HEALTH CARE

Now I'd like to ask you about some things specific to women's health.

34. What kind of surgeries have you had?
    List:

35. Please describe your experience with pregnancy and childbirth?

35a. How many times have you been pregnant? (including live births, stillbirths, miscarriages, and abortions)?
    # of times

35b. How many times have you given birth?
    # of times
    age at birth
    birthweights
    gestational age
    current status of children/where are they?

35c. What are your concerns regarding your children?

35d. What would be helpful to you regarding your children?

36. Are you concerned about becoming pregnant?

37. What would you do if you became pregnant?

38. Have you ever gotten pregnant while you were homeless?
    1. yes 2. no

39. Do you think that you are pregnant now?
    1. yes 2. no

40. What do you do to prevent yourself from becoming pregnant?
    Potential codes:
    - condom/rubber
    - jelly, foam, suppository
    - diaphragm
    - pill
    - IUD
    - withdrawal
    - douche
    - rhythm, menstrual calendar
    - other: describe

41. In the past year, did you or your partner(s) use birth control most of the time, about half the time, or seldom?

Potential codes:
- Most of the time
- half of the time
- seldom
- none

42. What problems have you had finding birth control?
43. What problems have you had using birth control?

Sexually Transmitted Diseases

44. When you have sex, do you ever worry about catching a disease?

1. yes 2. no

45. What do you do to protect yourself?
- use condom/rubber
- wash/douche
- other: describe

46. Have you ever had any sexually transmitted diseases or tested positive for AIDS?

46a. What did you have/How many times:

Potential Codes:
- gonorrhea
- syphilis
- herpes
- pelvic inflammatory disease
- chlamydia
- trichomiasis
- +HIV/AIDS
- other: describe

46b. What problems have you had getting treatment?

47. Have you ever been a prostitute?

47a. (If yes) How did that happen to you?

SUBSTANCES

48. Please describe to me your usual patterns of alcohol consumption?

1. Less than once a year or not at all
2. 1-3 drinks a week
3. Drink 4-13 drinks a week
4. Drink 2 or more a day
5. Drink 3-5 drinks a day
6. Drink over 6 drinks a day
7. Recovering alcoholic, not drinking currently

48a. How long dry/sober?

49. Do you gulp your drinks?

50. Do you ever feel bad or guilty about drinking?

51. Have you ever felt the need for an "eye opener"?

52. Do you believe that drinking affects you differently than others?

53. Are there people in your family that have problems with drinking?

54. If you don't drink but have a family member who is an alcoholic, are you
afraid that you might develop the problem?

55. What drugs or medications have you taken in the past month?
Potential Codes:
Marijuana/hash
Amphetamines/speed
Barbituates/downers/sleeping pills, seconal/quaaludes
Tranquilizers/valium/librium
Cocaine
Heroin
Opiates other than heroin such as demerol, codeine, morphine, methadone, darvon, opium.
Psychadelics (LSD, mescaline, peyote, psilocybin, dmt, pcp)
Other: specify

55a. If yes, were they prescribed by a doctor?

55b. How often do you use them?
1. daily
2. several times a week
3. several times a month
4. once a month
5. less than once a month
6. DNA (not using street drugs)

Treatment

56. Have you ever received help for drug use?

56a. Where did you get help?
Potential codes:
alcohol treatment center
drug treatment center
mental health clinic/center

physical health clinic
private doctor
county hospital/ER
druggist or nurse
counselor/psychologist/social worker
minister/priest/rabbi
teacher
family
friends
nowhere
other: describe
self-help groups (NA, AA, CA)

56b. How many times?

56c. How long were you there?

56d. When was the last time?
Within the last 2 weeks
within the last month
within the last 6 months
within the last year
within the last 3 years
more than 3 years ago

56e. When was the first time?
Age:

57. In the last year, have you had any problems with drugs you needed help with that you did not get?
1. yes 2. no

58. What is the main reason you didn't get help?
<u>Potential codes</u>:
Don't have drug problem
Didn't know where to go
Didn't want others to find out
Didn't have money
Inconvenient time/place
Fear arrest/detention
Didn't want to (why?)
Other: describe

59. In case you needed help with a drug problem, where would you go to get help?
<u>Potential codes</u>:
ETOH detox/treatment center
Drug detox/treatment center
mental health clinic
physcial health clinic

private doctor
county hosp/ER
druggist or nurse
counselor/psychologist/social worker
minister/priest/rabbi
teacher
self-help groups (AA, NA, CA)
nowhere
other: describe

60. Do you need help right now with a drug problem?

MENTAL HEALTH

61. How would you describe your current state of mental health?

62. How has homelessness influenced your mental health?

63. What do you do to cope with the stress?

64. In thinking back about some of your feelings over the last year, do you remember times when felt sad or depressed. or you lost all interest and pleasure in things that you usually care about or enjoy?
1. yes 2. no

64a. (If yes) How long did you feel that way?
Indicate : weeks; months

64b. Why did you feel that way?
Potential codes:
Main reason:________________
No money
No job
Divorce
Separation form family
Death in family/friend
No home
No future
Possessed/controlled by externals
Lonely
Robbed
Physical illness/injury
People around me
Other: specify

65. In the last year, have you ever felt so low you thought of committing suicide?
1. yes 2. no

65a. In the last year, did you attempt suicide?

65b. How many times?

65c. When did you last attempt suicide?

65d. What did you do?
Potential codes:
Pills, medicine, poison
Meds with ETOH
ETOH intoxication
Jumps/falls/vehicle
Firearms
Hanging
Cuts
Other:

66. Have you ever attempted suicide?

67. Have you ever been in counseling or been referred to a mental health clinic or center?
1. yes 2. no

67a. If yes, where?
67b. What kind of clinic?

67c. For what reason?
Potential codes:
Difficulties in managing life.
Drinking or a drug problem.
Emotional or nervous problems.

68. Have you ever been given medication for your mental health?
1. yes 2. no
What medicines were you given?
List medications:/ask to describe

69. Can you tell me the kind of emotional or nervous problem that led to your being seen by a doctor or other professional the last time?
Potential codes:
Schizophrenia
Personality disorder
Affective disorder
Depression
Bipolar
Suicide tendency
Insomnia
Paranoid
Anxiety
Violent Behavior
Suicidal Behavior

70. Have you ever been hospitalized for psychiatric reasons?

70a. How many times?

70b. How long ago was your most recent hospitalization for nervous or emotional problems?
Indicate months and/or years: years
months

71. How old were you the very first time you ever saw a doctor or a counselor because of mental or emotional problems?
Indicate age in years:

72. Are you seeing a counselor now?

72a. Do you have a case manager?

73. Do you believe that you have mental health problems you have not been treated for?
1. yes 2. no

73a. What kind of problems?

DOMESTIC VIOLENCE/ABUSE

74. Have you ever been physically abused? 1. yes 2. no

74a. (If yes) How old were you? Please tell me what happened?

74b. Were there other times that this happened to you?

74c. (If yes) Please tell me what happened?

75. Have you ever been sexually abused? 1. yes 2. no

75a. (If yes) How old were you? Please tell me what happened?

75b. Were there other times that this happened to you?

75c. (If yes) Please tell me what happened?

76. Have you ever been sexually assaulted or raped?

77. Are you currently involved in an abusive relationship?

78. Have you ever talked to anyone about this?

79. Have you ever talked to a counselor or been in a support group addressing these issues?

80. Are you interested in doing that?

SAFETY/VICTIMIZATION

81. Do you feel safe where you live now? 1. yes 2. no

81a. If no can you describe why?

82. In the last 12 months, has someone broken into a room or apartment of yours and taken some of your property? (Burglary)
1. yes 2. no

82a. (If yes) When did this happen?:
<2 weeks
<1 month
<6 months
<1 year

83. In the last 12 months, was something taken from you by someone who threatened you with violence if you didn't give it to them? (Robbery)
1. yes 2. no

83a. (If yes) When did this happen?:
<2 weeks
<1 month
<6 months
<1 year

84. In the last 12 months, have you been physically attacked or assaulted? (Assault) 1. yes 2. no

84a. (If yes) When did this happen?:
<2 weeks
<1 month
<6 months
<1 year

85. In the last 12 months, has anyone forced or pressured you to have sex with them? (rape)
1. yes 2. no

85a. (If yes) When did this happen?:
<2 weeks
<1 month
<6 months
<1 year

86. In the last 12 months, have you been the victim of any other crime?

1. yes 2. no

86a. (If yes) Please describe it to me?:

86b. When did it happen?

<2 weeks
<1 month
<6 months
<1 year

86c. Did you talk to the police about this?

1. yes 2. no

86d. (If no) Why not?:

87. Did the police help?

1. yes 2. no

87a. Which did they help with?

87b. How did they help?

88. In order to keep yourself from being harmed in any way do you:

carry a weapon?
stay away from certain places?
stay away from people
sleep during the day and stay awake at night?
make sure you're always with someone you can trust?

89. Is there anything else you do to protect yourself from harm?

89a. What do you do?

90. What do you need to feel safe?

NEEDS

91. What are your three most important needs on a daily basis, things that you need and want but cannot get?

APPENDIX II

Oregon Health Sciences University
CONSENT FORM

STUDY: Homeless Women and Health Care
PRINCIPAL INVESTIGATOR: Amy Pujanauski
OBJECTIVES: To describe the health status, health care experience and health care needs of homeless women.

The following is intended to be read to potential subjects by the researcher while they read their copy.

I am a graduate student from the School of Nursing at the Oregon Health Sciences University. This interview is part of a study I am conducting under the direction of Dr. MaryAnn Curry. The purpose of this study is to find out more about the health and health care needs and experiences of homeless women. I am asking women to participate by allowing me to interview them. The interview will probably take about 40 minutes. The cost to you will be your time only.

Your participation is completely voluntary and anonymous. You have the option of signing a consent form other than that I am reading to you which will not link you directly to participation in this research. With your permission, I would like to tape the interview but without our name it cannot identify you. Neither your name nor your identity will be used for publication or publicity purposes. The only other person who may listen to this recording or read my notes is my research advisor, Dr. MaryAnn Curry. The tapes will be kept in a locked file cabinet until data analysis is completed, at which time they will be destroyed.

The interview will ask you about your health, and what your experience and problems have been with getting health care. There will also be questions on your background and history related to physical and mental health, and homelessness. Please understand that I am required by law to report knowledge of child abuse and some diseases, such as gonorrhea, and that I cannot protect your confidentiality in court regarding illegal activity that I am witness to.

Your participation will help me learn more about the needs and experiences of homeless women. It is not expected to involve any risk to you although some women may be uncomfortable with some topics. You are free to withdraw from this study at any time without affecting the care or services you receive from this organization/clinic or Oregon Health Sciences University. If you would like,

at the end of the interview I will attempt to assist you with referrals to community and social services if you are not familiar with what is available to you.

The Oregon Health Sciences University, as an agency of the state, is covered by the State Liability Fund. If you suffer any injury from the research project, compensation would be available to you only if you establish that the injury occurred through the fault of the University, its officers or employees. If you have further question, please call Dr. Michael Baird at (503)279-8014. I am grateful for your assistance with this study. If you have any questions or concerns, please contact me at 279-7893.

______________________	______________
Subject	Date
______________________	______________
Witness	Date
______________________	______________
Investigator	Date

REFERENCES

Bassuk, E.L., Rubin, L. & Lauriat, MA. (1986). Characteristics of sheltered homeless families. American Journal of Public Health, 76(9), 1097-1101.

Bingham, R.D., Green, R.E. & White, S.B. (1987). The Homeless in Contemporary Society. Los Angeles: Sage.

Brickner, P.W. (1985). Health Issues in the care of the homeless. In Brickner, P.W., Scharer, L.K., Conanan, B., Elvy, A. & Savarese, M. (Eds.). Health Care of Homeless People (pp. 1-18). New York: Springer.

Brickner, P. W., Scharer, L.K., Conanan, B., Elvy, A. & Savarese, M. (Eds.). (1985). Healthcare of Homeless People. New York: Springer.

Chavkin, W., Kristal, A., Seabron, C. & Guigli, P.E. (1987). The reproductive experience of women living in hotels for the homeless in New York City. New York State Journal of Medicine, 87(1), 10-13.

Corrigan, E.M. & Anderson, S.C. (1984). Homeless alcoholic women on skid row. American Journal of Drug and Alcohol Abuse, 10(4), 535-549.

Crystal, S. (1984). Homeless Men and homeless women: The gender gap. Urbanand Social Change Review, 17(2), 2-6.

Filardo, T. (1985). Chronic disease management in the homeless. In Brickner, P.W., Scharer, L.K., Conanan, B., Elvy, A. & Savarese, M. (Eds.). Health Care of Homeless People (pp. 19-31). New York: Springer.

Lenehan, G.P., McInnis, B.N., O'Donnell, D. & Hennessey, M. (1985). A nurses' clinic for the homeless. American Journal of Nursing, 85, 1237-40.

Multnomah County Department of Human Services (1985). Homeless Women 1985. Portland, Oregon: Author.

Reuler, J.B., Bax, M.J. & Sampson, J.H. (1986). Physician house call services for medically needy, inner-city residents. American Journal of Public Health, 76(9), 1131-34.

Robertson, M.J., Ropers, R.H. & Boyer, R. (1985). The Homeless of Los Angeles County: An Empirical Assessment. Los Angeles: UCLA School of Public Health

Roth, D., Toomey, B.G. & First, R.J. (1987). Homeless women: Characteristics and needs. Affilia, 2(4), 7-19.

Sebastian, J.G. (1985). Homelessness: A state of vulnerability. Family and Community Health, 8(3), 11-24.

Slavinsky, A. T. & Cousins, A. (1982). Homeless women. Nursing Outlook, 30(6), 358-62.

Shelter Advisory Committee. (1986). Summary of the Work of the Shelter, Clean-up, and Clothing Ad Hoc Advisory Committee. Portland, Oregon: Author.

Stoner, M.R. (1984). The plight of homeless women. Social Service Review, 57(4), 565-581.

Strasser, J.A. (1978). Urban transient women. American Journal of Nursing, 78, 2076-79.

Walsh, B. & Davenport, D. (1981). The Long Loneliness in Baltimore: A Study of Homeless Women. Baltimore: Authors.

Wright, J.D. (1987). Homelessness is Not Healthy for Children and Other Living Things. Amherst: Social and Demographic Research Institute, University of Massachusetts.

Wright, J.D., Rossi, P.H., Knight, J.W., Weber-Burding, E., Tessler, R.C., Stewart, C.E., Geronimo, M. & Lam, J. (1987). Homelessness and health: The effects of life style on physical well-being among homeless people in New York City. Research in Social Problems and Public Policy, 4, 41-72.

ABSTRACT

Homeless Women and Health Care in an Urban Setting:

Portland Oregon

by

Amy Pujanauski

For the Master of Science degree, June, 1989

Approved____

Mary Ann Curry, R.N., D.N. Sc., Thesis Advisor

Homeless men have been a significant and well-studied population for many years, while homeless women, an emerging and more vulnerable group, have rarely been the focus of research. To better meet their health care needs, health care providers need more information about homeless women. The purpose of this exploratory study was to describe the health status, practices, needs and experiences of homeless women in Portland, Oregon.

A convenience sample of 18 homeless women, most of whom were under 35 years old, was interviewed at shelters and a meal site. The duration of the taped interviews ranged from 30 minutes to one and one half hours. The structured interview guide adapted by the researcher addressed the

following areas: demographics, history of homelessness, physical and mental health status and needs, health care experience, domestic violence, substance use, and safety. Content analysis of the data was based upon codes and categories which emerged from the initial interviews. About half of the women described their physical health as good or excellent, and half as fair or poor. Almost half depended upon one to two meals per day at meal sites, and most could describe inadequacies in their diet.

Most common health related concerns were mental health, dental problems and chronic respiratory infections. All but two women were smokers. Seven women had been pregnant at least once while homeless, and 4 thought they might now be pregnant. Only one of the 7 fertile women currently sexually active with men was using birth control.

Over half of the women described their mental health as fair, ok, or poor. Nearly one-half had had at least one psychiatric hospitalization, two for alcohol detoxification. All women could describe recent episodes of depression. Over half of the women had attempted suicide at least once. Over half of the women described themselves as alcoholics, four of whom were also addicted to drugs. Most women had been physically and/or sexually abused by their families of origin or male partners. Nearly one half had been raped.

Although most women received free health care through community or county clinics, inability to pay for care was named as the main problem with accessing care. Many also described difficulty with the interpersonal aspect of care, such as feeling stigmatized by their providers.

Implications for nursing practice suggested by the study include the need to address the multiple and complexhealth needs of homeless women and their need for case management and advocacy within the system. Providers also need to be aware of their clients' sensitivity to judgemental attitudes, and their need for communication, education and support.

This study suggested further nursing research into the demographic characteristics of homeless adult women and teenagers in Portland, Oregon. Research could then be focused on planning physical and mental health services which would be both age appropriate and accessible to the target population.