A Comparison of the Health Needs of Homeless Men and Homeless Women in Portland, Oregon

by

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CHAPTER I

Introduction

In the last 20 years, homelessness in America has become a social problem of great magnitude. Despite extensive research on the topic, many questions regarding persons who are homeless remain unanswered. Typically the homeless have poorer health and greater mortality than the general population (Alstrom, Lindelius, & Salum, 1975; Rossi, Wright, Fisher, & Willis, 1987; Wright, 1987). Health risks are inherent in an unsheltered and indigent life: exposure to environment, both natural and social; inadequate nutrition; uncertain hygiene; and indifferent, untimely or nonexistent health care.

Among many diverse definitions of persons who are homeless in the literature (Russo, 1982; Kaufman, 1984; Roth & Bean, 1986; Rossi et al., 1987), the most common definition is

> those who do not have customary and regular access to a conventional dwelling or residence and who are forced to seek a shelter or temporary housing (Kaufman, 1984, p. 21; Rossi et al., 1987, p. 1337).

Most information about the homeless describes the causes and the characteristics of homelessness. The main causes of homelessness are poverty, social isolation, deinstitutionalization of psychiatric patients, and lack of housing (Roth & Bean, 1986; Rossi et al., 1987; Rossi & Wright, 1987). Most demographic information about the homeless describes the skid row type man or the homeless in

general (Cohen, 1983; Cohen, Teresi, Holmes, & Roth, 1988; Brickner, Sharer, Conanan, Elvy, & Savarese, 1985). However the "new homeless" are getting more attention. They are more diverse, with more women, children, adolescents, single men and families. Compared to the homeless of the past, they are younger, better educated and disproportionally nonwhite (Robertson, Roper, & Boyer, 1985).

The number of homeless is hard to estimate due to the mobility of the clients. In 1983, the National Coalition for Homeless puts the figure at 2.5 million (Bassuk, 1984). This figure is in contrast to the Federal Department of Housing and Urban Development estimates that 250,000 to 350,000 were homeless in the U.S. in 1986 (Roper & Boyer, 1987). In Portland, estimates are that there were 27,000 homeless in 1988, 57% of whom were men, 11%, women, and 32%, youth and family groups (Oregon Shelter Network, 1988).

In the past most studies of the homeless have concerned men because they have predominated among the homeless. Recently women have become a popular focus of attention because they are part of the "new homeless" and because they have certain unique needs. However, little information yet exists which identifies the unique needs of younger or "new homeless" men or which compares homeless men and women with regard to their health needs and practices.

Purpose

The purpose of this study is to explore the health

status, health practices, and health care needs and experiences of homeless men in Portland, Oregon. This study built upon a study, by Pujanauski (1989), of the above issues related to women, so that the results describing the men might be compared with the results describing the women to establish similarities and/or differences between the two groups.

In order for nurses to meet the current health needs of both homeless men and women, they need to be aware of the unique health status, needs and experiences of men and how they compare to those of women. More information would help nurses provide better primary care in a manner more acceptable to the homeless. In turn, better care should result in fewer health crises, fewer hospitalizations and less of a burden on the health care system. Also, more information should prove useful to nurses in educating legislators and policy-makers at all political levels on how to develop and expand programs for the homeless.

Literature Review

The review of the literature was divided into four parts: studies of persons who are homeless in general, studies of homeless men, studies comparing homeless men to homeless women, and lastly, the homeless of Portland.

The Homeless In General

A study of 1264 homeless by the Phoenix South Community Mental Health Center (1983) revealed unemployment as the number one reason for being homeless. Of the sample, 89% were

men and 11% were women. This sample was described as comprised of the "new homeless". The mean age was 36.8. (The ages of men and women were not distinguished). Only 25% were chronic substance abusers. They were more likely to be white and more employable than the "old homeless" (those homeless for more than 5 years). Thirteen percent were coupled and 46% were never married. Fifty percent stated they were in good health, 25% in fair health, and 10% in poor health.

Brickner et al. (1985) reviewed the existing literature describing the general health problems of the homeless. Included in the review were problems of infestations, exposure, trauma, infection, nutrition, hypertension, peripheral vascular disease, tuberculosis, and alcoholism (Brickner et al., 1985). Although most studies have not reported the ages of their samples, a few of the more recent studies have commented on how "young" the population was.

Rossi et al. (1987) studied an urban homeless population with a sample of 76% men and 24% women. The average age of the men was 40; the average age of the women was not stated. The group was found to live in extreme poverty (the average income was less than half the poverty-level), with high levels of disability and social isolation. Prominent health conditions were mental illness, cardiovascular ailments, and gastrointestinal problems. Thirty-seven percent reported themselves as in fair or poor health. (This is twice the proportion in the general population.) One in four reported

hospital stays of longer than twenty-four hours. High levels of alcohol and drug abuse were evident, with one in three treated in detoxification centers.

Gelberg, Linn, & Leake (1988) surveyed the homeless in two beach communities of L.A. County. In that sample, 27% were male and 73% were female. The mean age was 34. Compared to the rest of the sample, it was found that those persons who had had previous psychiatric hospitalization were least likely to sleep in emergency shelters, had been homeless twice as long, had the poorest mental health status, used alcohol and drugs the most, and were the most involved in criminal activities. However, no health concerns were differentiated by gender.

Belcher (1988) followed 132 patients (55% male and 45% female) who were released from a midwest state hospital. Forty-seven became homeless within 3 months. The results suggested that severe mental illness, together with a tendency to decompensate in a nonstructured environment and an inability or unwillingness to follow through with aftercare contributed to involvement with the criminal justice system.

Homeless Men

Although the average age of the persons who are homeless has changed from 40-60 to less than 40 in the last decade, many of the studies reported in the literature have been of older, "skid row" type men (Brickner et al., 1972; Brickner & Kaufman, 1973; Lindelius & Salum, 1976; Cohen, 1983;

Cohen et al., 1988). The average age of the men in these studies was 50-55. The common health problems found were heart disease, respiratory infection, leg ulcers, and depression.

A few studies focused on young homeless men. Fischer, Shapiro, Breakey, Anthony, & Kramer (1986) surveyed 51 men who used the mission shelters. Their median age was 38. (The age of the women was not stated.) When compared to 1338 householders, large differences were found in their health care utilization patterns and social dysfunction. One third of the homeless scored high on measures of distress and had current psychiatric disorders. Also, the homeless had higher rates of hospitalization for mental and physical problems, but a smaller proportion received ambulatory care.

Koegel & Burnam (1988) found that alcoholism appeared more prevalent in the younger homeless persons. They drew a probability sample of 328 homeless adults and compared them with 3000 householders. Both lifetime and current prevalence of alcoholism were higher among the homeless. As often is the case, there were more men (97%) in this study than women (3%). The ages of the women versus men were not stated. However, the majority were between 20 and 40 years of age.

Pearson (1988) reviewed the records of the homeless who visited a health care clinic in Atlanta, Georgia. No specific age of the sample was stated; although the age of the group (90% of whom were men) was "20-40 mostly". The most frequent

health problems were respiratory infection and hypertension.

In Ohio, Roth and Bean (1986) interviewed 979 "new homeless" (81% men). Their median age was 34. Those interviewed gave the following reasons for being homeless: unemployment, lack of low cost housing, cuts in government benefits, and family conflict. However, no mention was made of health problems.

Susser, Struening & Conover (1989) interviewed 223 men to determine the prevalence of psychiatric problems in the homeless of New York. Of the sample, 84% were under the age of 40. The majority had a history of mental disorder or heavy substance abuse. The "newly homeless" were younger and had fewer psychiatric problems. Those over 40 years were more likely to have been homeless longer (> 5 years) than the "newly homeless".

Homeless Women

Unlike the "new homeless" men who have not been singled out because of their gender for study, new homeless women have been singled out and depicted as a vulnerable and large group (Boyer, 1986). Some reports indicate that women make up half the homeless population (Slavinsky & Cousins, 1982). From his review of the literature on homeless women, Stoner (1983) found women to be younger, less educated, and exposed to many more dangers than men (e.g., rape, trading sexual favors for food and shelter). Only one of the studies reviewed by

Stoner, namely a study conducted in 1982 in South Carolina, mentioned the age of the women as being forty or younger. Most of these South Carolina women were not employed. Their most serious problems were lack of money, nowhere to live, unemployment, separation from family, lack of friends, and illness.

Although Crystal (1984) interviewed both men and women, his focus was on the women. Women were more likely than men to have grown up in an institutional or foster care setting and were more likely not to have lived with either parent during most of their childhood. Women were more likely to have psychiatric histories, yet were less likely to have been in jail or be employed. Women were more likely to be married currently or previously and 53% had children with whom they maintained ongoing relationships in hopes of resuming caretaking in the future. No mention was made as to the age similarity of the women and men except that 67% of men and 63% of women with histories of psychiatric hospitalizations were less than 40 years of age.

Stoner (1984) investigated the quality and character of shelters for women. He found that the women's shelters were predominantly under private auspices, and disproportionally fewer in number than shelters for men. The existing shelters for women tended to operate with lower standards than those for men and had fewer trained people directly involved in staffing. Also, although shelters often provided meals, they

seldom adequately met the nutritional needs of pregnant women (Damrosch, Sullivan, Scholler & Gaines, 1988).

In Portland, Oregon, Pujanauski (1989) conducted a study in which she interviewed 18 homeless women. The age range was from 18 to 54 with a mean age of 30. Fifteen were under the age of 35. The following areas were the topics of the interview: demographic characteristics, history of homelessness, physical and mental health status and needs, health care experience, domestic violence, substance use, and safety.

The history of the women indicated that nearly half (8) had lived on the street most of the time since they became homeless. Also, nearly half (7) of the women had been essentially homeless since their teenager years.

About half of the women described their physical health as good or excellent, and half as fair or poor. The physical health concerns expressed most often were mental health, dentistry problems, chronic respiratory infections, and obtaining adequate nutrition. Although not expressed as a health concern, reproductive health needs appeared evident (e.g., 7 of the 18 women had been pregnant while they were homeless and 6 of these 7 sexually active women were using no birth control).

Mental health problems were evident, with all women describing episodes of depression. Over half of the women had attempted suicide at least once, and over half described

themselves as alcoholic. (Alcohol and drug abuse was reported by over 50%.) Also, almost all women (14) in the study had been physically and/or sexually abused as children or adults.

Their main problem in obtaining access to health care was inability to pay for care and unavailability of specialty care (e.g., dentistry, dermatology, or ophthalmology). If care was found, most women experienced interpersonal problems with the providers such as feeling stigmatized.

Although safety was not an issue with women who lived in a hotel, it was an issue for the remainder of women. Many had been raped, assaulted and/or been the victims of theft. Most did not feel the police were available to them and few sought their protection.

Homeless Men Compared to Homeless Women

Although some studies minimize the differences in causes of homelessness and the differences in health status between men and women, most current research appears to support the view that these differences do exist.

Although many of the studies reviewed by Brickner et al. (1985) were restricted to one sex, one study did explicitly compare men to women. That study concerned 340 homeless men and women admitted to San Francisco General Hospital for trauma from January 1983 to April 1983 (Brickner et al., 1985). Although women comprised only 22% of the homeless sample, they accounted for more than 76% of the homeless victims of sexual assault. Many women (46.2%) and the

majority of men (62.5%) were between 20 and 29 years old.

Robertson et al. (1985) surveyed 238 homeless people in Los Angeles of whom 73% lived on skid row and 27% lived in the westside area of L.A.. The mean age was 37 with no difference in age distribution by gender. The majority felt they were in good health (66%). However, less than 48% had a particular place or person to see for health care. No gender differences in help seeking behavior or hospitalization were found.

Seventy seven percent of Robertson et al.'s (1985) sample were male and 23% were female. The men were more likely to be single whereas the women were more likely to be divorced, widowed, or married. The men had been homeless on an average of 93 weeks, a period significantly longer than the average 54 weeks reported by the women. The precipitating causes of homelessness for men were no money and job loss, whereas women's causes of homelessness were runaway, abandonment, and, lastly, no money.

The women of Robertson et al.'s (1985) sample were twice as likely as men to report illness. The leading chronic physical health problems for women were hypertension, arthritis and asthma; and the leading chronic problem for men was hypertension. Mental illness appeared more pronounced among the women: they reported more feelings of depression and more attempts at suicide than men. However, men had more arrests for alcoholism and were more frequently jailed than women.

In contrast to Robertson et al. (1985), Hagan's review of literature (1987) found that homelessness in men resulted from running away, unemployment, alcoholism, and jail release. However, women became homeless as a result of eviction and domestic violence. No assessment was made of the health differences between the genders. However, this was the only study with a nearly equal distribution of the sexes: men-53% and women-47%. Thirty-nine percent were between the ages of 22 and 35. Ages by gender were not reported.

Wright et al. (1987) stated little has been written about physical health problems. They found that many diseases are two and three times more common in the homeless than in the general population. They interviewed men and women for similarities and differences in health problems. The most frequent health problems which did not differ between genders were acute upper respiratory infections (28% for both men and women), chronic diseases (21%), diseases of the extremities (19%), and hypertension (14%).

Frequent health problems which did differ between genders were trauma which occurred more often in men (32%-men, 21%-women) and mental illness which appeared more often in women (34%-women, 13%-men).

Under the sponsorship of the Johnson Foundation, Wright (1987) conducted research on 30,000 persons who were homeless. Although Wright's results focused mainly on homeless children, youth and women, he did present some comparisons of adult

homeless men and women. The women were younger than the men: 42% women and 30% men were ages 16-29. The men and women were similar in their ethnicity and education. The major difference was that 25% of the women but virtually none of the men had dependent children in their care. Wright concluded that homeless men were at higher risk for tuberculosis, hypertension and trauma. In contrast, women had higher rates of eating disorders and related nutrition disorders, endocrinology disorders, and genitourinary disorders. Women had three times less alcoholism and two times more mental illness than men.

This last finding supported an earlier study conducted in Boston by Bassuk and Rubin (1984). The median age of the 78 persons in their sample was 33.8; 83% were men and 17% were women. Ages of men and women were not compared. They found that 85% of the women in their study were mentally ill and that chronic alcoholics were predominately males.

Lam (1987) conducted a study which implied that men have more "killer diseases" (e.g., tuberculosis, seizure disorders, cardiac disease, hypertension, stroke, and liver disease) than women. Women appeared to have milder "transitory" diseases (e.g., gonorrhea, endocrine disorders, nutritional deficiencies, obesity, anemia, ear problems, and gastrointestinal disorders) than men.

Lastly, Breakey et al. (1989) conducted a study of the homeless people in Maryland. In the sample, 298 were men with

a mean age of 39.7 and 230 were women with a mean age of 32.7. The major health problems found (in the order of prevalence) were dental, dermatologic, cardiovascular, musculoskeletal, and respiratory. The only area in which women had a higher prevalence of a disease than men was musculoskeletal. There was a high prevalence of mental illness: 91% men and 80% women either had a major mental illness or substance use disorder. Also, the rate of alcohol use was high for both men and women: 68% and 32% respectively.

The Homeless of Portland

Five studies have appeared on the homeless of Portland. Pujanauski's study of homeless women conducted in 1988-89 has already been described. She noted the following health problems in women: mental illness, dental problems, chronic respiratory infections, inadequate nutrition, lack of prenatal care and birth control, alcoholism, and physical/sexual abuse.

In 1984, Multnomah County researchers interviewed 128 homeless persons and found the mean age to be 38 (Caulk, 1984). Men comprised 85% of the sample. Fifty percent drank daily, or more than two times per week, and 40% were admitted to Hooper Detoxification Center. Seventy five percent used no street drugs, and 83% had no history of psychiatric hospitalization. No comparisons were made between the sexes.

Representatives from Multnomah County Department of Human Services (1985) interviewed 190 homeless women. Average age was 32. Sixty-seven percent were divorced, separated or

widowed. Over a third of the women had children living with them. Sixty percent reported their health as fair or poor. Interestingly, 42% did not drink at all. Seventeen percent reported using street drugs. As in Pujanauski's sample, two-thirds of the women had been physically abused, 50% of them sexually.

Two studies dealt with the causes of homelessness. First, the Shelter Advisory Committee (1986) interviewed 2470 men and 960 women between July, 1985 and June, 1986. The first, second, and third most frequent causes of homelessness were unemployment, alcohol and drug problems, and domestic violence. No ages of the sample were stated nor were comparisons by gender made.

In contrast, Oregon Shelter Network (1988) found that alcohol/drugs were much less likely to be the cause of homelessness. Their sample consisted of 727 men and 170 women in Multnomah County. For 36% of the sample, unemployment, lack of work, lack of affordable permanent housing were the causes of homelessness; and for another 39%, domestic violence was the primary cause of homelessness.

Gender differences were found with this group from Multnomah County. The leading causes of homelessness (in order of importance) for men were alcohol/drugs, unemployment, mental illness. The leading causes of homelessness (in the order of importance) for women were listed as unemployment, domestic violence, and mental illness. There was no

discussion of health differences between the sexes.

Summary

There have been many studies describing the demographic characteristics of persons who are homeless and describing the causes of homelessness. The studies conducted specifically to describe homeless men provided much information about their health problems. However, most studies were limited to older men (Brickner et al., 1972; Brickner & Kaufman, 1973; Lindelius & Salum, 1976; Cohen, 1983; Brickner et al, 1985; Cohen et al., 1988). A few recent general studies about the homeless describe a younger (age 30-38) male population (Fischer et al., 1986; Roth & Bean, 1986; Rossi et al., 1987; Koegel & Burnam, 1988; Pearson, 1988).

The results of studying these young homeless men indicated a variety of health problems. Alcoholism was a frequently found problem in many of the recent studies (Multnomah County Department of Human Services, 1985; Rossi et al., 1987; Wright, 1987; Koegel & Burnam, 1988; Breakey et al., 1989; Susser et al., 1989). Also, hypertension was prevalent in many samples (Robertson et al., 1985; Lam, 1987; Wright, 1987; Pearson, 1988). In addition, criminal acts appeared to be a common theme (Lindelius & Salum, 1976; Robertson et al., 1985; Hagan, 1987; Belcher, 1988; Gelberg et al., 1988).

Although there are few studies that include homeless women, their conclusions are similar: most women are young

(< 40); many women have children living with them; many have mental illness; and many have reproductive health needs (Crystal, 1984; Wright, 1987; Pujanauski, 1989).

Few studies compare the health needs of homeless men and women (Robertson et al., 1985; Wright, 1987; Breakey et al., 1989). In only two studies (Robertson et al., 1985; Breakey et al., 1989) were the average ages of the men and women similar: 37. Since different age groups can have different health problems, this type of comparison of homeless men and women of similar ages would seem to be the most accurate comparison of health issues of homeless men and women.

Studies that have been conducted locally in Portland have contributed to understanding the demographics of this new homeless population of younger men and woman and the causes for their homelessness. However, four of the studies make only cursory mention of health problems and concerns. Pujanauski's (1989) study is the only one which addresses those issues and she confines herself to the problems of women only.

Conceptual Framework

The literature supports the view that today there is a new younger, better educated group of homeless persons in America that includes more women and single men than the homeless persons of yesterday (Roth & Bean, 1986; Crystal, 1984; Pujanauski, 1989). Also, the literature and actual observations in shelters indicate the new homeless of America

have a number of specific health problems, not just poorer health and greater mortality. Problems reported more frequently by the homeless than the general population were trauma, hypertension, heart disease, alcoholism, tuberculosis, exposure, and respiratory infection (Cohen, 1983; Brickner et al., 1985; Pearson, 1985; Cohen et al., 1988). Although the health problems, concerns and issues surrounding health care for women have been documented, information about the perceived health status, health practices and health care needs of young homeless men is lacking (Roth & Bean, 1986).

Adequate access to health care for the persons who are homeless is very difficult because the U.S. health care system is quite fragmented with many subsystems and many levels of care (Feder, Hadley & Mullner, 1984; Williams & Torrens, 1984). This difficulty is further compounded by the fact that their transient existence makes homeless people so disaffiliated from society that it is nearly impossible for them to get into <u>any</u> part of the health system for any level of health care (Bahr, 1970).

Research Questions

The issues of access and lack of information about the health status, health practices and health care needs of homeless men are addressed by the first two research questions that were originally formulated by Pujanauski (1989) for her study of homeless women. These questions (1 and 2 below) were addressed in this study of homeless men:

1. What are the perceived current health status, health practices and health needs of young homeless men?
2. What has been the experience of young homeless men regarding access to the health care system and to professionals?

Health status, as defined for this study, is the physical and mental state of a subject over the time period as specified by specific questions. Health practices are specific actions taken by the subject that affected or may affect the health of the subject. These "health practices" may take place either outside or inside the health care system, but for this study do not include the process of accessing the system. Health need, as defined for this study, refers to the subject's perceptions of health need. Access, as defined for this study is the ability of the subject to obtain health care in the health care system.

The interest in comparing findings from Pujanuaski's study of women with the findings of this study of men led to the two additional questions (3 and 4 below).

3. What are the similarities and/or differences between the perceived health status, health practices and health needs of young homeless men and the perceived health status, health practices and health needs of homeless women?
4. What are the similarities and/or differences between the experiences of young homeless men and homeless

women regarding access to the health care system and to health care professionals?

CHAPTER II

Methods

This exploratory and descriptive study of homeless men builds on Pujanauski's (1989) study of women. A sample of homeless young men was interviewed with the purpose of describing the men's health status, health practices, health needs and access issues and comparing that description of men with the conclusions reached in Pujanauski's (1989) earlier study of homeless women.

Design

Pujanauski's study was used as a foundation on which to build and as the basis for comparison of homeless men with homeless women. Pujanauski's interview schedule was revised to provide only information which was specific to men. Homeless men were interviewed to describe factors precipitating their current circumstances, their health status, health practices, health needs and experiences accessing health care.

Setting

This study was conducted at an urban shelter called Baloney Joe's in urban Portland, Oregon. Baloney Joe's is the street name for a multiservice center which, at the time of the interviews, offered job placement, alcohol and drug counseling, shelter (day and night), health clinic, and transitional housing opportunities to the poor, homeless and disenfranchised. Programs are directed by the Burnside

Community Council which is a non-profit organization.

Sample

The inclusion criteria for this study were: (a) homeless male, (b) age over 18 and under 41, and (c) consent to participate. Eighteen men were interviewed over a period of ten weeks. Five men were interviewed during the day and 13 were interviewed in the evening. Subjects were a nonprobability sample of temporarily sheltered or otherwise homeless men who met the study's operational definition of homeless:

> those who did not have customary and regular access to a conventional dwelling or residence and who were forced to seek a shelter or temporary housing (Kaufman, 1984, p. 21; Rossi et al., 1987, p. 1337).

The clinic staff were asked not to refer men who were very ill, appeared emotionally vulnerable, suicidal or potentially violent. Thus, the resulting sample consisted of the more cooperative, able-bodied, emotionally stable young homeless men. For example, four of the 18 men were volunteer workers at Baloney Joe's.

Procedures

The researcher arranged access to the above mentioned setting by contacting the day and evening clinic managers at Baloney Joe's. The clinic managers were asked to refer potential subjects to the researcher. Many homeless men refused to speak with the investigator. Since it was so difficult to obtain interviews during the day, the investigator chose to interview some men in the evening when

the shelter became more populated.

The researcher explained the study to each referred subject: participation would be completely voluntary, each subject could withdraw from the study at any time, and his decision would not affect his ability to receive services from the shelter. In accordance with the policy of the Oregon Health Sciences University Committee on Human Subjects, the men were informed that the law required that the researcher report knowledge of child abuse and some diseases (e.g., gonorrhea). Also, confidentiality of any illegal activities witnessed by the researcher could not be protected in court. However, the researcher also said that all other information obtained would be kept confidential. The risk to participants of physical or emotional damage was explained to be considered low; although certain questions could be psychologically stressful. It was explained that although the benefit to the subject might not be noticeable, the interview process had the potential for being therapeutic to some subjects.

The informed consent procedure was approved by the Oregon Health Sciences University Committee on Human Subjects, read to each subject, and consent to participate was obtained (see Appendices A and B). Interviews were conducted in an office area which provided privacy to subjects. The interviews were planned to take from 30 minutes to an hour. In actuality, the time of the interviews ranged from 20 minutes to two hours, with the average time being one hour. Each question was asked

without stating any possible answers. If the participant had difficulty understanding the question, the interviewer stated the possible answers which appear in parentheses next to the question or are listed below the question. (These possible answers were often codes derived from Pujanauski's content analysis.)

Data Collection and Instrument

Interview methods were selected in order to provide more in-depth information than would be possible to obtain with a self-administered survey. The interview schedule (see Appendix C) was adapted from the schedule used by Pujanauski (1989). She had adapted the tool from two schedules which had been previously tested with the homeless persons: namely, the Basic Shelter Index used by Robertson, et al. (1985) and the interview schedule used by the Multnomah County Department of Human Services study (1985). In Appendix D, the topics of the questionnaire are described in detail and cross referenced with the four research questions (which are the main foci of the study).

Some of Pujanauski's open-ended questions were modified to encourage fixed responses and short answers which were then coded into one or more of the categories uncovered by Pujanuaski. Questions were clarified as necessary for each subject's unique history. For example, there are six areas of need listed after question 97: health, basics, personal, family, social, and other. These six areas were selected from

the coded words that were part of the themes identified in Pujanauski's study. In this way, this questionnaire built on the broad base of Pujanauski's taped interviews, transcriptions, and resulting codes and information.

A pretest was given to two men at the shelter to assess the ordering of questions and to ask subjects if there should be additional/or deleted questions. A few questions were reorganized so the interviews would flow more smoothly. Also, as a result of the pretesting, questions relating to domestic violence were combined and reduced.

Analysis

The research questions were answered based on the responses to specific questions as explained in the Data Collection and Instrument section. The first research question was addressed by interview questions relating to the perceived health status, health practices, and health needs of subjects (see Appendix D). The second research question was addressed by interview questions relating to the men's experiences with access to health care and with access to health professionals. The third and fourth questions were addressed by comparing the responses of the men in this study (results from Research Questions 1 and 2) to items which correspond to the responses of women in Pujanauski's (1989) study.

All responses were coded and entered into a personal computer using a software package called CRUNCH. Frequencies

were created with all coded responses and the remaining individual answers were listed and compiled. Results were set up to be compared to Pujanauski's coded answers whenever possible. The results and the comparison of both studies are described and discussed by referring to tables originally created by Pujanauski (1989) to describe demographic characteristics, precipitants of homelessness, factors men and women stated might have prevented homelessness, chronic illnesses perceived by men, problems encountered accessing care, and custody status of dependent children. Pujanauski's (1989) tables have been revised to include the data results from this study. Additional tables were created for new information that was not included under Pujanauski's categories.

CHAPTER III

Results

In this section, a discussion of the demographic characteristics of the sample will be followed by a description of the history and precipitating events leading up to a homeless state of living. Them, information will be presented in the order of the following research questions: 1) What are the perceived health status, health practices and health needs of young homeless men? and 2) What has been the experience of young homeless men regarding access to the health care system and to health care professionals? Finally, the results obtained from this research on homeless men will be compared to the research of Pujanauski's study on homeless women to address research questions 3 and 4: 3) What are the similarities and/or differences between the perceived health status, health practices and health needs of young homeless men and the perceived health status, health practices and health needs of homeless women? 4) What are the similarities and/or differences between the experience of young homeless men and homeless women regarding access to the health care system and to health care professionals?

Sample

The sample of men in the study ranged in age from 19-40, with a mean age of 29 years. Eight men were Caucasian; 10 were members of minority groups (see Table 1). The amount

Table 1

Demographic Characteristics of Homeless Men and Women in Portland

Characteristic	MEN (N=18)	WOMEN[a] (N=18)
Age		
Range	19-40	18-54
Age Mean	29	30
Ethnic Background		
Caucasian	8	16
Black	3	0
Hispanic	2	0
American Indian[b]	5	2
Educational Level		
<8th grade	4	2
some high school	7	7
high school graduate	2	4
some college	3	4
college graduate	2	1
Marital Status		
Never married	10	4
Married	1	2
Partner	0	0
Widowed	0	2
Divorced/separated	6	10
Living Arrangement		
Hotel	0	3
With friend	0	2
Shelter[c]	12	6
Apt/House	0	4
Street	0	3
Other[d]	6	0

Table 1 (continued)

Characteristic	Men	Women
Duration of Homelessness		
< 6 months	9	1
6-11 months	2	1
1-2 years	3	7
3-5 years	1	2
> 5 years	3	7

[a] Data on homeless women are from Pujanauski (1989), p. 42.

[b] Five men and 2 women stated they were Indians or part Indian (Athabaskan, Cherokee, Blackfoot and Cherokee).

[c] All 12 men who stayed at a shelter stayed at Baloney Joe's.

[d] Two men responded "camping" and 1 each responded "under the bridge", mental hospital, or shifting between shelter, friends and street.

of education varied from less than eighth grade to a master's degree in economics (see Table 1). Only 22% (4) of the men were veterans. Most men reported being single and presently staying at Baloney Joe's shelter (see Table 1). Over 3/4 of the men (14) reported their involvement in 29 criminal offenses ranging from assault to robbery (see Table 2).

Duration and Precipitating Events of Homelessness

In contrast to samples in earlier studies (Robertson et al., 1985), this sample of homeless men reported being homeless a short time: less than 6 months in 50% of the cases (see Table 1). The major precipitant of homelessness reported by over half of the men (10) was being forced to leave home or simply leaving home and the second most frequent precipitant of homelessness reported by these men was job loss (9) (see Table 3). Only five men in the sample reported alcohol and/or drugs as a precipitant of their homelessness.

When asked what would have helped to prevent homelessness, subjects cited job skills and available/supportive family (see Table 4). As Table 4 indicates, there were many individual responses from saving money to "nothing would help".

Research Question #1

1) What are the perceived health status, health practices and health needs of homeless men?

Table 2

Criminal Offenses Committed by Homeless Men (N=18)

Criminal offenses	Number of men committing offenses
None	4
Robbery	5
Auto theft	4
Burglary	4
Public intoxication	3
Assault	2
Driving while license suspended	2
Embezzlement	2
Other[a]	7

Note. Total number of offenses = 29 with some of 14 men committing more than one type of offense.

[a] "Other" category included one instance each of arson, civil disobedience, driving while intoxicated, possession of controlled substance, selling drugs, suicide attempt and a misdemeanor.

Table 3

Precipitant of Homelessness: Perceptions of Homeless Men and Women Compared

Precipitants of homelessness	Men (N=18)	Women[a] (N=18)
Left home	10	7
Left abusive family	1	4
Job loss	9	7
Eviction	0	7
Alcohol/drugs	5	5
Loss of health	1	4
Other[b]	5	-

Note. Total number of precipitating circumstances exceed 18 for men and 18 for women, because 11 men and 11 women cited more than one circumstance.

[a] Data for women are from Pujanauski (1989), p. 43.

[b] "Other" circumstances five men stated include jail, theft, emotional abuse, lack of car, unauthorized use of car, car broke down.

Table 4

Factors Homeless Men and Women Stated Might Have Prevented Homelessness

Preventive factors	Number of homeless citing factors	
	Men (N=18)	Women[a] (N=18)
Supportive family	4	6
Job skills/employment	6	10
Nonabusive partner	0	6
No involvement with drugs/alcohol	2	4
Association with mainstream peers	2	2
Social service	0	1
Other[b]	8	-

Note. Columns add to more than 18 because 3 men and 9 women cited multiple factors.

[a] Data on women are from Pujanauski (1989), p. 46.

[b] "Other" category included counseling, affordable housing, visiting rights for daughter, saving money, more education, avoidance of crime, no peers encouraging drugs.

Health Status

Physical Health. Most of the men described their current health as good (9) or excellent (4). Only five described their health as fair. Although none of the men described their health as poor, 10 men stated many health concerns (e.g., back pain, blindness, smoking/shortness of breath, hearing loss, catching AIDS, and knee pain). Eight men described chronic health problems spanning from one week before interview to 17 years ago (see Table 5). Four of these men with chronic health problems also reported an acute illness in the last 2 months. In addition, one man reported using the health system in the last month for a "needed surgery".

Mental Health. Over 60% (12 men) perceived their mental health as good or excellent. Four men reported mental health as fair, and two, as poor. Five men reported formal diagnoses of mental illness: two of depression, and one each of schizophrenia, bipolar depression with paranoia, and affective disorder. One third (6) of the men reported that they had had suicidal thoughts in the past year. In the previous 3 months, two men had attempted suicide, one time each. Two other men said they had attempted suicide more than one year ago.

Although the men at first seemed little concerned over their mental health, once they began discussing their histories, 72% of them (13) admitted having felt depressed

Table 5

Chronic Illnesses as Described by Homeless Men

Illness	When illness began	Last time seen health provider	Reason for time since seen provider
Hard of hearing	17 years ago	6 years ago	not enough money
Torn left shoulder	18 years ago	1 month ago	no money, transportation, or place to stay after surgery
Heart problem	7 months ago	3 months ago	problem not serious
Shortness of breath	1 month ago	never	would have to wait too long, hours are bad for me working
Mental illness	1 year ago	1 week ago	does not apply
Left knee, neck and lower back pain	2 years ago	6 months ago	not enough money
XYZ chromosomal trisomy, blindness, Left ear deaf/painful	9 months ago	1 month ago	"can't be treated"
knee pain	1 week ago	1 week ago	not enough money, thought it would go away

in the past year. Seven men reported depression lasting less than one week, four men, depression lasting 2-3 weeks, and two, depression lasting 4 weeks.

Four men judged separation from family to be a major factor contributing to their depression. Four men thought alcohol and drugs contributed to their depression. Two men attributed depression to "people around me" and "don't know". One man each reported the following: "no money", "no home", "lonely", "illegal camping", "lack of companionship", and "lack of compassion from people not on the streets". The following potential codes from Pujanuaski's (1989) study were not stated as contributors to depression: no job, divorce, no future, robbed, and physical illness/injury. (Most answers to questions were unprompted, so the subjects were not encouraged to respond one way or the other.)

Although four men denied that homelessness affected their mental health, the other 14 provided multiple examples of their linkage. Four reported being depressed and four said they felt themselves stigmatized. One other man reported feeling angry and another insecure. One man stated, "homelessness...makes me nervous...", and another, "it sure makes me want to leave town on a train." One man said homelessness affected his mental health "negatively", but four men stated it was a "positive" experience (e.g., "...it gets me outside of myself and thinking of others...").

Substance Use. Fourteen men reported using alcohol

and/or drugs in the last month. Five men reported drinking more than two drinks per day (see Table 6). Two men stated they were recovering alcoholics, one, for 2 years, and the other, for 2 months. Two men said they "didn't know" the frequency of their drinking. More frequently than alcohol, unprescribed drugs (i.e., marijuana) were used by 13 men (see Table 6). Six men reported using drugs daily and three reported using drugs several times per week. One man said he used drugs several times per month and another that he used drugs "very rare" (approximately once/six months).

Domestic Violence. Seven men had been involved in domestic violence: three as victims of physical abuse from some family member (i.e., mom and dad; father, brother; and father). One of these men ended up in a psychiatric institution at age nine after being caught trying to sneak on a plane to Washington State. This man stated he was trying to run away because "father beat me with anything he could find in his house...I think my dad put me in the psych hospital because he had insurance for it and could get rid of me..." He never understood being hospitalized for 6 months because "the doctor said I was normal". When asked if he thought the hospitalization was prolonged in order to protect him from his father, he replied that yes-that could have been true.

Table 6

Substance Use by Homeless Men and Women

Type of Use	Men (N=18)	Women[a] (N=18)
Alcohol		
None	4	6
1-3 drinks/week	6	3
4-13 drinks/week	1	1
2-6 drinks/day	2	0
>6 drinks/day	3	0
recovering	2	4
binge "get drunk"	0	3
(no answer)	0	1
Drug Use		
Marijuana	11	0
IV Crank	0	1
Speed, Crank, Cocaine	1	0
Gun powder and alcohol mixed IV	1	0
Recovering addict	0	4
None	5	17

[a] Data for women are from Pujanauski (1989), p. 70-74.

Two men had been sexually abused as children. One man said, "I don't want to talk about it now or ever." The other man said that his brother and father sexually abused him "for years".

In contrast, two men, far from being victims themselves, physically abused some member of their own family (i.e., daughter's mother; brother and wife).

Health Practices

The health practices reported in this study included the persons' use of health providers, medications for physical and mental conditions, coping mechanisms, alcohol and drug treatment, and sexual health practices.

Health Providers. All men were asked where they would go for health care if they had a health problem. Two men answered they never became sick. Over half of the men (11) said they would use an emergency (ER) room of a hospital for health care. The remaining five men said they had used or would use a community volunteer clinic. These five men reported they were currently seeing one provider at a community volunteer clinic. In two cases this health provider was a chiropractor; in another case both a chiropractor and a mental health and drug counselor; and in still another case, the health provider was a dentist.

Of the eight men who reported chronic health problems, four men reported consulting a health provider for these problems in the last 6 months. At the time of the interviews,

four men with chronic conditions stated they were taking medicine, namely, Tylenol, Advil, Tylenol #3, Seldane, Zantac, Ibuprofen, Codeine. The conditions for which they were taking medication were (1) a torn left shoulder; (2) left knee, neck and lower back pain, and pneumonia; and (3) left ear deaf/pain. Two of these men were not seeing health providers at this time.

Four of the six men who reported accidents or sickness in the last 2 months contacted a health provider (see Table 7). Two men with minor problems (i.e., nausea, stomach ache; cold) thought their illnesses were not serious enough for them to contact a health provider.

Psychiatric Medication and Hospitalization. Other health practices included use of psychiatric medication and hospitalization. Four men stated they were taking psychiatric medication: (1) Thorazine, Imipramine, Amipramine, Benadryl, and Buspar; (2) Deseril; (3) Melleril; (4) Lithium and Trilifone. One additional man reported that he should have been taking lithium for bipolar depression, but wasn't.

During the period of homelessness, two men were hospitalized for psychiatric problems. One man tried to commit suicide 3 months ago, and was hospitalized. He said, "I tried, but it didn't work. I was put in a hospital, but it didn't help me."

The second man, diagnosed with bipolar depression,

Table 7

Accident or Sickness in Homeless Men in the Last Two Months in Relation to Seeking a Health Provider

Accident or sickness	Contacted health provider	Place went for care	Why did not see provider
Shoulder injured	Yes	Chiropractor	N/A
Nausea, stomach ache	No	None	Problem not serious enough
Needed surgery	Yes	Emergency	N/A
Chronic knee/ back pain	Yes	Free community clinic	N/A
Walked across a bridge, jumped into river because train was coming; cold; ear infection	Yes	Private hospital	N/A
Cold	No	None	Problem not serious enough

Note. N/A means not applicable because subject did see a provider.

reported he had been in a psychiatric hospital "as many as three times". The most recent episode was at a Washington State hospital. He said that he was taken to jail when he was found taking off his clothes in front of women on the street.

> When the police saw that I was not drunk or suicidal, they let me go. Then they (the police) found me again doing the same thing on the streets. They put me in the hospital. It was so embarrassing...why didn't they see I was crazy and needed help the first time?

Two men had been hospitalized before they became homeless. One man, previously described under Domestic Violence, had been hospitalized as a child in a psychiatric institution after running away from home and being found by an airlines employee. Another young man (age 21) stated he was hospitalized 7 years ago for psychotic episodes and was recently diagnosed as having an "affective disorder".

Coping Mechanisms. Health practices included coping mechanisms which varied from "talking to my ex-wife" to basketball to fighting someone on the street. Only two men said that they used drinking as a coping mechanism. (However, five men said that they drank >2 drinks/day. See Table 7.) Six men chose counseling as a coping mechanism for stress. The counseling sites used were Portland Rescue Mission, Forestry counselor and Alaska psychiatric hospital, Burnside Projects, mental health clinic, and Mental Health Center West. Reported counseling topics varied: difficulty in managing life (2 men), emotional/nervous problem (1 man), difficulties in managing life, drinking and drug problem, emotional and

nervous problem (1 man), and difficulties in managing life and drinking and drug problem (1 man). Only three men stated they were seeing a counselor currently.

Treatment for Substance Use. Eight men reported having been in treatment for alcohol and drug abuse in the past. However, only two of these men considered themselves recovering alcoholics. Most of the others continued to drink at least 2-6 drinks/day and did not give any definition of what type of treatment they had received. Four of the eight said they had been treated only for alcoholism, while two reported they had been treated only for drug abuse. Seventy-five percent of these eight treated men said they had received treatment only once.

The incidence and length of substance abuse treatment did not seem to relate to the onset or duration of homelessness. For example, one man, homeless less than 6 months, reported he was currently in alcohol and drug abuse treatment that had begun one year ago. Only one man reported where he received treatment 3 years ago for 2 weeks: the Rescue Mission. A third man, who had been homeless less than 6 months, reported participating 3 years ago in treatment for 1 month. Two men, who reported being homeless within the past 6 months to a year, reported participating 2 years ago in treatment for 1 year. One man, who had been homeless less than 6 months, reported finishing 6 months of treatment 6 months ago. One man, who had been homeless less than 6 months, reported

participating for the past 2 years in alcohol treatment with the most recent visit being in the last 2 weeks. Finally, one man, who had been homeless 1-2 years, reported participating for 1 year in alcohol treatment 1-3 years ago.

Sexual Practices Affecting Health. Sexual activity can influence an individual's health depending on certain health practices (e.g., use of condoms, number of partners, views about resulting children). Five of the 13 sexually active men expressed worry about contracting a sexually transmitted disease. Six men stated they used condoms to avoid contracting a sexually transmitted disease. One individual stated he used a condom and also obtained AIDS tests frequently. Six men stated they used no protection whatsoever. Eleven men said they had not had sex in the last month. Six men said they had had one sexual partner in the last month and one person explained he had had four sexual partners in the last month.

Only one person reported he had had a sexually transmitted disease: gonorrhea. Although he did not state when or how long treatment had occurred, he did report having it treated at a public health clinic.

In addition to protection from sexually transmitted diseases, fathering children and birth control are described under the heading classed here as health practices. Sixty percent of the men (11) reported fathering children: eight men said they had fathered one child and three men said they

had fathered two children. None of the children were reported to be living with these men. Only one man stated he had fathered a child while he was homeless. Three of the 13 men currently sexually active stated they used no birth control while 3 other men stated their partner used birth control pills. Of the eight men who claimed they or their partner used birth control methods, seven said they used them most of the time. One person said he and his partner used birth control about half the time. Five stated they used condoms for birth control. One man stated his partner had had her tubes tied. One man stated he was gay.

Health Needs

Thirteen (72%) of the men reported having enough to eat at different meal sites, shelters, relatives, homes and restaurants. However, 11 men felt their diets were lacking in at least one of the following : milk, fresh vegetables, fruit, vitamins, food with spices, and a variety of meat.

Two men expressed health care needs related to depression. Two men reported being in some form of informal counseling and one in formal counseling for physical or sexual abuse; no one else reported currently being interested in talking to anyone about physical or sexual abuse.

Getting someone pregnant while homeless was not an expressed concern of any of the men. However, 5 of the 11 fathers in the group expressed needs regarding their children. Ten men knew the children were in the custody of their mother,

but one man said, "...had no idea where it (the child) was..." These concerned fathers said:

> "I want to see her."
> "I want to watch her grow up"
> "If I'm not there, there is no one to discipline the children."
> "(I want to) see them more...I have to have a place before they can visit me."

In response to being asked "what would be helpful to you regarding your children", five men replied the following needs:

> "get food, clothes and things for her"
> "I need to see her before I would know her needs."
> "(I want them) to know that Dad cares for them
> "get back to her first"
> "I need a home for daughter to come to"

Another need was for help to get off drugs. One man said, "...no support from people I'm with." Also, two men said they needed help with a drug problem. (One of these two men was currently in a drug treatment program.) One man said he could not find a supportive AA group in Oregon. One man said he could quit on his own. The man who used the mixture of gun powder and alcohol intravenously said he "...quit two weeks ago on my own..." However, most men (13) stated they did not need help getting off drugs because they did not have a drug problem.

Seven men reported feeling unsafe in the homeless environment they lived in because of potential violence.

> "...people don't value life here. It isn't worth much."
> "People harass me and are violent towards me because I am gay."
> "...there are no restrictions on who can be in B.J.'s

at
night while I'm sleeping..."
"...men burst in at night...no place to keep my belongings."
"...there is so much fighting..."

The last question of the interview before the demographic questions asked about their "three most important meeds on a daily basis". Needs classified in the "basic" category were the most frequently mentioned (see Table 8). This was followed by individual responses under "other". These findings will be expanded upon in the results of Research Question 2.

Research Question #2

What has been the experience of young homeless men regarding access to the health care system and to health care professionals?

In the last 6 months, nine men reported difficulties when seeking health care and/or working with health professionals (see Table 9). In contrast, three men expressed no difficulties seeking health care, and six perceived no reason to seek health care. Thirteen men reported they did not pay for their health care. One man had a medical card. One man had always had health insurance until he was laid off from work. Two men had used services at the V.A. One of the veterans had used Alaskan Native benefits.

Table 8

The Most Important Needs Expressed by Homeless Men and Women

Needs	Men (N=18)	Women[a] (N=18)
Health		
concern about sexually transmitted disease	1	0
want "better health"	0	1
want "pediatrician, glasses, and dentistry	0	1
Basics		
food	1	#1[b]
employment	6	#3
money	4	#4
food/shower	2	
food/home/clothes	1	
home/shower	0	#2
clothes	0	#5
sleep	0	#6
Personal		
self esteem	1	2
return of prof. status	1	2
more time for self	0	2
leisure activities	0	2
Family	1	2
Social	1	2
support group	1	1
talking with others	0	1

Table 8 (continued)

Other		
privacy	1	0
sleep	1	0
school for skills	1	0
private space	1	0
love/compassion	1	0
keep body/clothes clean	1	0
no transportation to family	1	0
sleeping bag, one day work decent food	1	0

[a] Data for women are from Pujanauski (1989), pp. 83-90).

[b] Pujanauski did not report frequencies of the basic needs, but rank ordered them (e.g., the #1 most often mentioned basic need was for food).

Table 9

Problems Encountered by Homeless Men and Women in Accessing Care

Problems with Accessing Care	Men	Women[a]
Unable to access due to inability to pay for services	6	6
Became unable to afford regular source of care	2	4
Other		
lack of transportation	1	1
paperwork at V.A. Hospital		10
about a week to see MD at BJ's		10
obtaining AFS benefits	1	0
poor continuity of care	0	2
inadequate quality of free care	0	2

[a] Data on women are from Pujanauski (1989), p. 79.

The main reason the eight men with chronic illnesses gave for not seeking health care was a lack of money (see Table 5). Four of the men with chronic illnesses said they had taken prescribed medicine in the past, but were not currently doing so. Two of these four men said they could not afford it. A third said no provider would prescribe the pain pills for him. The last man said he did not know whom to ask and he felt O.K. now. This man had been diagnosed with bipolar depression and paranoia, had been in and out of state mental hospitals, and had been misjudged as drunk instead of in a psychotic state by the police.

Other access problems which these men perceived included inability to understand the V.A. paper work and lack of transportation to the hospital to receive help with it. Another young man said he could not get a decent job until he could get a hearing aid. His hearing aid had been smashed by a stranger on the street and he was hoping to get one from the Lions Club.

Thirteen men stated nothing helped them in gaining access to the health care system. Two men said Baloney Joe's was helpful because it had a health clinic right in the shelter and it was a good referral place for eye and ear problems. West Side Clinic and Burnside Clinic were also judged helpful because of their hours (i.e., often open in the evening).

Many men did not report a regular health provider: nine because they were well and did not need a provider; five

because of the cost; one because there was no provider close by; one because clinics were too inconvenient when working; and one because he moved around too much to have a regular provider.

Of the six men who had a sickness or accident in the last 2 months (see Table 7), only one man had trouble with access to care. He had to wait a week to see a chiropractor.

For those men who reported that they had a drug or alcohol problem, access to treatment for substance use was not perceived as a problem.

Research Question #3

What are the similarities and/or differences between the perceived health status, health practices and health needs of young homeless men and the perceived health status, health practices and health needs of homeless women? To answer this question, the men of this study were compared with the women in Pujanauski's (1989) study.

Sample Description

Although the age range of the women was broader, their mean age (30) was very close to that of the men (29) (see Table 1). The men and women also had quite similar educational backgrounds. However, the men were more ethnically diverse than the women. Many more men (10) than women (4) reported never being married. Most men stayed at Baloney Joe's shelter, whereas the women were scattered among hotels, friends, shelters, apartment, and street.

History and Precipitating Events of Homelessness

A stark contrast between the men and women related to length of homelessness (see Table 1). Of the men, 50% were homeless less than 6 months, whereas almost half (7) of the women were homeless more than 5 years. However, more similarities than differences emerged in the reporting of precipitating events of homelessness (see Table 3). Leaving family and job loss were reported to be factors contributing strongly to homelessness for both men and women. Also, drugs and alcohol were perceived to be factors in both groups. Other precipitating events were reported more frequently by the women than by the men: abusive family, eviction, and loss of health. In still another contrast, four men, but no women stated that instances of criminal offenses precipitated homelessness.

The men and women were similar in their view that supportive families and job skills might have prevented homelessness (see Table 4). A nonabusive partner was cited as a plus to prevent homelessness for women (6), but not for any men (0). Also, as Table 4 presents, the men reported "other" factors for preventing homelessness more frequently than women: counseling, affordable housing, saving money, more education, etc.

Health Status

Although 13 men and 10 women perceived their health as "good" or "excellent", no men and 4 women judged their health

to be "poor" (see Table 10). Men and women reported different health problems. Women's perceived problems were respiratory, orthopedic, reproductive, dermatologic, dental, Parkinson's disease, and seizure-related, whereas men's perceived health problems were hearing loss, injury, shortness of breath, mental illness and blindness (see Table 5).

In the area of nutrition, both men and women said they could get enough meals every day. Sometimes the women had to search "all day" for food, whereas the men found food at shelters more often. Both men and women claimed their diet lacked protein and fresh vegetables.

Overall, women viewed their mental health status as poorer than the men viewed their own (see Table 11). Five men and four women were diagnosed with mental illness. The incidence of depression and bipolar depression was similar in the two groups. However, two men were diagnosed with either affective disorder or schizophrenia; whereas only one woman had a "thinking problem".

As a result of depression, more women (10) than men (6) considered committing suicide. Also, suicide attempts were reported by over twice as many women (10) as men (4). The most common method of attempted suicide was overdose with pills, tried by three men and three women. One man (in addition to pills) and one woman stated that they tried jumping from a high spot. One man reported jabbing pencils in his chest; and in contrast, two women said they had cut their

Table 10

How Homeless Men and Women Perceived Their Health Status

Health	Men (N=18)	Women[a] (N=18)
Poor	0	4
Fair	5	4
Good	9	8
Excellent	4	2

[a] Data on women are from Pujanauski, (1989), p. 51.

Table 11
Self-Ratings of Mental Health Status by Homeless Men and Women

Mental health status	Men (N=18)	Women[a] (N=18)
Poor		23
Fair		48
Good		96
Excellent		31

[a] Data on women are from Pujanauski (1989), p. 60.

wrists, one woman used a gun and one woman drank alcohol. Information on when the women attempted suicide was not available. However, two men reported attempting suicide within the last 3 months; one had been homeless less than 6 months while the other, 1-2 years. Despite counseling in the past, the remaining two men reported attempting suicide more than one year ago, but had been homeless more than 5 years.

Both men and women were almost universally concerned about depression. As was the case with the women, some men reported short term depression and others long term depression. Men and women differed on "other" factors contributing to depression; loneliness (mentioned by one man), loss of children (mentioned by two women), and stigma (mentioned by two women). Although none of the men mentioned the following factors, three women had attributed depression to: loss of a relationship, premenstrual syndrome, stigma, and death of a family member.

The majority of both men and women referred to the negative effects of homelessness as leading to depression and stigma. Three men and two women claimed that the homelessness experience was a positive one because it made them reach outside of themselves and help others around them. Two women stated homelessness "makes me mentally sharper" (Pujanauski, 1989, p. 66).

Men most frequently mentioned alcohol or drugs as the main cause of their depression, whereas women mentioned abuse

by their partners (see Table 7). Also, men admitted to currently using alcohol and drugs more often than did women. However, none of the men described themselves as alcoholics and 10 of the women did. In the last month, the same number (7) of men and women reported being sexually active. Seven women reported becoming pregnant while homeless, whereas only one man reported fathering a child while homeless. Nine of the women, but none of the men said they had children living with them. These 9 women had experienced 57 pregnancies resulting in 30 living children. Eleven of 18 men in this study reported having had, all together, 14 children.

Only one man reported having had gonorrhea, but four women reported having gonorrhea and one woman, herpes.

Women reported being abused more than men (see Table 12). In contrast to 7 men, 14 women said they had been physically abused. Fourteen women reported the physical abuse originated with their partner. In contrast, the abuse of all men but two originated in childhood. Eight women reported being raped.

Health Practices

Since no information was presented by Pujanauski (1989) as to how many women saw health providers, no comparison in this respect was possible. However, the following areas could be compared: medication, coping mechanisms, treatment for substance abuse, and practices related to sexual health.

Except for Zantac and Seldane, the men reported taking only pain medications whereas the women reported taking

Table 12

Domestic Violence Reported by Homeless Men and Women

Type of abuse	Men (N=18)	Women[a] (N=18)
Physical abuse		
family origin	3	5
partner	2	14
Sexual abuse		
family origin	2	6
partner	0	2
Both physical and sexual abuse	0	3
Rape	0	8
Assaulted	0	4

[a] Data on women are from Pujanauski, 1989, p. 89.

medication only for such specific problems as Parkinson's tremor or estrogen replacement. Although four men had been hospitalized and four men were on medication for mental illness, nearly one-half of the women reported having been in a psychiatric hospital.

Different methods of coping with the stresses of homelessness were reported by men and women. Men listed as coping methods talking to ex-wife (1), fighting on the streets (1), drinking alcohol (2) and playing basketball (1), while the women stated they turned to marijuana (3), religion (2), friends/family (3) and crisis lines (1).

Counseling was only rarely given as an option for coping by either men or women. However, the men reported using many more sites (6 compared to one) for counseling than women. Three men reported currently seeing a counselor. In comparison, only five women stated they were currently using counseling at the West Women's Hotel, although nine women had received some form of short term counseling in the past. (It was unclear whether the five women currently using counseling were included with or exclusive of the nine who had counseling in the past.) Counseling issues for men and women were similar in the areas of managing their lives and emotional/nervous problems. Only women reported counseling for problems surrounding employment.

Three men reported having been in counseling for physical and/or sexual abuse and, at the time of interview, one man was

in counseling for abuse. In comparison, five women were currently in counseling for these issues. Four other women stated they had been in counseling in the past and, although no reasons were stated, did not want to continue it.

Although no women reported having been in any formal drug or alcohol treatment, six women said it was the number one issue in counseling. In contrast, eight men reported having been in alcohol and/or drug treatment, but no men considered it to be an issue in counseling.

In contrast to eight men who used some form of birth control, only one sexually active woman stated she took such precautions. No women reported using any form of protection against sexually transmitted diseases, but five of seven men stated they used condoms and the partners of three other men used birth control pills. Although no men currently spoke of intravenous drug use, one woman did report continuing to share needles with her partner since "...she had tested both positive and negative for HIV" (Pujanauski, 1989, p. 56).

Health Needs

Both men and women reported needs classified under "basic" most often (see Table 8). Men stated the need for jobs most often, while women considered food their most important need. Health, family and social needs were not ranked high. The men's needs were more varied than the women's. Two men, compared to three women, expressed a need for mental health counseling.

Most of the men and women knew where their children were (see Table 13) and had concerns about them. Whereas the needs of the men were directed towards "seeing" and visiting their children, the women's needs were related to health and regaining custody of children: getting enough to eat while pregnant, obtaining birth control pills, which they could not afford, and securing legal assistance to regain custody of their children.

Three men expressed a need to "get off" drugs, but no women wanted any help with substance abuse problems, perhaps because the women were already dealing with these issues in counseling. No men expressed an interest in counseling for the issue of physical and/or sexual abuse. In contrast, women expressed an interest in talking to someone about their abusive experiences.

Both men and women reported the feeling of being unsafe in their homeless environments. The men stated they were concerned with the fighting, the possible loss of their belongings, and the little value placed on life in the shelter environment. In contrast, the women were more concerned with personal safety (e.g., rape).

Research Question #4

What are the similarities and/or differences between the homeless men and homeless women regarding access to the health care system and to health care professionals?

Fourteen women and nine men were able to describe

Table 13

Custody Status of Dependent Children of Homeless Men and Women

Custody	Men (N=18)	Women[a] (N=18)
Mother's custody	10	5
Living with other family members	0	7
Foster care	0	5
Relinquished for adoption	0	3

[a] Data on women are from Pujanauski (1989), p. 87.

problems related to gaining access to health care. Both groups agreed that the main reason for lack of access was the inability to pay. Thirteen men reported being unable to pay for health care since they have been homeless. The second problem reported by the women was difficulty in gaining access to specialty care such as dentistry, dermatology or ophthalmology. In contrast, the men reported having difficulty obtaining basic care for injuries, pain management, stomach pains, and shortness of breath.

Men and women reported different sources of care. The women tended to report using free community or county clinics, although one woman regularly used the ER's. ER's were the number one choice of health care for men.

The women described several examples of being stigmatized and depersonalized once in the health care system. For example, one claimed, "...that my care has been determined more by where I live than who I am..." With accidents and/or sicknesses women expressed feeling stigmatized more than men. One woman expressed that she was made to feel at fault for her miscarriage. Another woman with pneumonia received treatment at an ER, but had difficulty getting follow-up care.

Although some men felt stigmatized by other sheltered men and by the public who saw them on the street, only one man gave any hint that he felt stigmatized by the health care professionals:

I was in the hospital for surgery and they just said I had to leave one day. I told the ambulance people to bring my clothes to the hospital when I got sick. When they told me to leave though, my clothes could not be found. They (the hospital) said I would have to leave in a hospital gown. As I was walking out I asked a man for his name and if he would be my eye witness that the hospital was making me leave without any clothes on. The man said yes and at that point the hospital officials said that they would reconsider the situation and try to help me find some clothes.

CHAPTER IV

Discussion

The present sample of homeless men resembled other samples of the "new homeless" discussed in the literature in that it was composed largely of young, single men of ethnic minority groups. In addition, a majority of these homeless young men had been involved in the criminal justice system as was true of the homeless in other studies (Robertson et al., 1985. Belcher, 1988). Finally, although these men stated that alcohol and drugs did not precipitate their homeless state of living, it appeared to be a current factor in their lives.

However, in contrast to the men studied by Hagan (1987) for whom release from jail was the precipitating factor for homelessness, in this study only one of the 14 men involved in crime claimed crime was the precipitant for homelessness. The other precipitants of homelessness for this study sample appear to be similar to those found in other research: poverty, social isolation, and lack of housing (Roth & Bean, 1986; Rossi et al., 1987; Rossi & Wright, 1987). That poverty and lack of housing were precipitants of homelessness may be inferred from the importance the men of this study placed on leaving home and on job loss. These factors were similar to those reported by Oregon Shelter Network's survey in 1988.

Social isolation was not stated as a precipitant of

homelessness. However, most men reported being single (never married) and appeared to have very weak support systems, if any.

Research Question #1

The findings from Research Question 1 address the variables of health status, health practices, and health needs.

Health Status

Even though most men stated their health to be good or excellent, their physical health status was fair at best. Fourteen men reported either a chronic illness or a more acute recent accident or sickness. For the most part their illnesses (e.g., injury, blindness, and shortness of breath) were different from the few illnesses described in the literature as characteristic of homeless men: namely, hypertension and respiratory infection (Pearson, 1988). The only illnesses that were similar to those of older homeless men were heart disease and depression (Brickner et al., 1972; Brickner & Kaufman, 1973; Lindelius & Salum, 1976; Cohen, 1983; Cohen et al., 1988).

The findings reported on the mental health status of young homeless men have been contradictory. Some studies have indicated that the prevalence of mental illness is quite high (e.g., Fischer et al., 1986; Breakey, et al., 1989). Other studies have indicated that young homeless men have less mental illness than other subgroups of homeless people (e.g.,

Susser et al., 1989). In this study, mental illness (depression, schizophrenia, affective disorder, psychotic episodes, and bipolar depression with paranoia) were reported frequently by many homeless young men.

Much of the current literature has indicated that substance abuse is a minor health problem for the "new homeless" (Phoenix South Community Mental Health Center, 1983; Oregon Shelter Network, 1988). However, a few studies indicated that substance abuse was prevalent in young homeless men (Koegel & Burnam, 1988; Susser et al., 1989). With 14 men reporting use of alcohol and drugs in the last month, substance use would seem a significant problem in this sample. In addition, it appeared to this investigator that alcohol use was underreported. Two men reported drinking 1-3 drinks/week. However, one of these men was seen, obviously drunk, by the investigator one week after his interview, staggering on the sidewalk in front of Baloney Joe's. During an interview, another man was laughing uncontrollably and appeared very drunk. However, he said he drank only 1-3 drinks/week. It was interesting that although men said alcohol contributed to depression, it was not recognized as an attempt at coping.

Health Practices

Four men reported having been in psychiatric hospitals for short periods of time. Although the men did not state that these events brought on homelessness, at least in three instances, they appeared to contribute to the situation. One

man felt suicidal after hospitalization and thought that the hospitalization was not helpful at all. One man was (and still is) noncompliant in taking his Lithium medication. The third man, with the affective disorder, was unable to organize his thinking during a third of the interview and obviously was not equipped mentally to handle the stresses of street life.

Health Needs

What the men perceived as their health care needs and what they appeared to need from the viewpoint of the interviewer were quite different. The men felt they needed better nutrition, care for injuries, counseling for depression, and help in getting to visit their children. Although it was a dominant part of their daily living, only a very few wanted treatment for substance abuse. In addition to these stated needs, they appeared to need health care for their chronic and acute illnesses; psychiatric care for depression, untreated suicidal histories, management of psychotic episodes; education about birth control and protection from sexually transmitted diseases; and an environment that they felt safe to live in.

Research Question #2

The second question addresses the issue of access. The men stated the main reason for difficulty with access to health care was inability to pay for care. A constant theme emerging from the interviews was that the men's preference for ER over ambulatory health care influenced their access to

health care and ultimately influenced their health.

Seeking health care was not reported as a usual practice of these men. Some men were seeing health providers for their problems. Others appeared to be either in denial, or lacking education to understand the need to seek health care. The man with an abnormal heart rhythm had not taken any heart medicine or seen a physician in 3 months. He did not recognize the seriousness of the problem, and perceived a need to use the health care system only during crisis situations. This crisis-oriented view of accessing health care appeared to be shared by many of the men, in that 50% of men reported using, or planning to use, the ER as their only form of health care.

The man who jumped off a bridge was met by an ambulance when he swam to shore. He did get his immediate needs met by being hospitalized for what appeared to have been hypothermia. However, when he was interviewed, he complained of having ear infections. He presented the antibiotics the hospital had given him and he said, "I'm not going to keep taking those (antibiotics) because they don't make the pain go away...I'll give them to someone else to use..." Obviously, this man needed much education about medicine and the need for follow up care for health problems.

Research Question #3

The third research question called for a comparison of the health status, health practices, and health needs of the homeless men and homeless women. As anticipated from the

literature and observations (Bassuk & Rubin, 1984; Brickner et al., 1985; Lam, 1987; Wright, 1987) there appeared to be more differences than similarities between the men of this study and the women of Pujanauski's (1989) study. The dramatic differences in duration of homelessness (see Table 1) and in the ethnic composition of the two samples may be related to many circumstances. One possibility is certain settings may attract persons of different durations of homelessness and different ethnic compositions. For example, these differences may have been related to the fact that the men were interviewed at only one setting whereas the women were interviewed at three different settings.

Another possible reason for the differences in duration of homelessness may be related to the fact that many women had children with them. Possibly the responsibilities associated with those children were the reason women reported a longer duration of homelessness. In contrast, men were free to search for employment and only had to worry about their own needs. Finally, mental illness may have been more severe among the women, resulting in an inability to solve problems that may have kept them in a homeless state longer.

It is interesting that only women cited eviction as a precipitant of homelessness. Since the men listed leaving family as the number one cause of homelessness, one wonders if men become homeless after being "kicked out" by their wives or families who then keep their homes. They did not consider

eviction a big influence in becoming homeless. Possibly a home was not valued greatly by these men, but was greatly valued by women, especially with children. Therefore, though not stated as an issue for the men, eviction of a different kind may have occurred.

Health Status

The finding in this study regarding the relative health status of men and women was in accord with previous research findings that trauma was reported more often by men while mental illness was reported more often by women (Wright et al., 1987). However, in contrast to Bassuk and Rubin (1984), Wright (1987), and Susser et al. (1989) the incidence of mental illness was high among both these men and women. One difference noted was that more men believed that alcohol contributed to depression, and more women believed that partner abuse contributed to their depression. Another difference was that several men reported clinical diagnoses for mental illness (e.g., bipolar depression), but the women described their mental illness more often simply as "depression". The accuracy of that self-definition was supported by the number of their attempted suicides. Interestingly, the strong indication of mental illness in homeless men and women of this study was supported by another recent study (Breakey, Fischer, Kramer, Nestadt, Romanoski, Ross, Richard, & Oscar, 1989). This raises the question of whether the "new homeless" men of today are more mentally ill

than the homeless of a few years back or whether the samples in the two studies are unrepresentative and extreme.

As Pujanauski (1989) concluded from her results, physical and sexual abuse was much more an issue for women: twice as many women reported being abused as men. According to the women, abuse was a major precipitant of homelessness, a definite contributor to mental illness (e.g., especially depression), and clearly a talked about topic for counseling.

However, these results should not discount the finding that young homeless men often experience or have experienced abuse. Again, as with alcoholism, although the men do not perceive abuse as a precipitant of homelessness or as a topic to discuss in counseling, it may still be a health problem of some consequence to the men, to their significant others, past, present and future, and to society. For insofar as men who were abused as children become in turn abusers, those homeless men with histories of physical and sexual abuse are potentially at risk of becoming abusive.

From the men's reports, it would appear that incidence of abuse is low. Only two men admitted to having abused members of their families. However, the incidence may be underestimated from the men's reports given the highly sensitive and taboo nature of the topic.

Health Practices

Health practices differed between men and women. The literature has presented conflicting information about the

influence of substance use on young homeless lives. The results of this study support Koegel & Burnam's (1988) conclusions that substance abuse appeared to influence many areas of the "new homeless" young men's and women's lives. Results also confirm Wright's (1987) conclusion that men abuse alcohol more than women, possibly because the women tend to recognize an alcoholism problem, seek treatment and talk about their problems more.

In addition, drug use appeared more prevalent among the men than women. One must question whether this difference was biased by underreporting of drug use by women who may have thought discussing their habits could have influenced whether or not they could continue having custody of their children. However, how drug use is defined may have a bearing on whether information across sections can be compared. Thus, Caulk (1984) stated that 75% of his population did not use street drugs, but he failed to define that term, so the men of the present study cannot be compared to the men in Caulk's study. However, the men of the present study can be compared to the women of Pujanauski's because use of similar drugs was investigated. Thus, it is accurate to say that men reported use of drugs much more than women. It was rather surprising to find that the most used drugs by men was marijuana and not harder drugs.

Also, the fact that more women than men reported sexually transmitted diseases may not have reflected reality but an

unwillingness on the part of the men to discuss that subject with the female investigator. Since for so many men birth control is only a moderate consideration, an added surprise was learning that only one man had fathered a child while homeless. Perhaps they had been homeless for only a short time or perhaps they had fathered more children than they knew.

Health Needs

As is often true in the general society, women's perceived responsibility for children greatly influenced the stated needs of the men and women. Nutrition while pregnant, custody of children, a place to live with children, and gynecological surgeries were not recognized as needs or values by men. However, men did express needs for health care for injuries, better nutrition, counseling for depression, safer environment, and an opportunity to visit their children.

Research Question #4

Both men and women reported difficulty in obtaining access to health care, and both attributed this difficulty to their lack of ability to pay. The difficulty, however, differed for men and women. For men, the problem was one of obtaining basic care, but for women, one of obtaining specialty care. Perhaps women were more successful than men in overcoming the barriers to basic care because they were more persistent; perhaps the barriers to basic care were in fact less formidable for women; or perhaps the women placed

more value on health and on health care. Conversely, the homeless men may have been less successful in getting basic care because the barriers were greater for them. Perhaps they preferred to use alcohol and drugs as coping mechanisms rather than seek treatment. Or perhaps alcohol and drugs impaired the men's ability to define uncontrolled heart rhythm problems, knee pain, and ear infections as immediate problems.

A second difference between homeless men and women in the matter of access related to perceptions of being wanted or unwanted. The women, more often than men, reported feeling stigmatized when they entered health care facilities. This difference in the perceptions of men and women might be attributed to a greater sensitivity in women to recognize stigmatizing attitudes where they do in fact exist, the women being associated with caring for their children in less than optimum environments or perhaps to a real difference in the way the two sexes are treated in health facilities. It may indeed be more acceptable for men than for women to be single, alone, "free", and lacking ties to the social structure. Homeless women may be more suspect of moral turpitude. Additional data are needed to decide among these alternative explanations.

CHAPTER V

Summary and Conclusions

Summary

Eighteen young, homeless men were interviewed at an urban shelter to describe and compare their current health status, health practices, health needs, and experiences in accessing health care with those of the homeless women studied by Pujanauski (1989).

With respect to their health status, the majority of men judged both their physical and mental health to be good or excellent. This would appear to be an over estimation when over half of the men reported a chronic and/or recent accident or acute illness. In addition, three-fourths saw homelessness as adversely influencing their mental health. Finally, they gave evidence of such mental health problems as alcohol and/or drug abuse and physical and/or sexual abuse.

Health practices of men included use of health providers, use of medications for physical and mental problems, coping mechanisms, alcohol and drug treatment, and sexual health practices. Over half of the men had reported that they had not recently received care from a health provider. The majority named the emergency room as their first choice when seeking health care, but a few men said they would see health providers in community clinics. The major medications reported being taken were for pain.

Coping mechanisms identified by the men were verbalizing

their problems, fighting, counseling, and by two men, drinking. Seeking drug and alcohol treatment was another health practice. Almost half of the men reported receiving such treatment, varying from periods as short as two weeks to periods up to 2 years. Three men reported that their treatment occurred while they were homeless. One of the men who had received treatment also had a diagnosis of schizophrenia and another had a diagnosis of depression.

The men expressed minor concern over the health implications of their sexual activities. One man reported having contracted a sexually transmitted disease, and 5 of 13 currently sexually active men expressed concern about the possibility of contracting sexually transmitted diseases.

With regard to their health needs, the men identified a need for better nutrition, counseling for depression, and a safer environment. However, other health needs perceived by the investigator, such as attention to mental illness needs, longterm recovery of substance abuse, and physical and sexual abuse, went unrecognized by the men.

When asked questions about their access to the health care delivery system, 5 of the 18 men interviewed reported seeing a provider in the last 6 months. Most, however, reported inability to pay as the major barrier to access to the health care delivery system.

When the health status, practices, and needs of these men were compared to those of the women of Pujanauski's (1989)

study, several differences became evident. Women reported being homeless for a much longer time, identified eviction as a major precipitant of homelessness, and listed health status problems related to dentition, chronic respiratory infections, physical and sexual abuse, reproductive care and health of children. In contrast, the majority of men listed as their health concerns better nutrition, health care for injuries, counseling for depression, and, rarely, treatment for substance abuse. Two other health concerns of the men were safer environment and opportunity to visit their children. Although depression was a concern for both sexes, women viewed their mental health as poorer than the men viewed theirs. In fact, five times as many women as men had attempted suicide and only women described themselves as "alcoholics" though more men than women admitted to currently using alcohol and drugs. Pregnancy and childcare were more of a concern for the women than the men. More women reported being physically and/or sexually abused recently. Most of the men who had experienced abuse had done so as children.

The men and women also differed in many of their health practices. Men took more medication, but reported fewer psychiatric hospitalizations than women. Also, men and women had different coping mechanisms for stress. More women than men currently and previously had been in counseling. Although men did not report seeking counseling for alcohol and/or drug issues, only men reported formal alcohol and/or drug

treatment. More men than women reported using precautions for birth control and the avoidance of sexually transmitted diseases.

The health needs identified by the homeless men were very different from those identified by the homeless women. For example, the men perceived needs related to injury, employment, and nutrition, whereas the women perceived needs related to respiratory infection and physical and sexual abuse.

Finally, with regard to access to the health care delivery, both the men and women experienced difficulty, but in different ways. The men reported having more problems getting basic care, whereas homeless women had difficulty in obtaining specialized care and experienced stigmatization in using basic care services.

Strengths and Limitations

This study is the first to describe the health status, health practices and health needs of homeless young men in Portland, and therein lies its primary strength. Despite the limitations of the study, the insights it provides into the world of homeless men, as they perceive it, should be useful in guiding future research and suggesting possible interventions.

Nevertheless, limitations to generalize findings should be acknowledged. The convenience sample, though small, was appropriate, in that the study was exploratory. The sample

was biased by including those homeless men who sought service in a shelter, thus excluding many others who preferred to live under bridges, in camps, and on the streets. The sample was additionally limited in being obtained entirely from one specific shelter, Baloney Joe's, which tends to serve the most destitute among the homeless. As a consequence of the nonrepresentative nature of the sample, generalization of the results is not possible. Hence the results must be considered as purely suggestive. Couched as hypotheses, the results need further testing before any extension to the broader population of the new homeless is appropriate.

The difficulty of obtaining a representative sample should be understood by future researchers. In this study, at least 50 men were asked to participate before 18 could be found who would consent. This was true even with the cooperation and encouragement of the managers of the shelter. Those who agreed were possibly the elite of the clients of the shelter, since the violent, the most disturbed and drunken men were screened out. Although there were exceptions, most of the homeless men interviewed appeared clean (due to the shelter facilities), though wearing old worn clothes. They carried their few belongings with them, appeared tired from lack of sleep and the "elements" of being homeless, and used most of the questions of the interview schedule as a preface for long, very articulate discussions about their individual experiences.

Another limitation of this study lies in the comparison of samples of homeless men and homeless women obtained from different types of shelters. The two samples were similar in mean age, urban setting, and time of year selected. However, Pujanauski (1989) drew her sample of homeless women from multiple sites, none of which was similar to Baloney Joe's. Those shelters may have served a group of women quite different from the men served by Baloney Joe's. For example, minority women were absent from Pujanauski's sample. In defense of the comparison, however, one might note that both men and women were compared in their "natural environments."

The interview process was a source both of strength and limitations. Conducting the interviews at the shelter, rather than in some place outside of the natural environment of the homeless, may have put the men more at ease, and resulted in richer data. On the other hand, since the clinic managers recruited all subjects, the managers' judgements of whom to select doubtless biased the sample. The day clinic manager recruited 6 subjects and the evening manager recruited 12. The two managers may have based their choices on different subjective criteria. Again, the interaction of the investigator and the respondent may have influenced the results. Some men were much more willing to talk than others. In addition, the responses of some men may have been influenced by the harsh words (mandated by the institutional review board) of the consent form which required the

investigator to report certain illegal activities.

Finally, since the interview schedule had not been fully tested with this population before, the process of assembling the data pertinent to each research question was cumbersome. An additional pretest and use of a somewhat different format might have alleviated that technical problem.

Conclusion

Many implications for nursing practice and research may be drawn from this study, the first of its kind in Portland, and the base, perhaps, from which further nursing research can develop. A first step in research might be to look at the relationship of homelessness to specific health problems and at health problems as a cause for homelessness or vice versa. For example, further research could look at the time of counseling in relationship to the time of homelessness. As another example, since a majority of men were involved in crime, the research question might be stated: What factors of homelessness are precipitants of crime? or is jail release an unrecognized precipitant of homelessness? Additional questions could explore substance abuse in relation to the cause or result of men's homelessness. In addition, another question could be posed in relation to the correlation between substance abuse and physical/sexual abuse. Finally, since this study only sampled men at a shelter, research is needed on a more representative subpopulation of young homeless men living on the streets, in family camps, and under bridges.

Besides nursing research, this study also has many implications for nursing practice. Since this study does suggest this new population of young homeless men do have specific health needs and no subjects in this study said they "liked" or wanted to continue to "be homeless", it is clear that these young men need help getting adequate health care, help that nurses could provide. However, the health problems identified by this study can act only as a guide to alert nurses to the potential gravity and multiplicity of problems specific to these men. One must remember that this sample is representative of the more able-bodied homeless young men (and not those screened out by managers or who refused to be interviewed, approximately 32). This view was supported by one subject's description of most of the men who slept around him at the shelter by saying "...I'm part of the minority here...really the real homeless are totally helpless..." Thus, the seriousness of the health problems of the total population of homeless men may be far greater than indicated by this study. Since the primary care provider of these men is the emergency room, nurses working there must be especially sensitive to the needs and environments of these homeless men and act as a referral network to community services. Besides being sensitive, nurses must become case managers to encourage use of ambulatory clinics.

Even if nurses support homeless men and women, America's health care system is very fragmented. There is suggestion

from the young homeless men in this study that lack of access to health care depends not only on their inability to pay, but also upon their own lack of recognition of what their health status is and how to use the care they receive when they do get access. Most of these men lacked a support system. In addition, many are single, substance abusers, mentally ill, and consequently, unable to advocate for their own health care. Finally, the men interviewed here appear to be the better functioning homeless young men. Who knows how many homeless men are much more helpless and worse off? Thus, nurses must advocate legislation for a better health system which recognizes <u>all</u> young homeless men as potentially capable and healthy members of society and nurses must take action to make that vision come true.

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APPENDIX A

OREGON HEALTH SCIENCES UNIVERSITY
Consent Form

TITLE: Health Needs of Homeless Men and How They Compare to Homeless Women in Portland, Oregon
PRINCIPAL INVESTIGATOR: Karina Martin
OBJECTIVES: To describe the health status, health care experience and health care needs of the "new homeless" men and compare these factors to 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. Donna Jensen. The purpose of this study is to find out more about the health and health care needs and experiences of homeless men. I am asking men 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 your 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. Donna Jensen. 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 of a personal nature on your background and history related to physical and mental health, homelessness, and use of illicit drugs and involvement in criminal activities. 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 men. It is not expected to involve any risk to you although some men 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 questions, 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 279-7709.

_____	_____
Subject	Date
_____	_____
Witness	Date
_____	_____
Investigator	Date

APPENDIX B

OREGON HEALTH SCIENCES UNIVERSITY
Alternate Consent Form

I have read, have had read to me and received information adequately informing me of the study which I am agreeing to participate in. In addition, I have received a copy of the other consent form which explains the study. My participation is completely voluntary and anonymous and I am free to withdraw at any time.

_____	_____
Subject	Date
_____	_____
Witness	Date
_____	_____
Investigator	Date

APPENDIX C

INTERVIEW SCHEDULE

HOMELESSNESS

I would like to start by asking you a few questions about your living situation.

1. How long have you been without a permanent place to stay?
   1. less than 6 months
   2. 6-11 months
   3. 1-2 years
   4. 2-5 years
   5. >5 years

2. Where are you staying now?
   1. Hotel
   2. With Friends
   3. Shelter:_____
   4. Apartment/House
   5. Street
   6. Car
   7. Other:_____

3. In reviewing the past year, what particular events or circumstances contributed to the situation you're in today?
   1. Left or made to leave family
   2. Left abusive relationship
   3. Job loss
   4. Eviction
   5. Alcohol &/or drugs
   6. Loss of health: physical_____
      mental_____
   7. Other:_____

4. What do you think would have helped prevent you from becoming homeless? (preventive/interventive)
   1. Available/Supportive Family
   2. Job skills/Employment
   3. Nonabusive Partners
   4. No involvement with drugs/alcohol
   5. Socialization with mainstream peers
   6. Social services
   7. Other:_____

NUTRITION

Now I would like to ask you some questions about your health. First, your eating habits...

5. How many meals do you eat every day?
   1. none
   2. one
   3. 1-2
   4. >2

6. Where do you usually eat?
   1. Meal site
   2. Shelter
   3. Other

7. Do you usually get enough to eat?
   1. Yes 2. No

8. What do you want that you're not getting (in the way of food)?_____

HEALTH STATUS

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

10. What are your major health concerns?
   1. mental health
   2. dental
   3. chronic respiratory problems
   4. other_____

11. Do you 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, respiratory problems, high blood pressure, diabetes, seizures, or cancer)
   1. (Yes)_____ 2. No_____
   (go to 12) (go to 15)

12. How long ago did you first notice the problem?
   Indicate problem: Years: Months:

13. When was the last time you saw a health provider about this? 1._____month _____year

14. Can you tell me what has kept you from getting help? (i.e., 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) 1._____

15. Are you seeing a health care provider now?
    1. Doctor
    2. Nurse
    3. Chiropractor
    4. Other_____

16. Are you taking medicine?
    1. yes 2. no

17. Are you receiving any medical treatment now?
    1. yes 2. no
    (go to 19) (go to 18)

18. Should you be taking any?
    1. yes 2. no
    (go to 19) (go to 21)

19. What type(s) of medicine and or treatment should you be taking? 1._____

20. Is there a reason why you are not taking the medicine?
    1. yes: reason_____
    2. no

21. Does your health limit your activity to the point you could not work or go to school?
    1. yes 2. no 3. some jobs

<u>HEALTH CARE ACCESS AND EXPERIENCE</u>
These next questions are related to your experience with access to health care.

22. In Portland over the last 6 months, when seeking health care and/or working with health professions, what has been difficult for you?
    1. Unable to access due to inability to pay for services
    2. Became unable to afford regular source of care
    3. Poor continuity of care
    4. inadequate quality of free care
    5. other_____

23. What has been helpful?
    1. _____

24. How do you generally pay for health care?
    1. don't pay
    2. medical card (go to 25)
    3. Veteran Administration
    4. Other_____

25. When did you first get a medical card?
    1. Year_____

26. Where do you or would you go for health care?
    1. ER
    2. Free clinic
    3. Public health dept.
    4. OHSU
    5. Other_____

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

28. (If applicable) Tell me why you don't have a regular person or place to go?
    1. Never get sick/don't need
    2. Dissatisfied with care
    3. Too expensive/no insurance
    4. Don't know where to go
    5. None available close by
    6. Doctors won't take medicaid
    7. Doctors want money only
    8. Move around too much
    9. Have to wait too long
    10. Have to take time off from my job
    11. Personnel are always changing at the place go to.
    12. Other_____

29. Thinking back over the past two months, were you sick or did you have any accidents?
    1. yes (go to 30) 2. no (go to 37)

30. What was the matter?_____

31. Did you contact a health professional about this problem?
    1. yes (go to 32)
    2. no (go to 36)
    3. tried, but didn't see anyone
    4. did not think seeing a health professional would be helpful for me.

32. Where did you go or call for care?
    1. ER
    2. County clinic
    3. Free community clinic
    4. private physician
    5. private hospital
    6. other_____

33. How long did you wait before you tried to get professional care?
    Number of days:
    Less than 1 day:

34. How many days did you have to wait for an appointment?
    1. Indicate number of days
    2. Less than one day
    3. Other

35. Once you arrived at _____, how long did you have to wait before you saw a provider?
    1. Less than one hour
    2. 1-2 hours
    3. >2 hours

36. If no, can you tell me why not?
    1. Problem not serious enough
    2. Couldn't find the time
    3. Couldn't afford to go to the doctor
    4. No transportation
    5. Doctor couldn't help
    6. Would have to wait too long to see the doctor
    7. Other_____

MENTAL HEALTH

The next section has questions relating to your mental health.

37. How would you describe your current state of mental health?
    1. Excellent
    2. Good
    3. Fair
    4. Poor

38. How has homelessness influenced your mental health?
    1. Negatively
    2. With depression
    3. By stigmatizing
    4. Other_____

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

1. internal coping mechanisms
2. counseling
3. drugs
4. alcohol
5. other_____

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

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

42. Do you know what originally made you feel that way?
(No money, no job, divorce, separation from family, death in family/friend, alcohol/drugs, no home, no future, possessed/controlled by externals, lonely, robbed, physical illness/injury, people around me). Main reason:_____

43. In the last year, have you ever felt so low you thought of committing suicide?
1. yes 2. no (go to 48)

44. In the last year, did you attempt suicide?
1. yes 2. no

45. How many times? _____

46. When did you last attempt suicide?
1. In past 3 months
2. 4-12 months
3. Over 1 year ago

47. What did you do?
1. Pills, medicine, poison
2. Meds with ETOH
3. ETOH intoxication
4. Jumps/falls/vehicle
5. Firearms
6. Hanging
7. Cuts
8 Other_____

48. Have you ever been in counseling or been referred to a mental health clinic or center?
1. yes (go to 49) 2. no (go to 51)

49. If yes, where?_____

50. For what reason?
    1. Difficulties in managing life.
    2. Drinking or a drug problem.
    3. Emotional or nervous problems.
    4. Other_____

51. Have you ever been given medication for your mental health?
    1. yes (go to 52) 2. no (go to 53)

52. What medicines were you given?
    1._____
    2._____
    3._____

53. Can you tell me the kind of emotional or nervous problem that led you to be seen by a doctor or other professional the last time? (i.e., schizophrenia, personality disorder, affective disorder, depression, bipolar, suicide tendency, insomnia, paranoid, anxiety, violent behavior, suicidal behavior)

_____

54. Have you ever been hospitalized for psychiatric reasons?
    1. yes 2. no (go to 57)

55. How many times?

56. How long ago was your most recent hospitalization for nervous or emotional problems?
    1. months_____ 2. years____

57. How old were you the very first time you ever saw a doctor or a counselor because of mental or emotional problems?
1. years_____ 2. never been to a doctor/counselor

58. Are you seeing a counselor now?
    1. Yes 2. No

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

60. What kind of problems?

<u>Family Health Care</u>

Now I'd like to ask you about some things specific to your family's health?

61. How many children have you fathered? ____

62. If the children are not with you, do you know where they are?
1. Mother's custody
2. Living with other family members
3. Foster care
4. Relinquished for adoption
5. Other_____

63. What are your concerns regarding your children?
1._____
2._____

64. What would be helpful to you regarding your children?

65. Are you concerned about getting someone pregnant while you are homeless? 1. Yes 2. No
3. Somewhat

66. Have you ever gotten anyone pregnant while you were homeless? 1. yes 2. no 3. don't know

67. Do you do anything to prevent your partner from becoming pregnant?
1. condom/rubber
2. withdrawal
3. other: describe

68. In the past year, did you or your partner(s) use birth control most of the time, about half the time, or seldom?
1. most of the time
2. half of the time
3. seldom
4. none

SEXUALLY TRANSMITTED DISEASES

Now, I would like to ask you a few questions related to sexually transmitted diseases?

69. When you have sex, if you do, do you ever worry about catching a disease?
1. yes 2. no

70. What do you do to protect yourself?
1. use condom/rubber
2. wash
3. other: describe

71. How many sexual partners have you had in the last month?
1._____

72. Have you ever had any sexually transmitted diseases?

1. Yes 2. No (go to 76)

73. What did you have/How many times (gonorrhea, syphilis, herpes, chlamydia, trichomiasis, +HIV, AIDS) 1. (disease)_____2. _____

74. Have you been treated for this problem?
1. yes 2. no

75. What problems have you had getting treatment:past/present?
1._____
2._____

76. Have you ever used sex for:
1. your own protection
2. your own safety
3. food
4. drugs/alcohol
5. safety of your partner
6. no

SUBSTANCES

Now, I would like to talk with you about alcohol and drugs.

77. Please describe to me your usual patterns of drinking alcohol in the last month.
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

78. (If recovering alcoholic) How long dry/sober?

79. What drugs or medications have you taken in the past month? (Marijuana/hash; amphetamines/speed/crank; barbiturates/downers/sleeping pills; seconal/quaaludes; tranquilizers/valium/librium; cocaine/crack; heroin; opiates other than heroin: such as demerol, codeine, morphine, methadone, darvon, opium; psychedelics: LSD, mescaline, peyote, psilocybin, dmt, pcp) 1._____
2._____

80. If yes, were any prescribed by a doctor?
    1. Yes 2. No

81. 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)
    7. other_____

Treatment

82. Have you ever received help for alcohol and/or drug use?
    1. Yes 2. No (go to 88)

83. Where did you get help?
    1. alcohol treatment center
    2. drug treatment center
    3. mental health clinic/center
    4. physical health clinic
    5. private doctor
    6. chiropractor
    7. county hospital/ER
    8. other_____

84. How many times? 1._____

85. How long were you there? 1._____

86. When was the last time?
    1. Within the last 2 weeks
    2. Within the last month
    3. Within the last 6 months
    4. Within the last year
    5. Within the last year
    6. Within the last 3 years
    7. More than 3 years ago

87. When was the first time?
    1. Age:

88. In the last year, have you wanted to get help to "get off" drugs but haven't gotten it? 1. yes 2. no

89. What is the main reason you didn't get help?
    1. Don't have drug problem
    2. Didn't know where to go
    3. Didn't want others to find out
    4. Didn't have money
    5. Inconvenient time/place
    6. Fear arrest/detention
    7. Didn't want to (why?)
    8. Other_____

90. Do you need help right now with a drug problem?
    1. Yes 2. No

DOMESTIC VIOLENCE/ABUSE/SAFETY

91. Have you ever been involved in domestic violence (i.e., physical abuse, sexual abuse)?
    1. Yes 2. No

92. Please tell me what happened?
    1. Physical abuse
    2. Sexual abuse
    3. Other_____

93. Have you ever talked to anyone about this?
    1. yes 2. no 3. NA

94. Are you interested in doing that?
    1. yes 2. no 3. NA

95. Do you feel safe in the area you live in?
    1. yes 2. no

96. What has happened to you to make you feel unsafe?
    1._____
    2._____
    3.NA

NEEDS

97. What are your three most important needs on a daily basis, things that you need and want but cannot get?
    1. Health
    2. Basics (food, home/shower, employment/career, money, clothing sleep)
    3. Personal (time for self, self esteem, "better life", "return of professional status")
    4. Family
    5. Social
    6. Other_____

DEMOGRAPHICS

In this last part, I would like to ask you a few questions about your background and living situation.

98. What is your date of birth?

99. Have you been in jail for a crime?
1. Yes (Go to 100) 2. No (Go to 101)

100. What crime did you commit?
1. assault
2. robbery
3. motor veh. theft
4. burglary
5. arson
6. sex assault
7. fraud
8. public intox/disturb the peace
9. other_____

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

102. How far along have you gone in school?
1. _____years

103. Are you a Veteran? 1. Yes 2. No

104. Where do you get the money that you use for (drugs, cigarettes, food)?_____

105. What is your marital status?
1. never married
2. married
3. living with partner
4. widowed
5. divorced
6. other

INTERVIEWER'S COMMENTS ABOUT THE INTERVIEW/INTERVIEWEE

Thank you for participating in this study.

APPENDIX D

How Questionnaire Items Relate to Research Questions

Questionnaire Topics (Item #'s)	Perceived Health Status (Item #)	Health Practices	Health Care Needs	Access to Health Care
Homelessness (#1-4)			1, 2, 3, 4	
Nutrition (#5-8)		5, 6	7, 8	
Health Status, Physical (#9-21)	9-12, 21	13-18	13-18	14-20
Health Care Access/ Experience (#22-36)	29-30	25-28 31-33 36		22-28 31-36
Mental Health (#37-60)	37, 40, 41 43-47, 53, 60	38, 39, 42, 48-52, 54-58	59	
Family Health Care (#61-68)		61, 66-68	62-65	
Sexually Transmitted Disease (#69-76)	72, 73	69, 70, 71, 74	69, 76	75
Substance Use Treatment (#77-90)	77-81	83-85	88-90	82, 83 86-90
Domestic Violence Abuse/Safety (#91-96)		91-93	93-96	
Needs (#97)			97	
Demographics /Other (#98-105)			98-105	

ABSTRACT

Title: A Comparison of the Health Needs of Homeless Men and Homeless Women in Portland, Oregon

Author: Karina D. Martin

Approved: Donna B. Jensen

Recently, a new and more diverse group of homeless has developed. The "new homeless" include more women, children, adolescents, and young single men and families. Women have been a popular focus of attention because they are part of the "new homeless" and because they have certain unique health needs. In contrast, young homeless men, who are also part of the "new homeless", have not been studied or their unique needs identified.

Thus, a sample of 18 homeless young men was interviewed with the purpose of exploring the men's health status, health practices, health needs and access issues and comparing the conclusions reached with those reached by Pujanauski (1989) from her study of homeless women. These men, ages 18 to 40, were interviewed at a shelter and eating establishment of Portland, OR.

The major findings suggested that young, homeless men do have specific health problems, health practices and health needs. Health needs as expressed by the men and apparent to the investigator were better nutrition, counseling for depression, treatment for physical and mental health problems such as injury and depression, hearing and vision problems, contraception, safer environment to live in, a mechanism for visiting their children, substance abuse, physical and sexual

abuse, and access to health care regardless of ability to pay.

More differences than similarities were apparent between these men and the women of Pujanauski's (1989) study. The women reported being homeless much longer, named eviction as a major precipitant of homelessness, and reported health needs related to dentistry and chronic respiratory infections, physical and sexual abuse, reproductive care and health of children. Women also expressed difficulty in accessing specialty care and reported feeling stigmatized when they were able to access care.

In contrast, the majority of men had been homeless less than six months, and had many health needs different from those of the women discussed above. A common need reported by both the men and women was help with mental illness. Men expressed difficulty in accessing basic care and did not even mention the concept of specialty care.

Many implications for nursing practice and research may be drawn from this study, the first of its kind in Portland, and the base, perhaps, from which further nursing research can develop. A first step in research might be to look at the relationship of homelessness to specific health problems and at where health problems lead to homelessness or vice versa. Also, since this study only sampled men at a shelter, research is needed on a whole subpopulation of young homeless men living on the streets, in family camps, and under bridges.

Besides nursing research, this study also has many implications for nursing practice. Since this study does suggest this new population of young homeless men do have

specific health needs and no subjects in this study said they "liked" or wanted to continue to "be homeless", it is clear that these young men need help getting adequate health care, help that nurses could provide. However, the health problems identified by this study can act only as a guide to alert nurses to the potential gravity and multiplicity of problems specific to these men. One must remember that this sample is representative of the more able-bodied homeless young men (and not those screened out by managers or who refused to be interviewed, approximately 32). Since the primary care provider of these men is the emergency room, nurses working there must be sensitive to the needs and environments of these homeless men and act as a referral network to community services. Besides being sensitive, nurses must become case managers to encourage use of ambulatory clinics.

Even if nurses in their direct patient care environments support homeless men and women, America's health care system is very fragmented. There is suggestion from the young homeless men in this study that lack of access to health care depends not only on their inability to pay, but also upon their own lack of recognition of what their health status is and how to use the care they receive when they do get access. Most of these men lacked a support system. In addition, many are single, substance abusers, mentally ill, and consequently, unable to advocate for their own health care. Finally, the men interviewed here appear to be the better functioning homeless young men. Who knows how many homeless men are much more helpless and worse off? Thus, nurses must advocate

legislation for a better health system which recognizes all young homeless men as potentially capable and healthy members of society and nurses must take action to make that vision come true.