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Reaching the Unreachable: Predictors for Successfully Linking
Chronically and Episodically Homeless Adults to Services

A Dissertation Presented

by

Jo Anne Collins

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Abstract of the Dissertation

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Homeless adults, specifically chronically homeless adults, experience difficulties accessing a variety of social welfare services. This is a quantitative analysis of the experiences of homeless adults regarding their access to multiple human service systems (substance abuse treatment, mental health treatment, medical care, housing assistance and income supports) and the barriers to service they experience. The purpose of this study is to determine which factors contributed to involvement in human service systems by homeless people and if there are differences based upon demographic characteristics, type of service and homelessness status.

This study utilized data collected from a retrospective chart review of client case records at a Drop-In Center for homeless adults in a suburban county in New York. Data utilized for this study consisted of individual client information collected by Drop-In Center staff during the regular course of operations during the 24 month period preceding this study. Data were analyzed to examine if there were differences in service usage between chronically and episodically homeless people, if there were predictors of human service acceptance or denial for chronically and episodically homeless adults and if there were factors beyond homelessness status that predicted successfully linking to services within this sample.

The data utilized for this study possessed both similarities and differences to other samples of homeless people. The large proportion of chronically homeless people, specifically female chronically homeless people, and the extensive service use histories of this population provided insight into gaps in service for these individuals. The data indicated large numbers of voluntary service referrals and denials among the sample, allowing for the possibility that resistance to service is less important than the availability of, and access to, appropriate and flexible services to the sample under study. Several additional factors were associated with access to service within this sample. These factors included the presence or absence of a dual diagnosis, social supports and race. These results suggest that future research should move away from an individual deficit model of homelessness and instead examine effective mechanisms to streamline human service provision to minimize the impact of categorical social welfare systems on homeless, and other marginalized, populations.

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Chapter One

Introduction

Problem Statement

Human service delivery in the United States is characterized by decentralized and categorical service systems. Navigating these systems requires specific skills sets regarding eligibility criteria, treatment histories, inclusion and exclusion criteria and, perhaps above all, the ability to withstand extensive waiting lists and service denials. Perhaps the categorical nature of U.S. social service delivery is no more evident than in that of the support afforded to homeless adults. Homeless adults, specifically chronically homeless adults, present problems similar to other marginalized populations and these presenting problems are complicated by factors such as extreme poverty, co-occurring disorders and limited social supports. This document will examine the human service use among a sample of homeless adults in a suburban community to attempt to identify patterns of service use within the sample and will discuss how these patterns relate to the larger discussion of human service delivery in contemporary United States.

The current understanding of human service use by homeless people presents an incomplete picture of the demographics and service needs of this population. This incomplete picture of service use also limits the ability of the social work profession to develop effective mechanisms for integrating homeless people into service systems designed to meet their diverse needs. This document will begin to clarify the nature and extent of the barriers to service that homeless people experience and how these barriers may speak to problems within the existing delivery system in the U.S. Specifically, homeless people present a diverse set of service needs and their ability to navigate human

service systems and access assistance may reflect a more far reaching pattern endemic to the large, decentralized and disjointed delivery systems that currently characterize the United States social welfare system.

Estimates regarding the demographics and service needs of homeless people throughout the United States vary dependent upon a variety of factors. Inconsistent eligibility and reporting criteria, limited access to homeless people and inconsistent definitions regarding homelessness all serve to limit the current understanding of this elusive group of people. This study seeks to contribute to the literature regarding the service needs of specific populations of homeless people as well as to identify barriers to integration in a variety of human service systems as a result of both individual and systemic factors.

Research involving the study of homelessness frequently does not distinguish by demographic group within samples of homeless people. In particular, there is very little research regarding the phenomena of suburban homelessness. Even less information exists regarding homeless people within the suburbs, particularly regarding length of time spent homeless and service utilization among this population. Research about homeless people is limited by a variety of factors including access to the population and data, willingness of participants to provide information, decentralized service provision evident within the suburbs and unclear information regarding causal factors and specific needs of the population under study. This study represents a first attempt to systematically examine the phenomena of human service usage within a sample of suburban homeless adults.

Purpose of the Study

This is a quantitative study of homeless single adults living in emergency housing on Long Island, New York. Contemporary literature is inconsistent regarding the homeless adult population and the barriers, both individual and systemic, which limit the integration of homeless people into a variety of human service systems. This study seeks to contribute to the current understanding of the homeless adult population and their access to five different human service systems. This study will utilize retrospective chart reviews to identify trends and predictors of service usage among this population. Data analysis will seek to clarify whether there are significant differences in service usage between chronically homeless adults and the broader population of episodically homeless people and to identify predictive factors that contribute to the likelihood of homeless people linking to necessary services. In particular, this study will examine the impact of both individual and systemic factors on the likelihood of homeless people linking to a variety of service systems.

Theoretical Framework

The residual nature of human service provision in the United States limits our ability to understand populations that are historically marginalized from mainstream service provision. This marginalization also limits the ability of the social science researcher to develop a conceptual framework through which to better understand homelessness. Despite attempts dating back to the 19th century, homelessness has not been ‘solved’ nor is it adequately understood. Researchers and service providers alike struggle to quantify the experience of homelessness and how best to address this state of

being that is characterized by the lack of a fixed nighttime residence. The definition of radicalism since the 1960s has “encompassed increasingly diverse ideological perspectives. It included radicals who regarded the structure of society and, sometimes, even the nature of the social work profession as the primary sources of individuals, family, and community problems” (Reisch & Andrews, 2001, p. 177). A radical analysis of human service systems, and their role in managing homelessness, merits further discussion at this time.

This study seeks to examine how the human service usage of homeless adults in a suburban community reflects larger social problems related to the disjointed human service systems that currently exist within the U.S. Radical theories of social work focus on the conflict that exists between individual need and the inadequate resources that are available to meet these needs. The underlying principles of radical social work include:

(1) the belief that the institutional structure of society is the primary source of the personal problems of clients; (2) a focus on economic inequality as a central concern and cause of other social and individual problems; (3) a critical view of social service agencies as instruments of social control, co-optation, or stigmatization; (4) a focus on both structural and internalized oppression; and (5) a linkage of cause and function and private troubles and public issues (Reisch & Andrews, 2001, p. 6).

Radical social work theorists generally focus on larger social issues, but the theory can also be applied to individual client and agency level work. Some radical social workers have “... attempted to formulate a model of radical practice that could be equally applied to work with individuals and communities” (Reisch & Andrews, 2001, p. 174). Despite these efforts, radical social work theory remains on the outskirts of contemporary social work practice.

“Social workers are increasingly being pushed into the role of gatekeepers and agents of social control in order to facilitate the search for new markets and higher profits” (Honkala, Goldstein, Thul, Baptist & Grugan, 1999, p. 534). As human service resources become increasingly limited, social workers will continue in our tradition as direct service providers yet we will also need to address how these limited services contribute to the marginalization of homeless people and other underserved populations. To increase access to supports by these populations, radical social workers will need “to challenge the status quo – inside and outside the profession – in ways that most social workers do not” (Reisch & Andrews, 2001, p. 214).

A discussion of the human service needs of homeless people lends itself easily to examination within a radical social work framework. “...Radical social work practice to date has been predicated on the notion that there are dichotomous relationships between those who manage the personal social services and those who work in them; and between those who work in them and those who use their services”(Dominelli, 2002, p.148). Specifically, as human service systems struggle to maintain equilibrium, it is likely that those individuals with the most significant barriers to service will be denied assistance. This lack of access to service is widely attributed to individual deficits among homeless people rather than to larger social factors such as residual social welfare and commodified human services. A radical critique of social work with regard to the service needs of homeless adults includes the thought that “explanations in traditional social work reduce complex social problems to individual psychological ones. They ‘blame the victim’, making clients responsible for problems which have social origins. In doing so,

they deflect attention from social circumstances” (Payne, 1997, p. 216). A radical analysis of the barriers to service experienced by homeless people indicates that

...there is simply no justification for cultural, political, and economic arrangements that endanger basic survival, that prevent people from accessing food, shelter, and education, and that restrict their freedom to determine and cultivate social relations, then deny them the means to obtain all these things” (Reisch & Andrews, 2001, p. 215).

Radical social work theory provides a framework by which to better understand, and ultimately address, the continued presence of homelessness in the United States. The persistence of homelessness as a social problem, indicates that “...the predominant theories and perspectives that inform contemporary social work are inadequate for meeting the current issues that we face” (Finn & Jacobson, 2003, p.58). Further,

...these issues call for approaches to thought and action that challenge our certainties, acknowledge our partial and positioned perspectives, and enable engagement with radically different ways of interpreting and acting in the world... In short, we need a fundamental rethinking of the nature and direction of social work practice as we come to grips with the rapidly changing environment in which we live and work” (Finn & Jacobson, 2003, p.58).

The fragmented system of human services that currently characterizes U.S. social welfare delivery serves to mask the impact that broader social policies and limited resources have on homeless people. Specifically, focusing on individual problems shifts the focus from access to resources to individual reasons for ‘failing’ to participate in these services. This individual deficit model of service provision cannot provide a complete picture of role of residual human service provision to the continued presence of homelessness. As a fundamental component of radical social work, “structural social workers start from the assumption that the dominant political and economic order directly contributes to social problems” (Finn & Jacobson, 2003, p.61).

Radical social work is not new to social welfare delivery. “There were attempts in the late 1970s and 1980s to achieve a fundamental reorientation of social work practice with a focus on changing the structural inequalities of society rather than changing the individual”(Skerrett, 2000, p.66). Radical social workers, “...made power a central theme and has placed questions of social justice in the foreground” (Finn & Jacobson, 2003, p. 61). Further, some radical social workers attempt to “...connect the issues of social struggle with the identification and overcoming of all forms of societal oppression” (Reisch & Andrews, 2001, p. 175). Unfortunately, these attempts have not met with success and have remained on the outskirts of social work. For example, “government response to radical social work was to oppose this new approach, claiming that social work was becoming too political” (Skerrett, 2000, p. 66). In the current climate of limited funding and program cuts, radical social work is increasingly difficult to implement without risking scarce program resources.

Given the limitations inherent to our categorical social welfare system, sweeping change remains unlikely. The absence of broad scale change does not limit the role of radical social work to human service delivery. Radical social workers can work within “systems rather than being solely ‘outside agitators’ railing against it. Their goals could now include radicalizing the social service organization to improve services to low-income and oppressed groups”(Reisch, & Andrews, 2001, p. 177). Radical incrementalism provides a framework through which to conceptualize social problems and social change. Specifically, radical incrementalism

...does not accept the conventional bounds, assumptions, context and limits that inform established policy. Instead, it explicitly challenges them, pushing for different sorts of changes than can usually be squeezed from the policy process. Yet, not any changes are acceptable for a radical

incrementalism. Instead, radical incrementalism pushes for the reluctantly granted concessions that not only improve the immediate circumstances of those most harmed by existing policy, but also lay the basis for building upon that success for even greater changes in the future, which can over time cumulatively result in the transition beyond the current limits-constraining policy (Schram, 2002, p.101).

Radical social work allows the researcher to begin to reframe the experiences of homeless people into part of a larger, systemic practice of marginalizing specific populations of people from mainstream human service provision.

The structural approach to social work, also referred to as the political-economy or conflict perspective, is part of a larger radical social work movement. Structuralists view the problems that confront social work as a fundamental, inherent part of the present social order, wherein social institutions function in ways that systematically maintain social inequalities along lines of class, race, gender, sexual identity, citizenship, and so forth... Informed by Marxist theory, structuralists place questions of conflict and exploitation at the center of social work theory. They see personal problems as the consequence of structural injustice and the resultant unequal access to means and resources of social and economic production” (Finn & Jacobson, p. 61).

Despite its tradition as a macro-level theory, radical social work is not inconsistent with micro-level work.

“... fighting the micropractices of behavioral modification of welfare reform at the local level is an important ingredient... in the end there may be no more important political work than recognizing the chiasmatic character of the micro/macro divide and working to resist one in terms of the other.” (Schram, 2002, p. 206).

Radical social work theory lends itself easily to a more complete understanding of homelessness as a social – and not purely individual – problem.

This research will utilize the radical theoretical perspective discussed here to interpret the experiences of the homeless people included in this study. As the literature review will clarify, there is currently a large amount of literature regarding the individual

problems experienced by many homeless people. By examining the research questions asked here through a radical perspective, this research seeks to contribute to our understanding of homelessness. “Both theory and research are inextricably intertwined and can build on and influence each other, provide a context for each other and aid a more holistic and well judged understanding of a problem or issue”(Green, 2006, p. 247). This research will expand the current understanding of homelessness to include larger social patterns of exclusion, not merely individual problems. Further,

Unless more progressive systemic-structural social work models are empirically studied and the findings of such studies reported in the mainstream professional press, it is likely that future funding opportunities for them and thus for their great potential for preventive and therapeutic benefits will be lost to future clients (Gorey, Thyer & Pawluck, 1998, p. 274).

A more complete understanding of homelessness through the lens of radical theory will provide social work with the opportunity to respond by modifying our profession to create an increased focus on the interaction of social policy and human service systems on individual suffering.

A human rights framework for social work would entail theoretical and technical training to *transform* oppressive systems and institutions as a legitimate professional response to client need where empathy, management, advocacy, and reform are not enough to guarantee human rights for all (Honkala, Goldstein, Thul, Baptist & Grugan, 1999, p. 536).

Radical social work provides an opportunity to integrate policy and systems change efforts with individual client work. Research indicates that these interventions are effective.

For more radical work – that is, where the focus is not so much on client adaptation to environment challenges but on mutual client-worker strategizing to change another target system (the environment itself [structural change]) – the prevalence of moderate to large interventive

effects may be fivefold greater among generalist, systemic, or radical social work orientations compared with cognitive behavioral ones”(Gorey, Thyer & Pawluck, 1998, p. 274)

Homeless people, specifically chronically homeless people and those with multiple presenting problems, continue to be marginalized by mainstream human service provision. Radical social work theory provides the researcher with a framework to analyze service provision with the context of competition for scarce resources (human services). By utilizing a radical framework to examine human service delivery systems through the experiences of homeless people within a suburban sample, this research will identify the extent to which the systems under study reflect broader patterns of residualized social welfare provision. This research seeks to contribute to the literature by providing an alternative to the ‘individual deficit’ model of homelessness. Specifically, this study provides quantitative data that suggest systemic, macro level factors that contribute to homelessness.

“While sophisticated critiques of quantitative research have effectively shown that it is never objective, statistical documentation is nevertheless not easily dismissed. . . .Refutation is still possible but must usually proceed by supplying alternative statistics and interpretations in ways that can be seen as no less convincing” (Schram, 2002, p. 140).

As is consistent with the tenets of radical theory, this research will demonstrate “how resources are inadequate to meet needs, and ways of dealing with this in a political context”(Payne, 1997, p. 215).

Research Hypotheses

The purpose of this study is to increase the current knowledge base regarding service usage among chronically and episodically homeless individuals within suburban settings.

To this end, this study answers the following questions:

1. What are the differences in application, acceptance and maintenance of services between chronically and episodically homeless people within a suburban sample?
2. What are the predictors for acceptance or denial to community-based services for chronically or episodically homeless adults and do these predictors vary by the nature of service?
3. Are there gender, race, age or other demographic differences (beyond homelessness status) that predict the likelihood of successfully linking to community based services?

Scope of the Study

This study provides clarity regarding the experience of homelessness in a suburban setting. In addition, this study also examines the extent and nature of service provision by a variety of human service systems to homeless people in a suburban county in New York. It is meaningful insofar as it contributes to the literature regarding suburban homelessness and human service systems. Given the uniqueness of the study location and the lack of random sampling, this study will not easily generalize to other populations of homeless people. It does, however, provide a framework by which to further examine homelessness and human service delivery in general.

Chapter Two

History: Definitions and Conceptualization

Homelessness in American History

Homelessness is not a new phenomenon within the United States. Patterns of homelessness, and mechanisms for managing homelessness as a social problem, are as old as our nation itself. Prior to the 19th century, homelessness was not a public problem for which the state shared any responsibility. During these early years in American history, "...it was custom and kinship that eased the bite of misfortune, not the interventions of the state. When those failed, and things seemed beyond repair, many single men took to the road. Making themselves officially homeless alleviated the burden at home" (Hopper, 2003, p.40). Early attempts to manage homelessness during the 19th century focused on removing these individuals from public view. "Specialized institutions were set up to deal with properly "classified" subgroups of the poor – in New York City, both the asylum (1839) and the workhouse (1850) had been added to the almshouse and the penitentiary by the mid-nineteenth century" (Hopper, 2003, p. 30). Because these efforts did little to address the causal factors of homelessness, it is not surprising that homeless people remained a component of 19th century society.

As the 19th century progressed, homeless people became an increasingly visible example of the impact of social and labor market changes and as such, public responses became necessary. These responses varied with respect to effectiveness - thereby beginning a pattern of inadequate service provision to this population that has continued to this day.

The mid-nineteenth century marks a crucial point in the transition from what might be called a *domestic* mode of relief, based in (sometimes subsidized) household, to an *institutional* one, based in separate facilities operated by the state. But among the dependent poor there were those for whom neither residual reach of kinship nor the mushrooming stock of institutional alternatives proved workable for long (Hopper, 2003, p. 29).

The development of the poorhouse, as the institution came to be known, represents an early example of outdoor relief to the poor in American history. Even this early example was plagued by problems regarding the diversity of needs within the client base, public perception and an inability to effectively manage certain groups of clients. “Neither at this facility, nor any subsequently set up to harbor the indigent, would solve the problem of people whose predicament could not be neatly classified, let alone those who preferred slip the strictures of official relief altogether”(Hopper, 2003, p.29). Despite these difficulties, the poorhouse continued to operate as a last vestige for people who did not fit anywhere else.

Despite, or perhaps because, there were few other options for the indigent,

...at no time in the nineteenth century was the poorhouse a monolithic institution, for it always sheltered many different kinds of people. The length of time people spent in the poorhouse highlights its dual role as both a short-term refuge for people in trouble and a home for the helpless and elderly (Katz, 1996, p. 93).

It is also notable that “only between one-fifth and one-quarter stayed there for a year or more” (Katz, 1996, p.93). Even in the earliest days of quantifying homelessness, the historic record documents the existence of specific populations and hard to reach segments of the larger group.

For specific populations of homeless people, the almshouse and the poorhouse proved to be inadequate. In some instances, these individuals turned to police stations for a nights’ respite. During the 19th century, this accommodation required very little,

beyond appropriate behavior, of the indigent. Although some homeless people preferred the police stations to the poorhouse, these accommodations were widely condemned as inadequate.

No one considered these arrangements satisfactory – in fact, they were repeatedly condemned as offenses to decency and hygiene – but they did provide an alternative to the stricter regimens of the almshouse and workhouse. Indeed, in their informality, the police stations were a new form of relief: unstructured, part-time, entailing no further submission to authority that agreeing to behave oneself for the night (Hopper, 2003, p. 30).

Despite the apparent inadequacy, many homeless people in 19th century America chose to sleep in police stations rather than submit to the forced labor and monitoring that was endemic in the poorhouses of the time.

Formal provision for overnight sheltering of the indigent in New York City dates from 1886, when the state legislature passed the Municipal Lodging House Act, authorizing the city to establish facilities for the overnight lodging of the homeless poor. Statute in this instance lagged well behind common practice. Spurred by recurrent depressions, the noisome importuning of beggars, and the specter of visible suffering, the city had long played host to “soup houses,” public work programs, and temporary shelters intended to ease the lot of the desperate poor. Such measures also served to mask evidence of their presence and to mute the threat to property (Hopper, 2003, p. 27).

And so began New York City’s long and tumultuous history of managing homelessness.

Contemporary Homelessness

The last several decades have witnessed drastic shifts in the composition of the homeless population. Homelessness is an issue that the American public historically has viewed as an inner city problem associated with tramps and skid row alcoholics (Rossi, 1994). The new homeless have gained national attention since the early 1980s, as they increasingly have become visible outside of traditional skid row areas (Rossi, 1994).

“Routes to homelessness, and the kind of subsistence strategies it entails, have varied across time and place. Historically, the great causes of homelessness have included pilgrimage, war, famine, social upheaval, itinerant labor, alcoholism, and the lure of the open road” (Hopper, 2003, p. 76). Contemporary homelessness seems to break from this pattern.

Estimates of the size of the population of homeless people vary according to researcher and the methodology utilized to obtain results. As will be discussed later in this document, choice of methodology tends to vary by political agenda and intent. For these reasons, estimates regarding the extent of America’s homeless population vary greatly. One study indicates that,

...annual homelessness figures exceed 1 percent of the total U.S. population and may represent as much as 10 percent of all poor people in this country. Even though many of these people are homeless for only a short time, each spell can be devastating. With 1 out of every 10 poor people in America facing homelessness at some time during an average year, current policies clearly are not working. Homelessness stems from desperate poverty combined with unaffordable housing in communities too strapped to support their most troubled members. These circumstances explain why between 5 and 10 percent of poor people experience homelessness in a period as short as a year” (Burt, 2001, p.1).

These results seem to take into account a variety of factors beyond individual deficits and may present an accurate estimate regarding the total population of homeless people in contemporary American society.

Contemporary homelessness is shaped by increased awareness of homeless people and the ensuing public perception of these individuals. This increased public attention to the plight of the homeless has forced researchers and policy makers to quantify the phenomena of homelessness in a novel manner. “Faced with the problem of describing a mobile and diverse population, researchers have employed a variety of

techniques to help them obtain an accurate portrait”(Blau, 1992, p. 15). A primary factor associated with defining contemporary homelessness is the lack of a conceptual framework regarding the diversity of this population.

One of the main consequences of this theoretical vacuum in current research efforts is an absence of shared definitions. The definitions of terms like temporary, shelter, and mental illness are so sensitive to changes in the political milieu that they have never shown much staying power... The absence of shared definitions is a major obstacle to the accumulation of knowledge”(Blau, 1992, p.19).

Limitations with regard to defining contemporary homelessness have shaped all ensuing programming and policy efforts. In particular, there is currently no complete theory that integrates both individual and systemic factors.

A brief historical overview illustrates that homelessness is not a new phenomenon in the United States. In fact, American homelessness consists of several major historical phases: preindustrial, early industrialization, mature industrialization and deindustrialization or the transition to a service economy (Blau, 1992). Contemporary homelessness, the subject of this research study, is characterized by several demographic shifts in the homeless population as well as by social welfare and market shifts. Hopper (2003) argues that contemporary homelessness is characterized not only by demographic and market changes, but also by decreases in the number of psychiatric facilities caused by deinstitutionalization. Debate about the impact of deinstitutionalization is extensive in the literature regarding homelessness. However, it seems likely that the limited supply of psychiatric facilities for the chronically mentally ill has affected specific subpopulations of homeless people in contemporary society. Although it is unlikely that deinstitutionalization is a causal factor of contemporary homelessness, the lack of

psychiatric facilities limits the availability of this form of housing, and associated services, for people who are mentally ill and homeless. While deinstitutionalization may not have caused contemporary homelessness, it certainly exacerbated it for some fragile individuals within the larger population.

Despite periods of economic recovery, the number of homeless people has continued to grow since the early 1980s (Blau, 1992). It is only recently that subpopulations of homeless people, specifically the chronically homeless and those living outside of urban areas, have gained attention as increasingly important components of the homeless population. Notably, contemporary homelessness has also come to be characterized as a social condition that encompasses more than simply housing status. “So profound is [sic] the link between habitat and inhabitant that sociologists have taken [sic] to defining homelessness – not as the lower end of a housing market spectrum – but as the social condition of “disaffiliation” from the usual ties that bind” (Hopper, 2003, p. 45). It is this disaffiliation that this study seeks to clarify.

Causal Factors

Causal factors regarding homelessness tend to fit into one of two general conceptual frameworks: individual deficits or a structural framework. This researcher argues that these two frameworks are not mutually exclusive, particularly when considering specific populations of homeless people such as chronically homeless adults. This research also examines the role of social work, and human service providers in general, in this framing. In an effort to most effectively facilitate the role of social work in shaping future

directions of work with chronically homeless adults, a more complete understanding of the current conceptual framework is necessary.

The individual deficit model of homelessness posits that homelessness results from personal factors such as mental illness, substance abuse or poor decision making.

For example,

...those who emphasize individual factors generally argue that homelessness is ultimately a personal disabilities issue because even if affordable housing were abundant, the nature of their disabilities render many of the homeless (particularly the chronic homeless) unable to maintain such housing in the long-term. Not only is their capacity to earn income and live independently severely limited, but government policies have failed to provide adequate support and treatment to assist them, or their families, in achieving these ends. As a result, individuals with one or more debilitating disorders often find themselves in a cycle of homelessness, temporary treatment and incarceration... the failure of Americans to admit that individual disabilities are the primary reasons for homelessness has led to ineffective public policies (Sommer, 2000, p. 20).

Alternatively,

...the disaffiliation model that has been used most notably to characterize skid row inhabitants posits that homeless individuals lack social ties to community, family, societal institutions, and each other. Such a model addresses the paradox of the savvy homeless person who cannot get off the streets by pointing to his lack of social capital. In this paradigm, it is not the social ties with other homeless that prevent individuals from making it off the streets, but rather, it is that individual's lack of ties that prevents successful integration into the housing market and mainstream society (Conley, 1996, p. 27).

It is clear that neither framework completely explains the phenomena of homelessness.

What is most striking, however, is that the models are not more frequently used to complement, rather than contrast, each other.

Some research indicates that,

...personal disabilities and social estrangement disproportionately affect homeless individuals and that these characteristics pose significant challenges to the rehabilitation process and prevention of future

homelessness. Most also agree that changing policy over time has resulted in decreased support for the disabled who in the past were primarily cared for in institutionalized settings. But those who examine structural causes of homelessness emphasize that economic and social trends, combined with government policies, have affected the ability of nondisabled individuals to keep themselves housed (Sommer, 2000, p.25).

Perhaps most important to contemporary research efforts is the understanding that structural and individual causes of homelessness are frequently intertwined and, in many instances, cannot be separated. In particular, it is evident that individual characteristics are clearly risk factors for homelessness, especially the chronic variety.

Once structural factors have created the conditions for homelessness, personal factors can increase a person's vulnerability to losing his or her home. Many factors can make a poor person more susceptible to homelessness, including limited education or skills training, mental or physical disability, lack of family to rely on (e.g., after being placed in foster care), and alcohol or drug abuse. But without the presence of structural fault lines, these personal vulnerabilities could not produce today's high level of homelessness (Burt, 2001, p. 2).

In addition, the number or extent of individual risk factors that a person presents may contribute to the likelihood of their having limited access to a variety of human service systems. Future research will need to focus on this interaction between individual risk factors and systemic barriers.

Subpopulations of Homeless People

Population Demographics

Research and programming efforts designed to better understand, improve and increase access to services for homeless people immediately face difficulties defining the very people they seek to help. Homeless people are not a homogenous group of individuals. “Homelessness is not a unitary phenomenon, and it is unlikely to respond to therapeutic interventions that fail to consider individual differences” (Argeriou, McCarty and Mulvey, 1995, p.734). Presenting problems, as well as the mechanisms for addressing individual needs, vary dependent upon the factors that contribute to homelessness. Definitions of homelessness vary by source and, as such, federal, state and local governments often have different definitions of homelessness.

The term ‘homeless’ has numerous meanings. This inconsistency creates difficulties when researchers attempt to quantify and study homeless people. As Blau (1992) indicates, these definitions vary by, in part, by political agenda and objective. For example,

in discussions of homelessness, three different usages of the term correspond to three different political agendas. In ascending estimates of the population, these usages include people in shelters; people in shelters and on the streets; or people in shelters, the streets, and at risk of losing their current housing (Blau, 1992, p. 8).

That the population under study varies dependent upon the examiner is a significant barrier to an effective investigation of homelessness. Further, varied definitions are also indicative of differences in the perception of the extent of homelessness in American society, both as a phenomenon that affects individuals

and families and also as a social problem rooted in American economic and social welfare policy.

This research requires that the author clearly define the population under study. The most widely acknowledged definition of homelessness is provided by the federal entity charged with responsibility for managing homelessness, the United States Department of Housing and Urban Development (HUD).

The definition of “homeless” is contained in the Stuart B. McKinney Homeless Assistance Act of 1987, which states that a homeless person is one who is:

- Sleeping in places not meant for human habitation, such as cars, parks, sidewalks and abandoned buildings;
- Sleeping in an emergency shelter;
- Living in transitional or supportive housing after having originally come from the streets or an emergency shelter;
- Staying for a short period (up to thirty days) in a hospital or other institution but who would ordinarily be sleeping in one of the above places;
- Being evicted within a week from a private dwelling unit; or
- Being discharged within a week from an institution in which the person has been a resident more than thirty consecutive days without having an adequate place to live in subsequent to discharge (New York State Consolidated Plan, 2005).

Advocates and policy makers have since developed additional categories to account for specific subpopulations of homeless people. Of these categories, chronic homelessness is of particular importance to this research.

Chronic Homelessness

“Despite their diversity, nearly all homeless tend to share three characteristics: they are extremely poor (incomes less than half the federal poverty line), they exhibit high rates of personal disabilities, and they show a tendency to be socially estranged”

(Sommer, 2000, p.11). In addition to issues including social conditions such as a lack of affordable housing and limited transitional and supported housing beds, some homeless people also experience additional barriers such as extended or multiple periods of homelessness, co-occurring disorders, ranging from chronic health conditions and disabilities to mental health and substance abuse disorders. These individuals, increasingly referred to as the chronically homeless within the literature, are among the most severely marginalized from mainstream human service systems. It is the experience of these individuals that this study seeks to examine.

The academic and human service communities are only beginning to understand chronic homelessness. Definitions of chronic homelessness vary.

The federal government's definition of chronic homelessness includes homeless individuals with a disabling condition (substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability) who have been homeless either 1) continuously for one whole year, or 2) four or more times in the past three years (National Alliance to End Homelessness, 2007, p.1-2).

Attempts to quantify chronicity of homelessness have focused on factors such as the number of episodes of homelessness, actual length of time spent homeless, contributing factors leading (or at least predating) homelessness or various combinations of these factors. Specifically, homeless individuals suffering from mental health or substance use disorders are disproportionately represented among the chronically homeless. Despite this, it is likely that "mental illness and substance abuse do not in themselves account for the current prevalence of homelessness, but rather are risk factors that leave people more vulnerable to homelessness where there is a dearth of affordable housing" (Booth, et. al., 2002, p. 431). It is this interaction of risk factors that this study seeks to understand.

Chronic homelessness is not a new phenomenon. Homeless people have been visible within American society since our beginnings – it is only our understanding of these individuals that has varied. Specific populations of homeless people, particularly those with multiple presenting problems and limited or nonexistent social supports, have always presented a challenge to human service systems and other entities charged with maintaining social control. In the 19th century, “the poorhouse (or ‘City Home’) and the shelters to which the more vigorous or cantankerous of its traditional clientele would be shunted remained outposts of institutional discards and people for whom no other option worked” (Hopper, 2003, p. 31). Unfortunately, the 20th and 21st centuries have demonstrated a continued lack of capacity and willingness, by human service systems and policy makers, to meet the needs of homeless people with multiple presenting problems.

The categorical nature of most human service systems serves to exacerbate the difficulties experienced by chronically homeless people. Funding constraints and program requirements frequently require a program to address only a specific set of needs. As such, these programs are frequently limited to their predetermined set of services. Clients that are unable to navigate these systems, or are in need of a wider array of services are frequently neglected altogether.

The chronically homeless population is characterized by its frequent inability to gain access to existing housing programs. Individuals in this group often have multiple disabling conditions, especially psychiatric conditions and substance abuse. Most programs are poorly equipped to treat people with dual diagnoses, let alone prepared to address their housing needs (Tsemberis, et. al., 2004, p.651).

Most programs have failed to adapt their services to individuals with multiple needs.

Difficulties engaging this population are frequently cited as a primary barrier to

successfully integrating chronically homeless people into a variety of human service systems. It is important to note that,

...any effort that expects to reduce chronic homelessness to any significant degree must attract and hold the target population—something that traditional approaches have often failed to do, or the people would not still be homeless. First and foremost, there have to be effective ways to contact and recruit chronically homeless people into programs. Equally important, there must be something to offer them that they will take—the programs need to fit the people, rather than the reverse (Burt, et. al., 2004, p.19).

Plainly, the needs of chronically homeless people have not yet been incorporated into mainstream human service provision. As previously referenced, the risk factors associated with chronic homelessness are not the sole predictors of homelessness but, rather, are indicative of limitations within human service systems and social policy efforts. The literature does seem to indicate a specific set of difficulties regarding service usage among chronically homeless people. It remains unclear if these difficulties are the result of individual characteristics or systemic efforts to limit access to a population that demonstrates intense service needs and inconsistent progress. It is important to understand which risk factors are most predictive of alienation from human service systems and if there are variations between these systems with respect to chronically homeless people.

Service Needs

Homeless single adults, particularly those meeting the criteria for chronic homelessness, present a unique set of service needs. Research regarding homeless single adults indicates that these individuals consistently utilize a variety of emergency services disproportionate to their numbers. “In addition to shelter and other resources of the

homeless assistance system, chronically homeless people drain the resources of hospital emergency rooms and inpatient services, psychiatric outpatient and inpatient services, substance abuse services, jails and prisons, veterans' services, and other public agencies”(Burt, 2003, p.1274). Despite this overwhelming reliance on emergency services, the literature has paid very little attention to the causal factors for this phenomena and how the needs of chronically homeless people might be more effectively met through engagement in preventive care.

Existing human service systems are largely unaware of the needs of chronically homeless people and are therefore unable to effectively meet the needs of people with multiple presenting problems. There is, moreover, only limited research regarding the needs of chronically homeless people and the likelihood of their receiving assistance.

...Whereas there is suggestive evidence to indicate that homeless individuals with psychiatric and substance abuse problems may not be receiving the treatment services that they need and there is also a growing literature on the failure of existing systems to meet those needs, we still lack an empirically-based understanding of the extent and predictors of service utilization among homeless individuals with serious mental health or substance abuse problems (Koegal, et. al., 1999, p. 307).

Human service systems cannot attempt to adapt their services to the multiple needs of a marginalized population until these needs are effectively quantified. Research efforts designed to identify these needs will have to focus not only on the personal characteristics of homeless individuals but also on how those characteristics impact the ability of human service systems to work with them and, therefore, their ability to access necessary social supports.

Whereas reports of mental health and substance abuse treatment utilization among the homeless are available, only a few attempts have been made to understand the extent to which homeless adults *with diagnosable disorder* receive treatment for their problems. Even more rare are multivariate

analyses that seek to understand predictors of treatment for psychiatric and substance abuse problems (Koegal, et. al., 1999, p. 307).

This study represents a first step toward quantifying the systemic barriers that exist for chronically homeless people within existing human service systems.

The literature indicates that homeless people utilize emergency services as a primary source of care. This increased use of emergency services does appear to be indicative of improved outcomes or likelihood of linking to additional supports. “Despite evidence that many of their service needs are unmet, some studies have documented high levels of service use in this population, suggesting that homeless persons with psychiatric and substance abuse disorders may incur substantial treatment costs for health care systems that serve them” (Rosenheck & Seibyl, 1998, p. 1256). Further, homeless people’s reliance on emergency services far outweighs that of their housed counterparts. It is likely that “homeless persons may use additional and more costly services compared with patients who have stable residences and other advantages, due to their serious health care problems, continued exposure to inhospitable living conditions, and limited material and social resources” (Rosenheck and Seibyl, 1998, p.1257).

The research indicates that overutilization of emergency care providers is not the only correlation regarding service usage by chronically homeless people. The literature also suggests a correlation between homelessness status and lack of access to a primary health care provider. One study indicated that,

...despite their high prevalence of physical illness, substance dependence, and chronic mental illness, almost half of the homeless adults in our sample lacked a regular source of care. Of those reporting a source of care, most utilized hospital outpatient departments and emergency rooms

instead of community clinics designed to provide primary care to the poor or clinics designed to serve the homeless (Gallagher, et. al., 1997, p. 825).

Consistent access to primary care may be predictive of linking to additional supports yet many homeless people do not have access to this basic level of care.

Homeless adults are at extremely high risk of not having a regular source of care. Community-based studies indicate that from 28% to 53% of homeless persons lack a regular source of care; of those with a source of care, most utilize hospital emergency rooms or public clinics rather than a private physician's office or a health maintenance organization (Gallagher, et. al., 1997, p. 815).

It is not currently clear what factors increase an individual's likelihood to link to primary care and, in turn, preventive care, yet it seems likely that homeless people with multiple presenting problems will benefit from this care. In addition to an increased emphasis on prevention, access to primary care may also serve as a mechanism to engage homeless people - and those in danger of becoming homeless - in a variety of services or supports that may ultimately mitigate a housing crisis.

The health status of homeless adults is also an enormous concern. In one study, "...nearly 40% of homeless individuals were [sic] reported to have some type of chronic health problem. Psychotic and affective disorders were [sic] common, with prevalence rates ranging for the former between 10% and 13% and for the latter between 20% and 40%"(Schanzer, et. al., 2007, p. 464). As previously referenced, lack of access to primary care may contribute to the occurrence of chronic conditions among homeless people. Additional research also indicates that "...nearly half, or 46 percent of the currently homeless reported having at least one chronic health problem. The most common chronic conditions were arthritis and related disorders, high blood pressure, and

some type of physical disability (lost limb, trouble walking, etc.)” (Sommer, 2000, p. 15). Given the illnesses described above, it is clear that primary or preventive care may more effectively manage the occurrence of at least some of these disorders among homeless people.

Homeless people experience multiple barriers to accessing primary care. The reader should note that “preventive care and follow up to emergency treatment are often made difficult, if not impossible, by the lack of health insurance, lack of financial resources or transportation, and other hardships experienced by the homeless. As a result, the homeless exhibit rates of both chronic and acute health disorders much higher than among the general public” (Sommer, 2000, p.14). Clearly, this lack of access to preventive care contributes to the occurrence of chronic health conditions, overutilization of emergency care services, and difficulty linking to additional health care or other supports. Lack of access to a variety of health care options illustrates an additional unmet service need of chronically homeless people that is not fully examined within the literature. When homeless people are unable to access necessary healthcare or support services, their needs may become far more severe and result in extreme behaviors or circumstances that are potentially avoidable.

When homeless people with multiple presenting problems are unable to integrate into existing human service systems, the result is often the criminalization of the behaviors that initially led or contributed to their homelessness. Effective intervention, in the form of treatment for any number of medical and psychiatric issues or housing assistance, may actually reduce the criminalization of homelessness. For example,

a primary objective of mental health treatment of psychotic disorders is to prevent psychotic episodes, and to minimize their impact when they cannot be prevented. Because many mentally ill individuals show highly recognizable patterns of behavior at the beginning of a relapse, the right treatment plan could monitor for this and implement preventive measures if necessary (Hodulik, 2001, 1092).

It is clear that in some instances, homeless people are criminalized for factors beyond their control. “Criminalizing homelessness, or more specifically, the homeless mentally ill, is a cruel, ill-fitting solution designed to hide the underlying lack of resources available to provide services to this community” (Hodulik, 2001, p. 1097). Further, “the increased duration of incarceration associated with homelessness and co-occurring severe mental disorders and substance-related disorders suggests that jails are de facto assuming responsibility for a population whose needs span multiple service delivery systems” (McNeil, Binder & Robinson, 2005, p.840). Incarceration of homeless people with multiple service needs does little more than mask the extent of the problem and further illustrates the need to develop a coordinated system of services for this population.

Given the intense service needs associated with this group of people, and the consequences of failing to meet them, contemporary research must begin to focus on those strategies that most effectively engage homeless people. It is not clear what strategies or combination of factors most effectively reaches homeless people. “Considerable evidence indicates that homeless people, including dually diagnosed individuals, are interested in help with meeting their basic needs much more than treatment... and that obtaining decent housing is a primary objective” (Drake, et. al., 1991, p. 1155). Initial efforts to engage this population may benefit from focusing on identified needs (e.g. concrete assistance) as a mechanism for involving these individuals

in additional service provision. Preliminary research indicates “that clients in a variety of case management models spent fewer days homeless than those in standard care and showed improvements in symptoms and self-esteem” (Chinman, Rosenheck & Lam, 2000, p. 1142). It is currently unknown exactly which components of the case management process lead to this reduction in homelessness, yet allowing for an extended engagement process seems to be a contributing factor. In addition, there is currently limited information regarding the varied success of different human service systems in engaging this population.

As Drake contends, “we know very little about engaging the dually diagnosed client and even less about what to do once the process of disaffiliation from people and institutions has eventuated in homelessness”(Drake, et. al., p. 1155). Given the demographics of the chronically homeless population, and homeless people in general, we must therefore examine the mechanisms currently in place to serve them in an effort to improve these systems and identify actual or potential barriers that may exist.

Federal policy initiatives designed to better serve chronically homeless people currently focus on a variety of factors including permanent supportive housing, service system integration and programming specific to the needs of individuals that have experienced disaffiliation and multiple co-occurring risk factors for extended homelessness. Of the research that does exist regarding chronically homeless people, some attention is paid to the role of substance abuse, mental illness, physical disabilities, co-occurring disorders and the variety of systemic barriers facing individuals that experience one or more of these issues. A recent study regarding the prevalence of comorbid disorders indicates that,

...prevalence findings from this sample of homeless adults add to a growing body of knowledge that suggests that rates of mental illness and substance dependence among the contemporary homeless population are disproportionately high. Moreover, those 2 disorders significantly overlap: 77% of those with severe and chronic major mental disorders were also chronic substance abusers (Koegel, 1999, p. 313).

Further, “in addition to mental illness and substance use disorders, many homeless persons have general medical illnesses, legal problems, skill deficits, and inadequate or antisocial support systems” (Drake, et. al., 1991, p. 1149). It is clear that the presence of multiple presenting problems is endemic to some segments of the homeless population. Given the variety of factors that are believed to contribute to chronic homelessness, and homelessness in general, this study seeks to increase the current understanding of the interaction of these factors and the impact of this interaction on the likelihood of integrating these individuals into appropriate human service systems.

“Addressing dually diagnosed persons forces us to confront clinical issues, service system issues, legal issues, and housing issues” (Drake, et. al., 1991, p. 1149). The literature indicates that mental illness and substance abuse, or a combination of these issues, are among the primary factors that contribute to the experience of chronic homelessness and, conversely, the experience of homelessness may contribute to the homeless person’s marginalization from systems designed to treat mental health, substance abuse or co-occurring disorders. “Previous research suggests that allocating resources for integrated service systems, assertive community treatment, dual diagnosis programs, community outreach, and supportive housing with on-site substance abuse services, medication and social services can be helpful with people who are homeless and have mental disorders” (McNeil, Binder & Robinson, 2005, p.845). Despite this emphasis on service integration, there remains little coordination between these systems

and, as such, homeless people with multiple service needs remain marginalized from the very supports that may effectively mitigate their experience of homelessness.

Barriers to Service

The intense service needs of homeless people, in particular those experiencing chronic homelessness, lead one to assume that navigating varied service systems will present a significant barrier to successfully accessing these services. “Human services have never been organized into coherent systems; rather, mental health, substance abuse, social welfare, and so forth are each organized as systems unto themselves with different funding and accountability structures”(Calloway & Morrissey, 1998, p. 1571). Treatment of individuals with multiple presenting problems, including homelessness, is problematic for a variety of reasons.

At the program level, categorical administration and funding, particularly in times of limited or shrinking financial resources and increasing demand, promote the identification of single disorders, for the purpose of either treatment or shunting to another system, and thereby institutionalize the denial of dual disorders. Differences in treatment philosophy, training, and credentialing of clinicians reinforce these barriers.” (Drake, et. al., 1991, p. 1151)

Given this tendency toward categorical administration and funding, it is likely that hard to serve homeless people will be among the first to be denied services.

These barriers are not only limited to psychiatric or substance abuse treatment systems. For example, one study indicated that within a group of homeless people with dual diagnoses,

...persons with schizophrenia were less likely to access treatment than persons without this disorder. It is well-known that co-occurrence of substance use and mental health disorders presents significant challenges for providers and for individuals wishing to receive help for their substance abuse from a program designed to address that problem only or

primarily. Our findings and subsequent recommendation echo those of other researchers: homeless individuals with co-occurring psychiatric disorders require outreach and an integrated suite of services to address both problems simultaneously (Wenzel, et. al., 2001, p. 1166).

Supportive housing programs, even those designed to house homeless people, also exclude individuals with multiple presenting problems. “Those with dual disorders encounter more than double jeopardy because of the combination of their problems and the categorical nature of supported housing arrangements. Housing programs for mentally ill persons often exclude substance abusers, and those for substance abusers often exclude severely mentally ill individuals” (Drake, et. al., 1991, p. 1149). In addition, funding streams for a variety of housing and support services for homeless people are diffuse and complicated. As a result, applicant agencies often have difficulty designing and implementing programs for homeless people with dual diagnoses.

Limited research exists regarding the individual factors associated with chronic homelessness and the myriad of social issues that seem to accompany this phenomenon. Far fewer studies attempt to examine structural factors related to chronic homelessness. In particular, “studies have described obstacles to substance abuse treatment for homeless people at both the individual and structural levels and have suggested that barriers to treatment tend to be especially pronounced for certain segments of this population, such as those with comorbid disorders of both substance abuse and mental illness” (Wenzel, 2001, p.1159). This limited availability of services very likely contributes to the continued disengagement from traditional human service systems. It is possible that some homeless people with multiple problems

prefer the relative independence of life on the streets to a fragmented treatment system that inadequately treats multiple diagnoses or addresses housing needs. Paradoxically, consumers’ reluctance to use traditional

mental health and substance abuse services as a condition of housing confirms providers' perceptions that these individuals are "resistant" to treatment, not willing to be helped, and certainly not ready for housing (Tsemberis, et. al., 2004, p. 651).

Until human service systems begin to consider homeless adults as complex beings with a variety of needs, and strengths, these individuals will continue to be underserved.

The complicated nature of the problems they face means that homeless people with multiple presenting problems are systematically denied access to the very services that may assist them with addressing these issues. These institutional barriers contribute to the vicious cycle that traps some people in extended periods of homelessness. It is possible that, "because they have little access to mental health, substance abuse, and general medical health services, homeless individuals with substance dependence may be at particularly high risk for continued homelessness" (Booth, et. al., 2002, p. 448). This lack of access to, and engagement in, treatment services can lead to "illness exacerbation and disruptive behavior related to substance abuse that [sic] make dually diagnosed individuals particularly visible and difficult tenants who are especially subject to community resistance" (Drake, et. al., 1991, p. 1151). Hence, no matter where they turn, some homeless people face overwhelming barriers from every direction, including the very systems designed to help them.

Beyond traditional barriers to accessing treatment, homeless people also experience a variety of barriers that are more difficult to quantify. In particular, "...nondiagnostic psychosocial characteristics such as social isolation may be more important than chronic psychiatric or substance use disorder in identifying those homeless adults at risk for access problems. The long-term homeless and the socially isolated may be "at risk" because of alienation from formal social service systems"

(Gallagher, et. al., 1997, p. 827). In addition to social isolation, alienation from mainstream services and issues regarding categorical eligibility, homeless people also experience difficulty accessing services as a result of their need to focus on survival in their daily lives. One study indicates that,

... "competing priorities," or the need to devote most of one's time and attention to securing the necessities of survival, such as food, clothing, shelter, and safety, is frequently cited as a barrier to health care among the homeless... because those who more frequently experienced difficulty in meeting their subsistence needs were less likely to have a regular source of care. This finding emphasizes the point that conventional health services pose access problems for the homeless and reiterates the importance of adapting the service delivery system to reduce the role of competing priorities as a barrier to care (Gallagher, et. al., 1997, p. 827).

In order to move beyond the current barriers that prohibit effective service provision to high need populations, human service professionals will need to overcome institutional barriers such as categorical programming and funding limitations. Further, social workers need to acknowledge that many individuals seeking assistance, not just chronically homeless people, possess a diversity of needs that extend beyond their presenting problem.

Systems Responses

Federal Policy Response

Efforts to manage homeless people are not new to American social policy. As early as the mid-nineteenth century, New York City saw its first institutional efforts to provide relief to the city's destitute, many of whom had constructed tent cities or were living 'rough' on city streets (Hopper, 2003). Even in these early efforts at managing homelessness, the reader sees attempts to quantify and label the homeless into various subcategories, each of which required (or deserved) specific levels of assistance. This institutionalization of homelessness has since been the source of a wide array of policy initiatives that have both served to maintain the focus on homelessness as an item on the national agenda, and also further institutionalized the 'maintenance' of homelessness within American society.

Even as a variety of limited income and social supports were implemented throughout the 19th and 20th centuries, housing and homeless assistance never became an officially sanctioned form of support. It is important to note that,

there is one important way in which housing assistance has always differed from other forms of public assistance. Unlike AFDC, food stamps, or Supplemental Security Income, housing never became an entitlement. The federal government, alone or in partnership with state and local governments, never could afford to provide housing, either directly or through rental subsidies, to all who qualified (Katz, 2001, p. 120-121) .

Throughout American history homeless assistance has always been provided under the framework of the 'minimum worthy of the name' insofar as assistance has always been provided in a piecemeal and insufficient manner. Not

surprisingly, homelessness has remained a component of American society in spite of, or perhaps because of, social and political efforts to minimize it.

Prior to the 1980s, homelessness had historically been viewed as the responsibility of the localities, with religious and other nonprofits providing the primary response. Since the late 1980s, the federal role in combating homelessness has increased steadily. The degree to which certain types of homeless intervention have been pursued in the United States has shifted over time... Tertiary or emergency programs dominated the responses to homelessness at all levels of governments and by all sectors, particularly in the 1980s (Sommer, 2000, p.44).

This emphasis on emergency assistance, rather than long-term solutions and increased coordination between human service systems is consistent with the history of managing homelessness in the United States. Contemporary homelessness however, requires a more complete management of the problem as homelessness has continued to increase, even during periods of economic prosperity.

If the 1980s taught us anything, it was that emergency relief was at best a necessary stopgap measure. Shelter neither solves homelessness nor prevents further displacement. Absent an adequate supply of affordable housing – and the jobs and income supports needed to sustain households once relocated – remedial efforts are doomed to an endless round of musical chairs (Hopper, 2003, p. 183-184).

The growth of contemporary homelessness, and the recognition of specific needs within the current population of homeless people, necessitated that the federal government develop new and farther reaching policies to address this increasingly visible problem.

Congress enacted the Stuart B. McKinney Homeless Assistance Act in July of 1987 (Foscarinis, 1996). The passage of the McKinney Act signified federal recognition that homelessness was not simply a local problem, but one that merited national attention.

Congress designed the McKinney Act to address four primary factors associated with homelessness: (1) housing, (2) income, (3) social services, and (4) civil rights (Foscarinis, 1996). In the two decades since it became law, the McKinney Act has focused primarily on the provision of funding streams to agencies that assist the homeless. The focus has been on the maintenance of existing services rather than on long-term solutions (Foscarinis, 1996). A consequence of this focus is that the McKinney Act isolates homelessness from the context of structural factors such as systemic poverty, discrimination, coordination between human service systems and market shifts. The funding streams within the McKinney Act have allowed for better tracking and monitoring of service provision to the homeless and, in turn, better attempts at increased coordination between agencies that assist the homeless. This tracking and monitoring is limited to those programs that specifically service homeless people but may serve as a model for increased coordination between service systems.

The lack of coordination associated with the McKinney Act, and homeless service provision in general, ultimately led to increased federal attention on the need for a streamlined system of services.

In 1993, the Clinton Administration attempted to weave the lessons learned from the early McKinney programs into a comprehensive framework to guide future efforts to combat homelessness. This framework was called the “Continuum of Care.” The concept emphasizes a continuous delivery of services from emergency interventions to preventive programs, encourages assessment of local needs, inventorying of available resources, identification of service gaps, and coordination of all local efforts (public and private) to serve the homeless population. Organizations and agencies applying for federal Homeless Assistance Grant support must demonstrate that a local continuum of care is in place and that the services to be funded fall within this continuum (Sommer, 2000, p. 47).

It is this Continuum of Care model that represents the most coordinated federal approach to homeless service provision in the United States to date.

The Continuum of Care approach to homelessness first became a federal priority during the 1980s although it was not formalized into policy until the 1990s. Advocacy efforts on behalf of homeless people brought the issue to the public spotlight and, in turn, onto the federal agenda (Hopper & Baumohl, 1994). What was seen previously as a local issue now became a component of the federal agenda during an era of drastic public welfare cutbacks (Hopper & Baumohl, 1994). Specifically, the passage of the McKinney Act in 1987 gave federal authority to coordination efforts regarding homeless services (Foscarinis, 1996). Under the McKinney Act, the Interagency Council on the Homeless was initially responsible for the oversight of 18 federal agencies; it first coined the term Continuum of Care with respect to service provision for the homeless (Foscarinis, 1996). The Interagency Council on the Homeless was defunded in 1994, but the Continuum of Care approach has continued to dominate homeless service provision under the provisions of the McKinney act.

A Continuum of Care is a local or regional system for helping people who are homeless or at imminent risk of homelessness by providing housing and services appropriate to the whole range of homeless needs in the community, from homeless prevention to emergency shelter to permanent housing (United States Department of Housing and Urban Development, 2002, pp. i).

Recent changes in the homeless population indicate that the previously existing services were insufficient to effectively meet the needs of this changing population. Specifically, as the number of homeless people has grown and the population has become more diverse, the need for a comprehensive set of services for this population has become increasingly evident among service providers and advocates. The homeless represent a

group that will likely benefit from increased coordination among services as well as a more comprehensive set of services (Hambrick & Rog, 2000). It is evident that “the level of fragmentation of services is great, and the capacity of clients to navigate a complex system is weak”(Hambrick & Rog, 2000, p. 354). It is this desire for continuity that the Continuum of Care model has sought to address within homeless service providers.

“In the organizational response to homelessness, “coordination” has been a (if not the) predominant theme at all levels”(Hambrick & Rog, 2000, p. 353). Specifically, the Continuum of Care emphasizes a variety of methods by which to ensure streamlined homeless service provision. These methods include, but are not limited to, the following: case management, service provider teams and networks, multiservice centers, electronic networks, coalitions and coordinating councils (Hambrick & Rog, 2000). Hambrick and Rog (2000) explain the Continuum of Care as follows,

While coordination has been a consistent federal theme in the homeless area, HUD’s Continuum of Care policy increases the coordination emphasis and the pressure on localities. Coordination at the local level, or at least its appearance, has become a condition for funding. The HUD funding incentive may well bring provider organizations to the table who otherwise would have gone their own way. The ideal in the Continuum of Care model guiding HUD funding for homeless programs is a systemwide planning process in each city resulting in a seamless system of services that enables individuals and families to receive the appropriate set of services depending upon their needs. The goal is to stimulate united planning efforts that eliminate turf battles and establish community priorities. The hope is to bring some rationality to what often has been perceived as a chaotic “nonsystem” (p.361).

Further,

The Continuum of Care concept now guides the award of competitive McKinney Act funds. The Continuum provides incentives for localities to develop community-wide coordination of homeless services and to develop long-term plans. The Continuum of Care guidelines create a mechanism for community-wide participation in setting priorities and organizing services. Four components are included: prevention, outreach

and assessment; emergency shelter; transitional housing; and permanent housing (p.360).

Despite this system of services designed to assist the homeless, there remains a lack of coordination between systems, especially those systems outside of the Continuum of Care model whose services are regularly utilized by the homeless adult population.

Although the Continuum of Care model represents progress regarding federal responsibility for homeless assistance programs and funding, it remains incomplete. “Between 1993 and 1995, the money that the Continuum of Care pumped into homeless programs increased the number of persons assisted. Although all programs benefited, HUD transferred its emphasis from emergency shelters to transitional and permanent housing” (Katz, 2001, p.134). In addition, this increase in emphasis on permanent housing did not decrease the numbers of people becoming homeless.

Despite some remarkable accomplishments in its first two years, Continuum of Care spent relatively little money on the prevention of homelessness, which, by all accounts, continued to increase. HUD’s innovative policies under Clinton still mainly addressed the already homeless rather than the source of their condition (Katz, 2001, p. 134).

As previously referenced, federal responses to homelessness will remain incomplete until a streamlined mechanism for coordination between systems is developed, particularly for those populations of homeless people most at risk for prolonged homelessness. In addition to housing, income and employment supports,

mainstream mental health and substance abuse agencies need to have an integrated approach to mental illness and substance abuse for chronically street homeless people. Mainstream agencies also need to accept that stable housing contributes to their clients’ well being—possibly as much as medications and other official “treatments” (Burt, et. al., 2004, p. xxvi).

State, Local and Private Responses

State, local and private responses to homelessness vary with respect to their efficacy and their ability to create and maintain coordinated systems of care for homeless people. Despite these difficulties, the federal government has consistently seen homelessness as a local phenomena that is the primary responsibility of the states, local governments and non-profit entities.

Ever since the early 1980s, the federal government has contended that since localities deliver services, homelessness was fundamentally a local problem. This argument confuses financing with service delivery. Cities deliver services because that is where the homeless are. Yet they can only deliver these services when the national government makes adequate monies available through a well-coordinated system of policy and program (Blau, 1992, p.114).

This lack of coordination seems to lie at the crux of the difficulties associated with categorical funding and service provision and the resulting extended periods of homelessness for specific subgroups.

Chronically homeless people, or those individuals with multiple presenting problems, experience unique difficulties when attempting to access variety of service systems. Because they do not fit neatly into any single system, the categorical nature of most human service provision, often makes them ineligible for any services.

At the program level, categorical administration and funding, particularly in times of limited or shrinking financial resources and increasing demand, promote the identification of single disorders, for the purpose of either treatment or shunting to another system, and thereby institutionalize the denial of dual disorders. Differences in treatment philosophy, training, and credentialing of clinicians reinforce these barriers (Drake, et. al., 1991, p. 1151).

It is clear that categorical funding and program requirements severely limit the ability of marginal and more fragile individuals to access these services. Until human service

systems begin to operate in a more streamlined and less categorical manner, chronic homelessness and prolonged homelessness for people with a variety of presenting problems will continue to grow.

Limited research indicates that there are systems responses that are proving effective at engaging chronically homeless people. “The vast majority of people who become chronically homeless interact with multiple service systems, providing a multitude of opportunities to break the cycle by preventing a recurrence of homelessness”(National Alliance to End Homelessness, 2007, p.2). Despite the current dearth of research regarding engaging this population, models for outreach and engagement are being developed.

In recognition of the difficulty of attracting and rehabilitating these individuals, programs generally accept the need for a lengthy engagement process that emphasizes outreach, help with basic needs, and slowly building a trusting relationship. Common program elements include comprehensive assessment, intensive case management, supported housing, peer groups for support and therapy, training in independent living skills, and mental health and substance abuse treatment (Drake, et. al., 1991, p. 1150-1151).

Further, some success is demonstrated by “low-demand settings may at least reduce morbidity and permit the development of trusting relationships (i.e. engagement) so that residents can be persuaded to participate in treatment and to pursue abstinence” (Drake, et. al., 1991, p. 1152).

It is currently unclear exactly which components of these programs lead to successful engagement by homeless persons with multiple presenting problems.

Preliminary research indicates that,

“a key predictor of receiving treatment was receiving help from nonservice providers in accessing formal treatment system or direct help from service providers themselves. The nonservice providers included

staff from a shelter, a drop-in center, or other service program. Because nonservice providers can serve as gateways into the formal treatment system, increasing motivation for engaging in treatment is critical, as well as increasing the availability of treatment programs and treatment capacity for the homeless. These data also suggest that substance abuse treatment and other services for the homeless with substance abuse or dependence need to deal with the broad range of vulnerabilities, many long-standing, identified here, not just with the substance dependence alone if these individuals are to regain stable housing” (Booth, et. al., 2002, p. 447).

Despite this inconsistency with the current categorical approach to human service delivery, it seems increasingly clear that a multifaceted approach to outreach and engagement is the most effective mechanism for reaching this marginalized group of people.

Programs that demonstrate the most effectiveness with regard to serving difficult to reach homeless people also demonstrate the most flexibility in service provision. One model, Housing First, has demonstrated success in improving the lives and living conditions of chronically homeless people. “The Housing First approach is designed to improve housing stability for people who traditionally have been very difficult to house or have had difficulty maintaining their housing” (Pearson, et. al., 2007, p. xxiv). More specifically, programs that follow the housing first model attempt to

...target the hardest-to-serve homeless individuals who have a serious mental illness, often with a co-occurring substance-related disorder. Moreover, these programs are designed to increase housing stability for people who traditionally have been very difficult to house or have had difficulty maintaining their housing. The presumption is that once housing stability is achieved, clients are better prepared to address their mental illness and substance-related disorders” (Pearson, et. al., 2007, p. xxiv).

Perhaps most significantly, the Housing First model assumes that homeless individuals with multiple presenting problems are capable of managing permanent housing and that this housing should not be offered contingent upon acceptance of

support services. An assumption behind this model is that if an individual can survive while living on the street, then they are also capable of managing permanent housing.

This paradigm shift of viewing chronically homeless individuals who have serious mental illness and often co-occurring substance-related disorders as “housing ready” differentiates the Housing First approach. The Housing First approach is not a single model, however, but rather a set of general features that communities may interpret somewhat differently (Pearson, et. al., 2007, p.97).

These features are those components that offer the most promise with regard to service provision for chronically homeless people.

These characteristics necessitate flexibility in program planning, housing development, funding sources and within entire communities. The Housing First model

emphasizes reducing and eventually ending chronic street homelessness through an integrated community-wide approach that includes substantial participation by mainstream public agencies... The paradigm shift to low-demand permanent supportive housing on a broad scale affects policymakers, funders, program planners, and service providers. The new approaches can be especially challenging for traditional housing developers and social service providers. For mental health and social service providers, low-demand environments mean they cannot require tenants to use services, and they have to deal with both mental health and substance abuse issues, and do so simultaneously. In addition, tenants may not use their services consistently, thus reducing reimbursements on which the providers may rely. For housing providers, a low-demand residence means that tenants may not act as predictably as the property managers might wish. For both, the challenges are as much philosophical as financial, in that the new model demands that they conduct business in ways that had formerly been considered not just impractical but wrong (Burt, et. al., 2004, p.10).

Despite these serious difficulties, the Housing First model presents a unique opportunity to increase the well-being of chronically homeless people. “Current trends in working

with chronically homeless individuals with serious mental illness and often co-occurring substance-related disorders indicate that Housing First is recognized as a promising strategy to serve this population” (Pearson, et. al., 2007, p. 3). This research will attempt to add to the current discourse regarding service provision to chronically homeless people.

Homelessness in New York

New York State Homelessness

New York State is a large and socio-economically diverse region of the United States. As such, the extent of homelessness, the specific needs of homeless people in any given region and the ability of that locality to meet the needs of its homeless population vary greatly throughout New York. As is consistent in the majority of data available about homeless people, very little is known about the true nature and extent of homelessness throughout New York, particularly in regions outside of urban areas.

An analysis of estimates of the size and characteristics of the homeless population and the services currently provided indicates that, while much is currently being done, unmet needs remain in the following areas:

- homelessness prevention;
- emergency shelter;
- transitional housing;
- permanent supportive housing;
- supportive services; and
- resources targeted to homeless subpopulations (Division of

Housing and Community Renewal, 2005, p. i-ii).

New York State has an extensive system of homeless assistance programs designed to meet these needs and yet an unmet housing need for 17,139 homeless individuals throughout New York State remained as of 2004 (Division of Housing and Community Renewal, 2005). Notably, “emergency shelter providers in all areas of the state have identified a need for enhanced resources for supportive services such as case management, assessment and treatment for mental illness and substance abuse, life skills training, employment services, benefits advocacy, legal services, housing placement, financial assistance, parenting support, HIV-related services, and domestic violence services” (Division of Housing and Community Renewal, 2005, p.24). It is evident that

homeless people may benefit from increased access to a variety of support services and that the nature of the barriers to these services remains unclear.

The complicated system of homeless service providers throughout New York consists of private, public and non-profit entities. The diversity of service providers in New York is widely viewed as a strength due to the resulting expertise and efficiency in providing housing and other forms of assistance to homeless people. “While a diverse and comprehensive structure is generally a strength, it can sometimes act as a weakness. Housing programs in New York are administered by a number of state agencies, sometimes resulting in providers dealing with several agencies in order to undertake one proposal” (Division of Housing and Community Renewal, 2005, p.120).

New York State is also beginning to examine specific subpopulations of homeless people.

Throughout New York State localities have begun to focus on the needs of chronically homeless persons defined by HUD as unaccompanied adults with disabilities who have been homeless continuously for one year, or have had four episodes of homelessness in the last three years... Continuum of Care coordinating bodies across the state have identified a total of 4,934 sheltered chronically homeless persons and 3,951 unsheltered chronically homeless persons throughout the state (Division of Housing and Community Renewal, 2005, p.28).

As is explained within this literature review, the Continuum of Care process represents the primary mechanism by which localities receive federal funding for homeless assistance programs. As part of a federal and statewide effort, all localities within New York

that participate in the Continuum of Care process have developed strategies for ending chronic homelessness, which include some or all of the following: enhanced street outreach; development of better linkages with soup kitchens and other programs that serve chronically homeless persons; creation of day shelters and drop-in shelters for chronically

homeless persons; development of “Safe Havens” and other “low-demand” housing models; use of a “Housing First” philosophy; provision of substance abuse and/or mental health services on demand; and redirection of funding to programs that serve chronically homeless persons (Division of Housing and Community Renewal, 2005, p.28).

The data that will be utilized for the purpose of this study will be taken from one of these “low-demand” model programs, the only Drop-In Center in a suburban county outside of New York City.

Suburban Homelessness

Suffolk County, New York is the easternmost county on Long Island, the metropolitan region east of New York City. In comparison to many of the regions north and west of New York City, Suffolk County is reasonably affluent, with some of the highest property values and area median incomes throughout New York State. Despite (or perhaps because of) this relative affluence, Suffolk County also maintains a population of homeless people – both individuals and families – that regularly utilize the countywide system of shelters and emergency housing options available to the community. Notably, Suffolk County was among the counties in New York State that indicated the highest need for supportive housing beds for homeless individuals and families. Suffolk County was also among the localities (outside of New York City) that reported the largest number of chronically homeless people (Division of Housing and Community Renewal, 2005). It is clear that this identified need is inconsistent with the commonly accepted image of homelessness as an urban phenomenon.

Suburban homelessness appears different to the passive observer than the all too common images of urban homelessness that come to mind.

Differences between cities complicate the issue of what homelessness means. In New York, the homeless are spread throughout the city, and people see them wherever they go. Los Angeles, by contrast, is a cluster of suburbs. Although its homeless population is almost as large as New York's, it is dispersed differently. ... Like homelessness in any suburb, this diminished visibility defuses the urgency of homelessness in Los Angeles and alters its social meaning (Blau, 1992, p.6).

Similar to Los Angeles, suburban homelessness in New York is less visible than its urban counterparts and therefore gives the impression that the condition is somehow less urgent. The occurrence of suburban homelessness is further complicated by

Anecdotal evidence suggests that, despite its relative invisibility, homelessness does exist in rural and suburban communities... they [homeless people] may be forced to stay in substandard housing with inadequate plumbing and/or electrical systems or to live in dilapidated structures that lack insulation... they may sleep in church basements or other structures that are not meant to provide overnight shelter (Division of Housing and Community Renewal, 2005, p. 27).

As is consistent with other populations of homeless people, homeless people in the suburbs are often forced to 'double up' with friends or family members.

Further, homeless people that originate from the suburbs frequently do not have access to the shelter and support service options that their urban counterparts do.

In suburban areas in which there are no emergency shelters, local social service districts provide funding for overnight stays in motel rooms... Most of the housing and services for homeless people in New York State are located in cities or large urban areas. In order to access these resources, homeless persons in rural and suburban areas often have to uproot themselves from their communities and move to locations where housing and services are available (Division of Housing and Community Renewal, 2005, 28).

In fact, when shelter and support services exist at all, they may be difficult or impossible to access by those in need of assistance.

Very little is known about the homeless population in Suffolk County. Some preliminary data from the Suffolk County Department of Social Services (SCDSS) indicates that homeless adults in an emergency housing motel setting in 2004 presented multiple service and housing needs. This data also indicated that 52% of those surveyed said that they had been homeless for over one year during their lifetime, suggesting that many of these individuals may fit the definition of chronic homelessness (Suffolk County Department of Social Services, 2004). Further, of those interviewed, “89% reported having been involved with other service delivery systems, such as mental health, criminal justice, substance abuse, domestic violence and/or child welfare services” (Suffolk County Department of Social Services, 2004, p. 5). It is these interactions with multiple service systems, in addition to extended periods of homelessness, that this study seeks to examine.

Chapter Three

Research Methodology

Specific Research Questions

By determining the accuracy of the current conceptualization of many homeless people as “unreachable,” this study seeks to contribute to the overall understanding of the factors that predict homeless people’s ability to integrate into a variety of service systems. In order to increase the current knowledge base regarding service usage among this population, this study attempts to answer the following questions:

1. What are the differences in application, acceptance and maintenance of services between chronically and episodically homeless people?
2. What are the predictors for acceptance or denial to community based services for chronically or episodically homeless adults and; do these predictors vary by the nature of service?
3. Are there gender, race, age or other demographic differences (beyond homelessness status) that predict the likelihood of successfully linking to community based services?

Although these questions do not predict positive or negative relationships between variables, analysis will indicate the directionality of these relationships.

Research Design

This is an exploratory research study regarding the experiences of homeless adults in Suffolk County, New York. The researcher will use a formative program evaluation to identify areas where improvements in program implementation may lead to most

effectively linking chronically homeless people to identified services. This research will provide clarity regarding existing barriers to service provision for this high need population by identifying predictive factors associated with referral, acceptance and utilization of a variety of human service systems by the homeless people under study.

“Formative evaluations are employed to adjust and enhance interventions” (Royse, Thyer, Padgett & Logan, 2006, p.116). By combining the most current research on homelessness with information gleaned from client case records, the researcher will examine which factors contribute to client involvement in the human service systems outline below. In particular, this research will provide clarity not only on outcomes for chronically homeless adults but also on other factors that impact human service system involvement for respondents in this sample. “Formative evaluation is also used to help ground interventions in theoretical underpinnings and to adapt interventions to specific target groups” (Royse, Thyer, Padgett & Logan, 2006, p.118). By examining demographic characteristics beyond homelessness status, this evaluation will help the program under study adapt their procedures to additional populations of participating clients.

This research includes an analysis of retrospective data collected by Drop-In Center staff during the 24 months preceding this research study. The data utilized for this study consists of individual client information collected by Drop-In Center staff during the regular course of operations at a Drop-In Center for homeless adults in Suffolk County, New York. Staff that collected data during regular program operations included Client Advocates, Case Managers, Housing Specialists, Social Work interns and supervisory staff. Data was collected through client intakes and follow up service

provision, usually over the period of numerous contacts with each client, case notes, collateral contacts with other service providers and supporting documentation. The data collected during program operations was regularly used to facilitate service provision to the client base, make referrals to other services and improve program operations. The data includes information that documents demographic information, presenting problems, self-reports of client histories, verification of client self-reports, emerging issues, case management services referrals and acceptance and denials of services where known.

This study received approval from Stony Brook University's Office of Research Compliance Committee on Research Involving Human Subjects on November 30, 2007. As part of this approval, all data utilized for the purpose of this study were provided to the researcher in a manner consistent with HIPPA de-identification regulations. Data were analyzed using the Statistical Package for the Social Sciences 15.0 (SPSS).

Subjects

The units of analysis for this study are the individuals seen at Suffolk County's only Drop-In Center for homeless adults during the time period under study. Although these individuals display a variety of sociodemographic factors, the unifying factor for each unit of analysis is that they each represent an adult that presented to a Drop-In Center for emergency housing after the Suffolk County Department of Social Services establish their eligibility for emergency housing. While it is not known to what extent these individuals are representative of the larger homeless adult population throughout New York and the United States, they do represent the majority of Suffolk County's

homeless adult population that requested emergency housing assistance during this time period.

Sampling

This study will utilize purposive, nonprobability sampling methodologies. The researcher will utilize data from a de-identified data set created by Drop-In Center staff. The data set will include de-identified information regarding homeless single adults that present to a Drop-In Center for emergency housing for at least one night during a 24-month period. This research consists of all available de-identified data collected at the Drop-In Center during this time period. As is consistent with data collection in other studies regarding homeless people, the researcher relied on available data, since true random sampling of Suffolk County's homeless adult population was not possible or feasible for this study. The impact of purposive sampling to the generalizability of this study is discussed below.

The generalizability of this study is limited by the nonprobability sampling methodologies that are necessitated by most research involving homeless and other difficult to sample populations. Specifically, "feasibility constraints in social work research make it so difficult to meet all of the assumptions of statistical significance tests, especially those regarding perfectly random sampling"(Rubin & Babbie, 2001, p. 554). Further, "just as sophisticated statistical analysis should not cause us to overlook design flaws, a debatable statistical analysis alone should not be sufficient grounds for disregarding the potential utility of an otherwise well-designed study" (Rubin & Babbie, 2001, p. 555). As is consistent with other research involving populations of homeless

people, it was not feasible to collect a random sample of homeless adults for this study.

Literature regarding ‘difficult-to-sample’ populations addresses the issues surrounding purposive sampling. In particular,

Both probability and nonprobability sampling strategies must be considered when designing surveys for the difficult-to-sample. The choice of the strategy is driven by a careful consideration of cost and error as well as feasibility (Lepkowski, 1991, p.419).

Additional research specifically regarding homeless populations further indicates that appropriateness of obtaining samples from shelters. With regard to obtaining purposive samples from shelters,

The findings support the researcher who focuses primarily on shelters and secondarily on food programs in order to obtain a sample... suggest that the researcher can focus on less time-consuming sites and still obtain a reasonably representative sample of homeless people. Persons who use multiple services can generally be readily found at the shelters and food programs (Toro, Wolfe, Bellavia, Thomas, Rowland, Daeschler, McCaskill, 1999, p.171).

The study referenced above also encourages including food service programs in sampling for homeless people, but that was beyond the scope of this research.

The researcher recognizes that, as with many studies involving homeless people, nonprobability sampling presents a challenge to the validity of this sample. The data set that was utilized for the purpose of this research was created by homeless service providers based upon information gleaned from client files, experience in the field, input from oversight agencies and agency administrative concerns. While this information will not easily generalize to other populations of homeless people, the data does represent the most complete information regarding this client base available at the time of the research.

The Drop-In Center that regularly collects information for the aforementioned data set implements a model that allows them to accept client referral regardless of

presenting problems or specific client issues such as acute psychiatric or substance use issues. Within this model, no clients are denied access to service (i.e. emergency housing), regardless of the nature of presenting problems, and no clients are required to participate in service provision in order to remain at the Center for the evening. For these reasons, the Drop-In Center likely provides the most representative sample of suburban, homeless single adults that currently exists, although this sample is by no means exhaustive. The researcher also recognizes that the first person accounts evident in client case records – the source of information for program staff entries into the data set - may impact the validity of the data. The nonprobability sampling methodology will also limit the reliability of this study insofar as the study may not be easily replicated using a similar client base, geographic setting and service parameters.

Procedures

This study will consist of a retrospective analysis of data regularly collected within existing program parameters. Program staff regularly enter demographic and service usage data from client case records into an existing database and the researcher will utilize this existing information for the purpose of this study. Informed consent was not necessary for this study as there will be no contact with the client base for the purpose of this research and all data that will be analyzed is information that was previously collected for the purposes of the Drop-In Center. All information that will be utilized for the purpose of this study will be gleaned from a data set that meets federal HIPPA criteria as a ‘de-identified data set.’ In at least one other study involving retrospective data analysis, informed consent was not required. “Because the study involved retrospective analysis of data sets that did not identify individuals, the committee affirmed that

informed consent was not necessary” (McNeil, Binder & Robinson, 2005, p.841). This is consistent with research approval previously referenced here. The researcher has obtained permission from the agency that administers the Drop-In Center to utilize existing data for the purpose of this study. All data will be password protected and only accessible to the researcher.

Variables

Chronicity of homelessness will be the primary independent variable for this study. Chronicity is coded as a dichotomous variable dependent upon whether the individual meets the HUD definition of chronic homelessness explained previously.

Demographic information and dependent variables, and their levels of measurement, are listed below.

Demographic information

Variable	Level of Measurement
Age	Ratio
Race	Nominal
Gender	Nominal
Number of Social Supports	Ratio
PA benefits	Nominal
Health insurance	Ordinal
Income (sources)	Ordinal
Income (amounts)	Ratio
Medical diagnoses (number)	Ratio
Medical diagnoses (type)	Ordinal
Psych diagnoses (number)	Ratio
Psych diagnoses (type)	Ordinal
Substance abuse diagnosis	Nominal

Dependent Variables

Variable	Level of Measurement
Referrals for MH treatment (number)	Ratio
Receipt of MH treatment	Ratio
Denial of MH treatment (reason)	Ordinal
Referrals for SA treatment	Ratio
Receipt of SA treatment	Ratio
Denial of SA treatment (reason)	Ordinal
Referrals for medical treatment (number)	Ratio
Receipt of medical treatment	Ratio
Denial of medical treatment (reason)	Ordinal
Referrals for housing (number)	Ratio
Receipt of housing	Ratio
Denial of housing (reason)	Ordinal
Applications for benefits (number)	Ratio
Receipt of benefits	Ratio
Denial of benefits (reason)	Ordinal

The following terms will be utilized throughout this document and merit further clarity at this point. Research indicates that “a widely acceptable and uniformly interpreted definition of homelessness has yet to emerge among either researchers or homeless advocates” (Fitzgerald, Shelley & Dail, 2001, p.122). For the purposes of this study, a ‘homeless person’ is considered any individual that presents to the homeless service facility (Drop-In Center) for the purpose of securing an emergency housing placement for the evening. Throughout this study, the researcher will utilize the Department of Housing and Urban Development’s (HUD) definition of ‘chronic homelessness’ discussed earlier. The ‘Drop-In Center’ refers to the emergency housing facility where individuals that present to SCDSS - in person or through the after hours hotline number - are placed (by DSS) on a nightly basis.

‘Emergency housing’ refers to a county wide system of shelters where homeless people can be housed on an emergency basis. These shelters are operated exclusively by not-for-profit agencies that have contracted with the Suffolk County Department of

Social Services (SCDSS) for the purpose of providing shelter and support services to homeless people. The Drop-In Center represents the largest of these shelter facilities for single adults. This facility also represents the only low-demand shelter designed to accommodate chronically homeless people and other homeless people experiencing a range of acute issues.

Data Analysis

The data has been analyzed using the plan of analysis outlined below.

Research Question	Variables	Test/Analysis
Are there differences in service usage between chronically and episodically homeless adults?	Homelessness status (IV) Receipt/Denial of services <ul style="list-style-type: none"> • MH treatment • Medical treatment • SA treatment • Housing • Benefits 	Chi-square T-test
What are the predictors of acceptance or denial to community based services for chronically or episodically homeless adults?	Demographic variables Receipt/Denial of services <ul style="list-style-type: none"> • MH treatment • Medical treatment • SA treatment • Housing • Benefits 	Multivariate Regression
Are there demographic differences (beyond homelessness status) that predict the likelihood of successfully linking to community based services?	Demographic variables Receipt of services <ul style="list-style-type: none"> • MH treatment • Medical treatment • SA treatment • Housing • Benefits 	Multivariate Regression

Study Limitations

As with much of the research involving homeless people, this study will have several limitations. The results of this study will have limited generalizability as a result of the nonprobability sampling methodology employed, the sample size (N=379), the fact that it will utilize data collected from clients at a single site and that much of the information contained in the case records will be obtained from self-reports. In addition, all case records will involve clients that were deemed eligible for by DSS for emergency housing at some point during the 24 month time period. Despite utilizing the federal definition of chronic homelessness, the researcher recognizes that the experiences of chronically homeless people residing in a suburban county may have limited generalizability to populations outside of this region. Nevertheless, this study will represent an important step toward improving the implementation of programs that serve homeless people by utilizing program evaluation methodologies.

Chapter Four

Research Findings

Data Screening

Prior to analysis, data were screened for accuracy, missing values, outliers and the adequacy of fit between the data and the intended procedure. As indicated below, data screening adhered to recommendations delineated in Mertler and Vannatta (2002). The size of the data set allowed the researcher to examine individual cases against the original, de-identified and coded data set provided by the agency. The researcher also examined frequency distributions and other descriptive statistics for each variable within the data set. No coding or other errors were found within the data. Although the data did not represent a random sample all variables were screened for and did not violate, assumptions related to normality, linearity and homoscedacity. All variables were examined for skewness and kurtosis and were determined to be adequate for analysis. Several variables were recoded to consist of broader categories and these will be discussed in each analysis. As discussed previously, data from samples of homeless people frequently contains missing or incomplete information. For the purpose of this study missing data was coded as Unknown and included as a category for each variable.

Univariate Data Analysis

After being coded and screened, data were analyzed as follows. Descriptive information regarding the sample are illustrated in Table 1.

Table 1
Sample Demographic Information by Homelessness Status

	Episodic		Chronic		Status Unknown	
	f	%	f	%	f	%
Gender						
Male	101	52.3%	64	33.2%	28	14.5%
Female	93	51.1%	61	33.5%	28	15.4%
Missing						
Race						
Caucasian	99	54.7%	62	34.3%	20	11.0%
Black/African Am.	71	55.5%	46	35.9%	11	8.6%
Other/Mixed race	27	38.6%	18	25.7%	25	35.7%
Mean Age	40.37		40.09		39.82	
Mean Income (Monthly)	\$358		\$391		\$301	
Social Supports						
None Known	44	44%	32	32%	24	24%
At Least One	153	54.8%	94	33.7%	32	11.5%
Medical Condition						
None Known	80	49.4%	46	28.4%	36	22.2%
Single Condition	51	56.7%	28	31.1%	11	12.2%
Multiple Conditions	66	52%	52	41%	9	7%
Psychiatric Diagnosis						
None Known	108	60.7%	36	20.2%	34	19.1%
Single Axis I	55	48.2%	45	39.5%	14	12.3%
Multiple	34	40.5%	42	50%	8	9.5%
Substance Use Diagnosis						
None Known	109	60.9%	41	22.9%	29	16.2%
At Least One	88	44%	85	42.5%	27	13.5%
Dual Diagnosis						
None Known	154	61.4%	57	22.7%	40	15.9%
Dual Diagnosis	43	29.4%	69	47.3%	34	23.3

n=379

Bivariate Analysis by Homelessness Status

Mental Health Services

Bivariate analyses were conducted between the primary independent variable, Homelessness Status, and dependent variables in each of the human service systems in this study. Bivariate analysis allowed the researcher to test for significant differences between categories of the dependent variable (Chi-square) and group means (T-test) as a result of the primary independent variable, Homelessness Status. The null hypothesis indicates that there would be no differences in service referral, receipt and denial between

chronically and episodically homeless adults in this sample. Bivariate analyses included Cross-Tabulations, Chi Square and T-tests. Table 2 illustrates Chi-square results for each of the variable combinations included in this section. The results of these analyses are explained below.

Chi Square and T-test analyses indicated that the Chronically Homeless adults in this sample were significantly more likely to be referred for mental health treatment than their Episodically homeless and Unknown status counterparts. A Cross tabulation was completed by recoding the variable Mental Health Treatment Referrals into a dichotomous categorical variable, Mental Health Treatment Referrals Categories. The cross tabulation indicated the 63 chronically homeless adults in this study received at least one referral for mental health treatment, exactly 50% of the total number of referrals made within the sample. The Chi-square statistic indicated significant differences between observed and expected counts $X^2(2, N=379) = 29.931, p < .01$. An independent samples t-test also indicated results between these two variables at $p < .05$. Results from Levene's test indicated $F=34.155$, causing the researcher to reject the null hypothesis that the two population variances were equal. When equal variances were not assumed, results from this analysis remained significant with a two-tailed significance at $p < .05$ and a t value of -5.030 . These results indicate that the researcher can reject the null hypothesis that there are no significant differences between chronically and episodically homeless adults regarding mental health service referrals.

Chronically Homeless adults in this sample were significantly more likely to receive mental health treatment than the Episodically Homeless and Unknown status groups. The variable Mental Health Treatment Receipt was recoded into the

aforementioned variable by grouping like responses into broader and meaningful categories. A cross tabulation was also completed between the variables Homelessness status and Recoded Mental Health Treatment Receipt. Notably, the cross tabulation indicated that 27% of chronically homeless adults in this sample received inpatient or other intensive mental health treatment whereas only 9.1% of the episodically homeless respondents received the same level of treatment. The Chi-square statistic indicated significant differences between observed and expected counts, $X^2(4, N=379) = 22.324$, $p < .01$. These results indicate that the researcher can reject the null hypothesis that there is no difference in mental health treatment receipt between chronically and episodically homeless adults.

The Chronically Homeless adults in this sample were also more likely to be denied mental health treatment services than the Episodically and Unknown status groups. The researcher conducted a cross tabulation between the primary independent variable, Homelessness Status and a recoded variable, Recoded Mental Health Treatment Denial. To increase the power of this analysis, the variable Mental Health Treatment Denial was recoded into the aforementioned variable by grouping like responses into broader yet still meaningful categories. Notably, the cross tabulation indicated that 29.4% of chronically homeless adults in this sample were denied mental health treatment whereas only 10.7% of the episodically homeless respondents were denied the same treatment. The Chi-square statistic indicated significant differences between observed and expected counts $X^2(2, N=379) = 18.263$, $p < .01$. These results indicate that the researcher can reject the null hypothesis that there is no difference between denial of mental health services between chronically and episodically homeless adults.

Table 2

Chi-square results for Mental Health Treatment Referral, Treatment Receipt and Treatment Denial by Homelessness Status^a

	χ^2	df	p
Treatment Referral	29.931	2	p<.01
Treatment Receipt	22.324	4	p<.01
Treatment Denial	18.263	2	p<.01

^aFor all analyses, N=379

Substance Abuse Services

The next analysis sought to identify group differences between chronically and episodically homeless adults with regard to substance use treatment services. There were not significant differences between categories of the variable Homelessness Status with regard to substance use treatment referrals. To complete a cross tabulation in this analysis, the variable Substance Use Treatment Referrals (Type) was recoded into a categorical variable, Recoded Substance Use Referrals. As illustrated in Table 3, the cross tabulation and Chi-square statistic indicated no significant differences between observed and expected counts $\chi^2 (4, N=379) = 5.700, p>.05$. Although the Chi-square did not indicate significant differences between categories of the dependent variable with regard to actual and expected counts, an independent samples t-test indicated significant results between these two variables at $p<.05$. Results from Levene's test indicated $F=10.334$, causing the researcher to reject the null hypothesis that the two population variances were equal. When equal variances were not assumed, results from this analysis remained significant with a two-tailed significance at $p<.05$ and a t value of -2.091. These results indicate that the researcher can reject the null hypothesis that there are no

significant differences between chronically and episodically homeless adults regarding the number of substance use service referrals for each.

Table 3 also illustrates that there were not significant differences between categories of Homelessness Status with regard to substance use treatment receipt. A cross tabulation was also completed between the variables Homelessness Status and Recoded Substance Use Treatment Receipt. The variable Substance Use Treatment Receipt was recoded into the aforementioned variable by grouping like responses into broader and meaningful categories. The cross tabulation and Chi-square statistic indicated no significant differences between observed and expected counts $X^2 (4, N=379) = 5.096, p > .05$. These results indicate that the researcher must fail to reject the null hypothesis that there is no difference in substance use treatment receipt between chronically and episodically homeless adults.

Although there were no significant differences between Homelessness Status and either Substance Use Treatment referrals or Receipt, chronically homeless adults within this sample were more likely to be denied substance use treatment referrals than their Episodically Homeless and Unknown Status counterparts. To test the null hypothesis that there was no difference in frequency of denial of substance use treatment between chronic and episodically homeless adults, the researcher conducted a cross tabulation between the primary independent variable, Homelessness Status and a recoded variable, Recoded Substance Use Treatment Denial. The variable Substance Use Treatment Denial was recoded into the aforementioned variable by grouping like responses into broader and meaningful categories. The cross tabulation and Chi-square statistic indicated significant differences between observed and expected counts $X^2 (2, N=379) =$

7.042, $p < .05$. Table 3 illustrates that the researcher can reject the null hypothesis that there is no difference between denial of substance use treatment services between chronically and episodically homeless adults.

Table 3
Chi-square results for Substance Use Treatment Referral, Treatment Receipt and Treatment Denial by Homelessness Status^a

	χ^2	df	p
Treatment Referral	5.700	4	$p > .05^b$
Treatment Receipt	5.096	4	$p > .05^b$
Treatment Denial	7.042	2	$p < .05$

^aFor all analyses, $N=379$

^bp value not significant at $p < .05$

Medical care

The next analysis sought to identify group differences between chronically and episodically homeless adults with regard to medical care. Table 4 illustrates that there were not significant differences between categories of the variable Homelessness Status with regard to medical treatment referrals. To complete a cross tabulation in this analysis, the variable Medical Treatment Referrals was recoded into a categorical variable, Recoded Medical Treatment Referrals. The cross tabulation and Chi-square statistic indicated no significant differences between observed and expected counts, $\chi^2(4, N=379) = 7.149, p > .05$. Although the Chi-square did not indicate significant differences between categories of the dependent variable with regard to actual and expected counts, an independent samples t-test indicated significant results between these two variables at $p < .05$. Results from Levene's test indicated $F=21.153$, causing the researcher to reject the null hypothesis that the two population variances were equal.

When equal variances were not assumed, results from this analysis remained significant with a two-tailed significance at $p < .05$ and a t value of -3.229 . These results indicate that the researcher can reject the null hypothesis that there are no significant differences between chronically and episodically homeless adults regarding the number of medical treatment referrals for each group.

A cross tabulation was also completed between the variables Homelessness status and Recoded Medical Treatment Receipt. The variable Medical Treatment Receipt was recoded into the aforementioned variable by grouping like responses into broader categories. The cross tabulation and Chi-square statistic indicated no significant differences between observed and expected counts $X^2(4, N=379) = 3.145, p > .05$. These results indicate that the researcher must fail to reject the null hypothesis that there is no difference in medical treatment receipt between chronically and episodically homeless adults.

To test the null hypothesis that there was no difference between frequency of denial of medical treatment between chronic and episodically homeless adults, the researcher conducted a cross tabulation between the primary independent variable, Homelessness Status and a recoded variable, Recoded Medical Treatment Denial. The variable Medical Treatment Denial was recoded into the aforementioned variable by grouping like responses into broader and meaningful categories. Table 4 indicates that the cross tabulation and Chi-square statistic did not indicate significant differences between observed and expected counts $X^2(2, N=379) = 5.769, p > .05$. The reader should note that these results approached significance with a confidence level of $p = .056$. These results indicate that the researcher must fail to reject the null hypothesis that there is no

difference between denial of medical services between chronically and episodically homeless adults.

Table 4
Chi-square results for Medical Treatment Referral, Treatment Receipt and Treatment Denial by Homelessness Status^a

	χ^2	df	p
Treatment Referral	7.149	4	p>.05 ^b
Treatment Receipt	3.145	4	p>.05 ^b
Treatment Denial	5.769	2	p>.05 ^b

^aFor all analyses, n=379

^bp value not significant at p<.05

Permanent Housing

The following chi-square and t-test analyses sought to identify group differences between categories of the independent variable, Homelessness Status, with regard to permanent housing. Data regarding housing referrals, receipt and denials were collected based upon the type of housing and, as such, the following analysis includes data specific to each type of housing. The first cross tabulation included the variables Private Housing Referrals and Homelessness Status. Private Housing referrals was recoded into a dichotomous categorical variable, Recoded Private Housing Referrals. The cross tabulation and Chi-square statistic indicated no significant differences between observed and expected counts $\chi^2 (2, N=379) = 3.241, p>.05$. The researcher must fail to reject the null hypothesis that there are not differences between categories of Homelessness Status with regard to Private Housing Referrals. Table 5 itemizes the Chi-square results for each analysis completed regarding housing referrals, receipt and denial.

Another chi-square analysis sought to identify group differences between chronically and episodically homeless adult with regard to supported housing referrals.

Chronically Homeless Adults in this study were more likely to be referred to supported housing than their episodically and unknown status counterparts. The cross tabulation included the variables Supported Housing Referrals and Homelessness Status. Supported Housing Referral was initially coded as a dichotomous categorical variable and did not necessitate recoding for this analysis. The cross tabulation and Chi-square statistic indicated significant differences between observed and expected counts $X^2 (2, N= 379) = 20.274, p<.01$.

The final chi-square analysis regarding housing referrals sought to identify group differences between chronically and episodically homeless adult with regard to Other Housing Referrals. The chronically homeless adults were more likely to be referred to other housing than their episodic and unknown status counterparts. The cross tabulation included the variables Recoded Other Housing Referral and Homelessness Status. The initial variable Other Housing Referral was recoded into a dichotomous categorical variable and renamed Recoded Other Housing Referral. The cross tabulation and Chi-square statistic indicated significant differences between observed and expected counts $X^2 (2, N=379) = 15.054, p<.01$.

Table 5 illustrates that there were significant differences between Chronic and Episodically Homeless adults with regard to the number of housing referrals. An independent samples t-test was conducted utilizing the two variable Homelessness Status and Housing Referrals (Number). The t-test indicated significant results between these two variables at $p<.01$. Results from Levene's test indicated $F=1.237$, causing the researcher to reject the null hypothesis that the two population variances were equal. When equal variances were not assumed, results from this analysis remained significant

with a two-tailed significance at $p < .01$ and a t value of -3.437 . These results indicate that the researcher can reject the null hypothesis that there are no significant differences between chronically and episodically homeless adults regarding the number of permanent housing referrals for each group.

A cross tabulation was also completed between the variables Homelessness status and Recoded Housing Receipt. To increase the power of this analysis, the variable Housing Receipt was recoded into the aforementioned variable by grouping like responses into broader yet still meaningful categories. Even after recoding the initial variable into a dichotomous variable, the cross tabulation and Chi-square statistic indicated no significant differences between observed and expected counts $X^2 (2, N=379) = 5.094, p > .05$. As Table 5 indicates, these results indicate that the researcher must fail to reject the null hypothesis that there is no difference in housing receipt between chronically and episodically homeless adults.

Chronically homeless adults were significantly more likely to be denied housing than their episodic and unknown status counterparts. To test the null hypothesis that there was no difference between frequency of housing denial between chronic and episodically homeless adults, the researcher conducted a cross tabulation between the primary independent variable, Homelessness Status and a recoded variable, Recoded Housing Denial. The variable Housing Denial was recoded into the aforementioned variable by grouping like responses into broader and meaningful categories. As indicated in Table 5, the cross tabulation and Chi-square statistic did indicate significant differences between observed and expected counts $X^2 (4, N=379) = 14.103, p < .01$. These results indicate that the researcher can reject the null hypothesis that there is no

difference between denial of permanent housing between chronically and episodically homeless adults.

Table 5
Chi-square results for Housing Referral (Private, Supported, Other), Housing Receipt and Housing Denial by Homelessness Status^a

	<u>X²</u>	<u>df</u>	<u>p</u>
Housing Referral			
Private	3.241	2	p>.05 ^b
Supported	20.274	2	p<.01
Other	15.054	2	p<.01
Housing Receipt	5.094	2	p>.05 ^b
Housing Denial	14.103	4	p<.01

^aFor all analyses, n=379

^bp value not significant at p<.05

Benefits

The final chi-square and t-test analyses sought to identify group differences between chronically and episodically homeless adults with regard to both means tested and entitlement benefits. As demonstrated in Table 6, there were not significant differences between the categories of the independent variable (Homelessness Status) with regard to Benefit Referrals. To complete a cross tabulation in this analysis the variable Benefit Referrals was recoded into a categorical variable, Recoded Benefit Referral. The cross tabulation and Chi-square statistic indicated no significant differences between observed and expected counts $X^2(4, N=379) = 6.323, p>.05$. There also were not significant differences between the means for each category of the independent variable with regard to benefit referrals. An independent samples t-test indicated no significant results between these two variables at p<.05. Results from Levene's test indicated $F=.035$, causing the researcher to reject the null hypothesis that

the two population variances were equal. When equal variances were not assumed, results from this analysis were also not significant with a two-tailed significance at $p > .05$ and a t value of .354. These results indicate that the researcher must fail to reject the null hypothesis that there are no significant differences between chronically and episodically homeless adults regarding the number of benefit referrals for each group.

Chronically homeless adults in this sample were more likely to receive benefits than their episodically and unknown status counterparts. A cross tabulation was also completed between the variables Homelessness status and Recoded Benefit Receipt. To increase the power of this analysis, the variable Benefit Receipt was recoded into the aforementioned variable by grouping like responses into broader yet still meaningful categories. The cross tabulation and Chi-square statistic indicated significant differences between observed and expected counts $X^2(4, N=379) = 19.535, p < .01$. These results indicate that the researcher can reject the null hypothesis that there is no difference in benefit receipt between chronically and episodically homeless adults.

To test the null hypothesis that there was no difference between frequency of denial of benefits between chronic and episodically homeless adults, the researcher conducted a cross tabulation between the primary independent variable, Homelessness Status and a recoded variable, Recoded Benefit Denial. The variable Benefit Denial was recoded into the aforementioned variable by grouping like responses into broader categories. Table 6 illustrates that the cross tabulation and Chi-square statistic did not indicate significant differences between observed and expected counts $X^2(4, N=379) = 7.544, p > .05$. These results indicate that the researcher must fail to reject the null

hypothesis that there is no difference between denial of benefits between chronically and episodically homeless adults.

Table 6

Chi-square results for Benefit Referral, Benefit Receipt and Benefit Denial by Homelessness Status^a

	χ^2	df	p
Benefit Referral	6.323	4	p>.05 ^b
Benefit Receipt	19.535	4	p<.01
Benefit Denial	7.544	4	p>.05 ^b

^aFor all analyses, n=379

^bp value not significant at p<.05

Additional Bivariate Analyses

Dual Diagnosis and Mental Health

As explained in the Methodology section of this document, the researcher utilized additional demographic variables to examine their impact on group differences for each of the dependent variables. In particular, the presence of a dual diagnosis proved to be an important characteristic for subjects within this sample. Chi Square and T-test analyses indicated that the Dually Diagnosed adults in this sample were significantly more likely to be referred for mental health treatment than their counterparts. A Cross tabulation was completed between the independent variable, Dual Diagnosis and Mental Health Treatment Referrals Categories. As evidenced in Table 7, the Chi-square statistic indicated significant differences between observed and expected counts $\chi^2 (2, N=379) = 22.725, p<.01$. An independent samples t-test also indicated statistically significant results between these two variables at p<.01. Results from Levene's test indicated $F=21.403$, causing the researcher to reject the null hypothesis that the two population variances were equal. When equal variances were not assumed, results from this analysis

remained significant with a two-tailed significance at $p < .01$ and a t value of -4.231 .

These results indicate that the researcher can reject the null hypothesis that there are no significant differences between dually diagnosed and other homeless adults regarding mental health service referrals.

Dually diagnosed adults in this sample were significantly more likely to receive mental health treatment than the No Dual Diagnosis and Unknown status groups. A cross tabulation was completed between the variables Dual Diagnosis and Recoded Mental Health Treatment Receipt. The Chi-square statistic indicated significant differences between observed and expected counts, $X^2(4, N=379) = 31.408, p < .01$. These results are illustrated in Table 7 and indicate that the researcher can reject the null hypothesis that there is no difference in mental health treatment receipt between dually diagnosed and other homeless adults within this sample.

The Dually Diagnosed adults in this sample were more likely to be denied mental health treatment services than their counterparts. The Chi-square statistic indicated significant differences between observed and expected counts $X^2(2, N=379) = 18.128, p < .01$. These results indicate that the researcher can reject the null hypothesis that there is no difference between denial of mental health services between chronically and episodically homeless adults.

Table 7
Chi-square results for Mental Health Treatment Referral, Treatment Receipt and Treatment Denial by Dual Diagnosis^a

	<u>X^2</u>	<u>df</u>	<u>p</u>
Treatment Referral	22.725	2	$p < .01$
Treatment Receipt	31.408	4	$p < .01$
Treatment Denial	18.128	2	$p < .01$

^aFor all analyses, $N=379$

Dual Diagnosis and Substance Use

The next analysis sought to identify group differences between dually diagnosed and other homeless adults with regard to substance use treatment services. There were significant differences between categories of the variable Dual Diagnosis with regard to Substance use treatment referrals. Table 8 demonstrates that the cross tabulation and Chi-square statistic indicated significant differences between observed and expected counts $X^2(4, N=379) = 48.118, p < .01$. An independent samples t-test also indicated significant results between these two variables at $p < .01$. Results from Levene's test indicated $F=45.935$, causing the researcher to reject the null hypothesis that the two population variances were equal. When equally variances were not assumed, results from this analysis remained significant with a two-tailed significance at $p < .01$ and a t value of -5.116 . These results indicate that the researcher can reject the null hypothesis that there are no significant differences between categories of Dual Diagnosis regarding the number of substance use service referrals for each.

As seen in Table 8, there were significant differences between categories of Dual Diagnosis with regard to substance use treatment receipt. The cross tabulation and Chi-square statistic indicated significant differences between observed and expected counts $X^2(4, N=379) = 64.950, p < .01$. These results indicate that the researcher can reject the null hypothesis that there is no difference in substance use treatment receipt between dually diagnosed and other homeless adults in this sample.

Table 8 illustrates that Dually Diagnosed adults within this sample were more frequently denied substance use treatment than their counterparts. The cross tabulation and Chi-square statistic indicated significant differences between observed and expected

counts $X^2(2, N=379) = 13.836, p < .01$. These results indicate that the researcher can reject the null hypothesis that there is no difference between denial of substance use treatment services between dually diagnosed and other homeless adults.

Table 8

Chi-square results for Substance Use Treatment Referral, Treatment Receipt and Treatment Denial by Dual Diagnosis

	X^2	df	p
Treatment Referral	48.118	4	p < .01
Treatment Receipt	64.950	4	p < .01
Treatment Denial	13.836	2	p < .01

^aFor all analyses, n=379

Dual Diagnosis and Medical Care

The next analysis sought to identify group differences between dually diagnosed and other homeless adults with regard to medical care. Multiple analyses (Chi-square and t-test) indicated no significant results between dually diagnosed and other homeless adults in this sample with regard to medical treatment referral, receipt and denial.

Dual Diagnosis and Permanent Housing

The following chi-square and t-test analyses sought to identify group differences between dually diagnosed and other homeless adults with regard to permanent housing. All Chi-square data for Dual Diagnosis and Housing variables are itemized in Table 9. Data regarding housing referrals, receipt and denials were collected based upon the type of housing and, as such, the following analysis includes data specific to each type of housing. The first cross tabulation included the variables Private Housing Referrals and Homelessness Status. The cross tabulation and Chi-square statistic indicated no

significant differences between observed and expected counts $X^2 (2, N=379) = 1.021$, $p < .05$.

Another chi-square analysis sought to identify group differences between dually diagnosed and other homeless adults with regard to supported housing referrals. Dually diagnosed adults in this study were more likely to be referred to supported housing than their episodically and unknown status counterparts. The cross tabulation included the variables Supported Housing Referrals and Dual Diagnosis. Supported Housing Referral was initially coded as a dichotomous categorical variable and did not necessitate recoding for this analysis. The cross tabulation and Chi-square statistic indicated significant differences between observed and expected counts $X^2 (2, N= 379) = 15.232$, $p < .01$.

The final chi-square analysis regarding housing referrals sought to identify group differences between dually diagnosed and other homeless adults with regard to other housing referrals. The dually diagnosed adults were more likely to be referred to other housing than their episodic and unknown status counterparts. The cross tabulation included the variables Recoded Other Housing Referral and Dual diagnosis. The initial variable Other Housing Referral was recoded into a dichotomous categorical variable and renamed Recoded Other Housing Referral. The cross tabulation and Chi-square statistic indicated significant differences between observed and expected counts $X^2 (2, N=379) = 22.919$, $p < .01$.

There were significant differences between Dually Diagnosed and other homeless adults with regard to the number of housing referrals. An independent samples t-test was conducted utilizing the two variable Homelessness Status and Housing Referrals (Number). The t-test indicated significant results between these two variables at $p < .01$.

Results from Levene's test indicated $F=9.542$ causing the researcher to reject the null hypothesis that the two population variances were equal. When equal variances were not assumed, results from this analysis remained significant with a two-tailed significance at $p<.01$ and a t value of -3.022 . These results indicate that the researcher can reject the null hypothesis that there are no significant differences between dually diagnosed and other homeless adults regarding the number of permanent housing referrals for each group.

A cross tabulation was also completed between the variables Dual Diagnosis and Recoded Housing Receipt. To increase the power of this analysis, the variable Housing Receipt was recoded into the aforementioned variable by grouping like responses into broader and meaningful categories. Even after recoding the initial variable into a dichotomous variable, the cross tabulation and Chi-square statistic indicated no significant differences between observed and expected counts $X^2(2, N=379) = .430$, $p<.05$. These results indicate that the researcher must fail to reject the null hypothesis that there is no difference in housing receipt between dually diagnosed and other homeless adults.

Dually diagnosed homeless adults were significantly more likely to be denied housing than their counterparts. To test the null hypothesis that there was no difference between frequency of housing denial between dually diagnosed and other homeless adults, the researcher conducted a cross tabulation between the primary independent variable, Dual Diagnosis and a recoded variable, Recoded Housing Denial. The variable Housing Denial was recoded into the aforementioned variable by grouping like responses into broader and meaningful categories. The cross tabulation and Chi-square statistic did indicate significant differences between observed and expected counts $X^2(4, N=379) =$

11.083, $p < .05$. These results indicate that the researcher can reject the null hypothesis that there is no difference between denial of permanent housing between chronically and episodically homeless adults.

Table 9

Chi-square results for Housing Referral (Private, Supported, Other), Housing Receipt and Housing Denial by Dual Diagnosis^a

	χ^2	df	p
Housing Referral			
Private	1.021	2	$p > .05^b$
Supported	15.232	2	$p < .05$
Other	22.919	2	$p < .01$
Housing Receipt	.430	2	$p > .05^b$
Housing Denial	11.083	4	$p < .05$

^aFor all analyses, $n=379$

^bp value not significant at $p < .05$

Dual Diagnosis and Benefits

The final chi-square and t-test analyses sought to identify group differences between dually diagnosed and other homeless adults with regard to both means tested and entitlement benefits. As indicated in Table 10, there were significant differences between the categories of the independent variable (Dual Diagnosis) with regard to benefit referrals. To complete a cross tabulation in this analysis, the variable Benefit Referrals was recoded into a categorical variable, Recoded Benefit Referral. The cross tabulation and Chi-square statistic indicated significant differences between observed and expected counts $\chi^2(4, N=379) = 13.060, p < .05$. There were not significant differences between the means for each category of the independent variable with regard to benefit referrals. An independent samples t-test indicated no significant results between these two variables at $p < .05$. Results from Levene's test indicated $F=5.730$ causing the researcher

to reject the null hypothesis that the two population variances were equal. When equal variances were not assumed, results from this analysis were also not significant with a two-tailed significance at $p < .05$ and a t value of $-.454$. These results indicate that the researcher must fail to reject the null hypothesis that there are no significant differences between chronically and episodically homeless adults regarding the number of benefit referrals for each group.

A cross tabulation was also completed between the variables Dual Diagnosis and Recoded Benefit Receipt. To increase the power of this analysis, the variable Benefit Receipt was recoded into the aforementioned variable by grouping like responses into broader and meaningful categories. The cross tabulation and Chi-square statistic indicated significant differences between observed and expected counts $X^2 (4, N=379) = 25.770, p < .01$. These results indicate that the researcher can reject the null hypothesis that there is no difference in benefit receipt between dually diagnosed and other homeless adults.

As demonstrated in Table 10, dually diagnosed homeless adults in this sample were more likely to receive benefits than their episodically and unknown status counterparts. To test the null hypothesis that there was no difference between frequency of denial of benefits between dually diagnosed and other homeless adults the researcher conducted a cross tabulation between the primary independent variable, Dual Diagnosis and a recoded variable, Recoded Benefit Denial. The variable Benefit Denial was recoded into the aforementioned variable by grouping like responses into broader and meaningful categories. The cross tabulation and Chi-square statistic did not indicate significant differences between observed and expected counts $X^2 (4, N=379) = 26.838,$

p<.01. These results indicate that the researcher must fail to reject the null hypothesis that there is no difference between denial of benefits between chronically and episodically homeless adults.

Table 10
Chi-square results for Benefit Referral, Benefit Receipt and Benefit Denial by Dual Diagnosis^a

	<u>X²</u>	<u>df</u>	<u>p</u>
Benefit Referral	13.060	4	p<.05
Benefit Receipt	25.770	4	p<.05
Benefit Denial	26.838	4	p<.01

^aFor all analyses, n=379

^bp value not significant at p<.05

Multivariate Analysis

Mental Health Treatment

Because all independent variables were categorical, multinomial logistic regression was conducted to determine which independent variables were most likely to predict the likelihood of receiving mental health treatment. The categorical dependent variable, “Recoded Mental Health Treatment Receipt” was created by recoding the variable Mental Health Treatment Receipt into three categories. The independent variables in this analysis included: Gender, Race, Homelessness Status, Social Supports, Type of Psychiatric Diagnosis and Dual Diagnosis. All variables were categorical and contained no outliers. Results of Model Fitting Tests allow the author to assume overall good model fit (-2 Log Likelihood=326.595; X²=139.00 at p<.01). Pearson’s Chi-square Goodness of Fit test assessed the fit of the model against actual outcomes and also supported the assumption of good model fit (X² (288)= 292.283, p>.05).

Results of the regression indicate that two of the predictor variables, Recoded Social Supports and Type of Psychiatric Diagnosis were statistically significant in distinguishing between categories of the dependent variable. The absence of Social Supports or a documented mental illness significantly predicted receiving no mental health treatment (for Social Supports these results are as follows: $B=1.302$; $SE B=.544$; $Wald=5.721$; $ExpB=3.676$; $p<.05$; for Type of Psychiatric Diagnosis these results are as follows: $B=3.033$; $SE B=.656$; $Wald=21.387$; $Exp B=20.752$; $p<.01$). The absence of social supports was also significant in predicting the likelihood of receiving ER/Inpatient Mental Health Treatment ($B=1.170$; $SE B=.571$; $Wald=4.197$; $p<.05$). Regression coefficients are presented in Tables 11 and 12, respectively.

Table 11

Regression Coefficients for No Known Mental Health Treatments as a function of Social Supports and Mental Health Diagnosis

	<u>B</u>	<u>Wald</u>	<u>df</u>	<u>p</u>	<u>Exp B</u>
Social Supports					
None	1.302	5.721	1	p<.05	3.676
Mental Health Diagnosis					
None	3.033	21.387	1	p<.01	20.752

Table 12

Regression Coefficients for No Psychiatric ER/Inpatient Treatment as a function of Social Supports

	<u>B</u>	<u>Wald</u>	<u>df</u>	<u>p</u>	<u>Exp B</u>
Social Supports					
None	1.170	4.197	1	p<.05	3.221

Mental Health Treatment Denials

The following analysis sought to predict mental health treatment denials as a function of several independent variables. The categorical dependent variable, “Recoded

Mental Health Treatment Denial” was created by recoding the variable Mental Health Treatment Denial into two categories. The independent variables in this analysis included: Gender, Race, Homelessness Status, Social Supports, Type of Psychiatric Diagnosis and Dual Diagnosis. All variables were categorical and contained no outliers. Results of Model Fitting Tests allow the author to assume overall good model fit (-2 Log Likelihood=165.139; $X^2=114.899$ at $p<.01$). Pearson’s Chi-square Goodness of Fit test assessed the fit of the model against actual outcomes and also did not support the assumption of good model fit ($X^2(144)=189.567$, $p<.05$), although the Deviance Goodness of Fit test did support good model fit ($X^2(144)=.930$, $p>.05$). The author chose to proceed with the regression analysis but will consider these results in the discussion.

Results of the regression indicate that three of the predictor variables, Homelessness Status, Recoded Race and Type of Psychiatric Diagnosis were statistically significant in distinguishing between categories of the dependent variable. Identifying as Black/African American significantly predicted the likelihood of being denied mental health treatment ($B=1.1.892$; $SE B=.728$; $Wald=6.749$; $ExpB=6.636$; $p<.01$). Three categories within Type of Psychiatric Diagnosis (No Known Diagnosis, Mood Disorder, Thought Disorder) negatively predicted the likelihood of being denied mental health treatment (the results for each category are as follows: $B=-4.036$, -2.110 , -1.199 ; $SE B=.602$, $.443$, $.490$; $Wald=44.883$, 22.648 , 5.988 ; $Exp B=.018$, $.121$, $.302$; $p<.01$, $.01$, $.05$). Within Homelessness Status, being Episodically Homeless negatively predicted the likelihood of being denied mental health treatment ($B=-1.290$; $SE B=.599$; $Wald=4.648$; $p<.05$). Regression coefficients are presented in Table 13.

Table 13

Regression Coefficients for Mental Health Treatment Denials as a function of Homelessness Chronicity, Race and Mental Health Diagnosis

	<u>B</u>	<u>Wald</u>	<u>df</u>	<u>p</u>	<u>Exp B</u>
Homeless Status					
Episodic	-1.290	4.648	1	p<.05	.275
Race					
Black/AA	1.892	6.749	1	p<.01	6.636
Mental Health Diagnosis					
None Known	-4.036	44.883	1	p<.01	.018
Mood Disorder	-2.110	22.648	1	p<.01	.121
Thought Disorder	-1.199	5.988	1	p<.05	.302

Substance Abuse Treatment

The following multinomial regression sought to determine which independent variables were most likely to predict the likelihood of receiving substance use treatment. The categorical dependent variable, “Recoded Substance Use Treatment Receipt” was created by recoding the variable Substance Use Treatment Receipt into three categories. The independent variables in this analysis included: Gender, Race, Homelessness Status, Social Supports, Type of Psychiatric Diagnosis and Dual Diagnosis. All variables were categorical and contained no outliers. Results of Model Fitting Tests allow the author to assume overall good model fit (-2 Log Likelihood=278.207; $X^2=105.283$ at $p<.01$). Pearson’s Chi-square Goodness of Fit test assessed the fit of the model against actual outcomes and also supported the assumption of good model fit ($X^2 (288)= 227.356$, $p>.05$).

Results of the logistic regression indicate that two of the predictor variables, Dual Diagnosis and Type of Psychiatric Diagnosis were statistically significant in distinguishing between categories of the dependent variable. The presence of a Dual Diagnosis (both substance abuse and mental health) significantly predicted the likelihood

of receiving both inpatient and outpatient substance use treatment (for Outpatient Treatment these results are as follows: $B=6.355$; $SE B=1.765$; $Wald=12.958$; $ExpB=575.277$; $p<.01$; for Inpatient Treatment these results are as follows: $B=3.562$; $SE B=1.155$; $Wald=9.510$; $Exp B=35.240$; $p<.01$). The absence of a mental health diagnosis was also a significant predictor of the likelihood of receiving both Outpatient and Inpatient Substance Use Treatment (for Outpatient Treatment the results are as follows: $B=3.508$; $SE B=1.485$; $Wald=5.583$; $p<.05$; and for Inpatient Treatment, these results are as follows: $B=2.687$; $SE B=1.102$; $Wald: 5.950$; $p<.05$). Regression coefficients are presented in Tables 14 and 15, respectively.

Table 14

Regression Coefficients for Outpatient Substance Use Treatments as a function of Dual Diagnosis and Mental Health Diagnosis

	<u>B</u>	<u>Wald</u>	<u>df</u>	<u>p</u>	<u>Exp B</u>
Dual Diagnosis					
Dual Diagnosis	6.355	12.958	1	$p<.01$	575.277
Mental Health Diagnosis					
None Known	3.508	5.583	1	$p<.05$	33.395

Table 15

Regression Coefficients for Inpatient Substance Use Treatments as a function of Dual Diagnosis and Mental Health Diagnosis

	<u>B</u>	<u>Wald</u>	<u>df</u>	<u>p</u>	<u>Exp B</u>
Dual Diagnosis					
Dual Diagnosis	3.562	9.510	1	$p<.01$	35.240
Mental Health Diagnosis					
None Known	2.687	5.950	1	$p<.05$	14.692

Housing Receipt

Results of the multinomial logistic regression indicate that three of the predictor variables, Homeless Status, Dual Diagnosis and Mental Health Diagnosis were statistically significant in distinguishing between categories of the dependent variable. The absence of a Dual Diagnosis (both substance abuse and mental health) significantly predicted the likelihood of receiving housing ($B=1.843$; $SE B=.891$; $Wald=4.276$; $ExpB=6.316$; $p<.05$). Identifying as episodically homeless or possessing a Mood Disorder negatively predicted the likelihood of receiving permanent housing (for Homelessness Status the results are as follows: $B=-1.690$; $SE B=.613$; $Wald=7.602$; $p<.01$; and for Mental Health Diagnosis, these results are as follows: $B=-1.460$; $SE B=.728$; $Wald: 4.023$; $p<.05$). Regression coefficients are presented in Table 17A.

Table 16

Regression Coefficients for Housing Receipt as a function of Homelessness Status, Dual Diagnosis and Mental Health Diagnosis

	<u>B</u>	<u>Wald</u>	<u>df</u>	<u>p</u>	<u>Exp B</u>
Homelessness Status					
Episodic	-1.690	7.602	1	p<.01	.184
Dual Diagnosis					
None Known	1.843	.891	1	p<.05	6.316
Mental Health Diagnosis					
Mood Disorder	-1.460	4.023	1	p<.05	.232

Housing Denials

The following analysis sought to determine the likelihood of predicting housing denials as a function of several independent variables. The categorical dependent variable, “Recoded Housing Denial” was created by recoding the variable Housing Denial into three categories. The independent variables in this analysis included: Gender, Race, Homelessness Status, Social Supports, Type of Psychiatric Diagnosis and Dual

Diagnosis. All variables were categorical and contained no outliers. Results of Model Fitting Tests allow the author to assume overall good model fit (-2 Log Likelihood=387.818; $X^2=58.267$ at $p<.01$). Pearson's Chi-square Goodness of Fit test assessed the fit of the model against actual outcomes and did support the assumption of good model fit ($X^2(288)=269.562$, $p>.05$).

Results of the logistic regression indicate that two of the predictor variables, Recoded Social Supports and Type of Psychiatric Diagnosis were statistically significant in distinguishing between categories of the dependent variable. The lack of any social supports negatively predicted the likelihood of being denied housing due to wait lists or incomplete application ($B=-1.029$; $SE B=.456$; $Wald=5.082$; $Exp B=.357$; $p<.05$). The lack of a mental health diagnosis also negatively predicted the likelihood of being denied housing due to wait lists or incomplete application ($B=-1.485$; $SE B=.499$; $Wald=8.853$; $Exp B=.227$; $p<.01$). Both categories of these variables also negatively predicted Housing Denial as a result of Ineligibility/Noncompliance (for No Social Supports: $B=-.736$; $SE B=.328$; $Wald=5.055$; $Exp B=.479$; $p<.05$ and for No Mental Health Diagnosis: $B=-1.440$; $SE B=.385$; $Wald=14.012$; $Exp B=.237$; $p<.01$). Regression coefficients are presented in Tables 17 and 18, respectively.

Table 17
Regression Coefficients for Recoded Housing Denial (Incomplete or Pending Application/Waiting List) as a function of Recoded Social Support and Mental Health Diagnosis

	<u>B</u>	<u>Wald</u>	<u>df</u>	<u>p</u>	<u>Exp B</u>
Social Support					
None	-1.029	5.082	1	$p<.05$.357
Mental Health Diagnosis					
None	-1.485	8.853	1	$p<.01$.227

Table 18

Regression Coefficients for Recoded Housing Denial (Ineligible/ Noncompliance) a function of Recoded Social Support and Mental Health Diagnosis

	<i>B</i>	Wald	df	p	Exp <i>B</i>
Social Support					
None	-.736	5.055	1	p<.05	.479
Mental Health Diagnosis					
None	-1.440	14.012	1	p<.01	.237

Benefit Receipt

The following multinomial logistic regression was conducted to determine which independent variables were most likely to predict the likelihood of receiving means tested or entitlement benefits. The categorical dependent variable, “Recoded Benefit Receipt” was created by recoding the variable Benefit Receipt into three categories. The independent variables in this analysis included: Gender, Race, Homelessness Status, Social Supports, Type of Psychiatric Diagnosis and Dual Diagnosis. All variables were categorical and contained no outliers. Results of Model Fitting Tests allow the author to assume overall good model fit (-2 Log Likelihood=422.254; $X^2=83.247$ at $p<.01$). Pearson’s Chi-square Goodness of Fit test assessed the fit of the model against actual outcomes and also supported the assumption of good model fit ($X^2(288)=303.072$, $p>.05$).

Results of the regression indicate that three of the predictor variables, Homelessness Status, Recoded Race and Type of Psychiatric Diagnosis were statistically significant in distinguishing between categories of the dependent variable. Identifying as Black/African American significantly predicted receiving means tested (Public

Assistance) benefits ($B=1.252$; $SE B=.538$; $Wald=5.421$; $ExpB=3.496$; $p<.05$). The absence of a psychiatric diagnosis was also significant in negatively predicting the likelihood of receiving means tested benefits ($B=-.952$; $SE B=.415$; $Wald=5.262$; $p<.05$). With regard to receipt of both Means Tested and Entitlement Benefits, Homelessness Status significantly predicted the likelihood of receiving these benefits ($B=1.133$; $SE B=.550$; $Wald=4.241$; $p<.05$). Identifying as either White or Black/African American also predicted the likelihood of receiving both means tested and entitlement benefits (White: $B=2.040$; $SE B=.773$; $Wald=6.961$; $p<.01$; Black/African American: $B=2.071$; $SE B=.787$; $Wald=6.919$; $p<.01$). Having no known mental health diagnoses or a thought disorder also significantly predicted categories of the dependent variable (no diagnosis, negative prediction: $B=-.800$; $SE B=.398$; $Wald=4.043$; $p<.05$; thought disorder: $B=1.065$; $SE B=.528$; $Wald=4.064$; $p<.05$). Regression coefficients are presented in Tables 19 and 20, respectively.

Table 19
Regression Coefficients for ‘Public Assistance/Means Tested Only’ as a function of Race and Mental Health Diagnosis

	<u>B</u>	<u>Wald</u>	<u>df</u>	<u>p</u>	<u>Exp B</u>
Race					
Black/AA	1.252	5.421	1	p<.05	3.496
Mental Health Diagnosis					
None	-.952	5.262	1	p<.05	.386

Table 20

Regression Coefficients for Means Tested and Entitlement as a function of Homelessness Status, Race and Mental Health Diagnosis

	<i>B</i>	Wald	df	p	Exp <i>B</i>
Homelessness Status					
Chronic	1.133	4.241	1	p<.05	3.106
Race					
White	2.040	6.961	1	p<.01	7.689
Black	2.071	6.919	1	p<.01	7.932
Mental Health Diagnosis					
None	-.800	4.043	1	p<.05	.449
Thought Disorder	1.065	4.064	1	p<.05	2.901

Benefit Denial

The final multinomial logistic regression was conducted to determine which independent variables were most likely to predict the likelihood of denied benefits. The categorical dependent variable, “Recoded Benefit Denial” was created by recoding the variable Benefit Receipt into three categories. The independent variables in this analysis included: Gender, Race, Homelessness Status, Social Supports, Type of Psychiatric Diagnosis and Dual Diagnosis. All variables were categorical and contained no outliers. Results of Model Fitting Tests allow the author to assume overall good model fit (-2 Log Likelihood=389.227; $X^2=57.205$ at $p<.01$). Pearson’s Chi-square Goodness of Fit test assessed the fit of the model against actual outcomes and also supported the assumption of good model fit ($X^2(288)=289.494$, $p>.05$).

Results of the regression indicate that two of the predictor variables, Recoded Social Supports and Recoded Race, were statistically significant in distinguishing between categories of the dependent variable. Having no social supports negatively predicted being denied benefits as a result of Ineligibility/Noncompliance ($B=-1.165$; SE $B=.485$; Wald=5.766; Exp $B=.312$; $p<.05$). The absence or presence of a dual diagnosis

was also significant in predicting the likelihood of having a pending application for benefits (No Dual Diagnosis $B=1.951$; $SE\ B=.551$; $Wald=12.537$; $p<.01$; Dual Diagnosis: $B=1.407$; $SE\ B=.623$; $Wald=5.101$; $p<.05$). Only Unknown Status with regard to Dual Diagnosis was not predictive of the likelihood of having at least one pending benefits application. Lacking social supports was also negatively predictive of a pending application for benefits ($B=-.863$; $SE\ B=.315$; $Wald=7.516$; $p<.01$). Regression coefficients are presented in Table 21 and 22, respectively.

Table 21

Regression Coefficients for ‘Ineligible/Noncompliance’ Benefit Denial as a function of Social Supports

	<u><i>B</i></u>	<u>Wald</u>	<u>df</u>	<u>p</u>	<u>Exp <i>B</i></u>
Social Supports					
None	-1.165	5.766	1	p<.05	.312

Table 22

Regression Coefficients for ‘Pending Application’ Denial as a function of Dual Diagnosis and Social Supports

	<u><i>B</i></u>	<u>Wald</u>	<u>df</u>	<u>p</u>	<u>Exp <i>B</i></u>
Dual Diagnosis					
None	1.951	12.537	1	p<.01	7.035
Dual Diagnosis	1.407	5.101	1	p<.05	4.083
Social Support					
None	-.863	7.516	1	p<.01	.422

The researcher attempted to conduct a multinomial logistic regression using the variable “Recoded Medical Treatment Receipt” and the following categorical independent variables: Gender, Race, Homelessness Status, Social Supports, Type of Psychiatric Diagnosis and Dual Diagnosis. Results of Model Fitting Tests caused the researcher to fail to reject the null hypothesis ($-2\ \text{Log Likelihood}=416.370$; $X^2=19.313$ at

$p > .05$). In addition to a demonstrating a poor model fit, no ensuing calculations produced significant results at $p < .05$.

The researcher attempted to conduct a multinomial logistic regression using the variable “Recoded Medical Treatment Denial” and the following categorical independent variables: Gender, Race, Homelessness Status, Social Supports, Type of Psychiatric Diagnosis and Dual Diagnosis. Results of Model Fitting Tests caused the researcher to fail to reject the null hypothesis ($-2 \text{ Log Likelihood} = 86.680$; $X^2 = 12.639$ at $p > .05$). In addition to a demonstrating a poor model fit, no ensuing calculations produced significant results at $p < .05$.

Chapter Five

Discussion

Summary of Results

Univariate Analyses

Table 1 provides the reader with an overview of some of the key characteristics of the study sample. These results are also notable because they provide with a rare glimpse into the demographics of suburban homelessness. As previously referenced, very few samples of suburban homeless adults currently exist and snapshots of this population are even more rare. Annual point in time homeless counts, the primary mechanism currently used by the federal government to quantify homelessness, fail to capture specific client level data beyond homelessness status. Although no mechanism currently exists by which to collect a random sample of homeless people, the data utilized in this study represents a large portion of the homeless people that accessed emergency housing in this community during the time period under study.

The reader should note several key areas where this sample both reflects, and varies from, other samples of homeless adults. These similarities and differences are significant insofar as their ability to provide information about an underserved population and to suggest future areas of research. In 2004, the Suffolk County Department of Social Services commissioned the Stony Brook School of Social Welfare to complete a study to describe the demographic characteristics of 75 homeless adults living in emergency housing in Suffolk County between December and January, 2003-2004. It is notable that the study conducted in 2004 was designed to inform the Department of Social Services about the specific needs of the homeless adult population in Suffolk

County so that they could develop “shelter programs for homeless individuals based upon the specific needs of these individuals” (Suffolk County Department of Social Services, p. 8). The data utilized in this document was collected from case records at the largest of these facilities developed after the 2004 report and consists of information from over five times as many homeless adults from the same community.

Given the longer time period under study, the larger sample size and variations from the data collection methods used in 2004, the demographic information obtained in this document provides additional insights into the homeless population under study. Specifically, Table 1 indicates several differences from other data sources regarding homeless adults. These differences include the large number of female chronically homeless adults as compared to other samples of chronically homeless people. This sample is almost evenly split with regard to gender. The data also reflect a larger proportion of chronically homeless adults, both male and female, than is generally available within samples of homeless adults. This data was collected over a two year period and, as such, these results may speak to the ability to establish trust, elicit information and provide support to this population utilizing an incremental approach to service provision. Unlike point in time counts of homeless people and intensive intake procedures evident in many service programs, the drop-in center model allowed for incremental engagement that, while generally accepted as most effective with this population, is not commonly implemented.

Bivariate Analysis

Also notable within the sample under study is the lack of large differences between income, social supports, age and specific psychiatric and substance use diagnoses as a function of chronic homelessness for the adults in this sample. These results suggest several things. Specifically, the presence or absence of these variables do not appear to be protective factors against experiencing chronic homelessness within this sample. In fact, chronically homeless adults within this sample reported higher incomes and fewer substance abuse diagnoses than their episodically homeless counterparts.

These results speak to the lack of a definitive line between chronically and episodically homeless adults with regard to individual characteristics within this sample. These demographics provide the reader with insight into an extremely difficult to sample population with regard to homelessness status. These data lend themselves to the possibility that chronic homelessness may be more indicative of larger systemic problems and an individual's ability to navigate human service systems (and these systems' inability to serve clients with multiple services needs) than of the presence or absence of a specific set of characteristics.

Bivariate analysis of group differences between categories of the independent variable Homelessness Status found significant differences in several areas. Regarding Mental Health Services, Chronically homeless adults in this study were significantly more likely than their Episodically and Unknown status counterparts to be referred, receive and be denied Mental Health Treatment. These data support the existing literature regarding the presence of mental health disorders among chronically homeless adults but varies insofar as the frequency of service referrals and receipt. These results

are notable with regard to our understanding of chronically homeless adults' desire to seek treatment and the ability of suburban human service systems to absorb these clients.

These results provide insight into the mental health needs, specifically regarding their willingness to seek treatment, of chronically homeless adults. Notably, the data contradicts the generally held belief that chronically homeless people are unwilling to seek treatment. As indicated in the results, the chronically homeless people in this sample were significantly more likely to have one of three types of contact with mental health services (referral, service receipt or denial) and this contact speaks to their desire to receive these services. This willingness of chronically homeless adults to participate in mental health treatment (as evidenced by their willingness to at the very least complete an application for these services voluntarily) is encouraging. Unfortunately, the higher rate of denial also speaks to the inability of these programs to absorb chronically homeless adults. Future research should seek to clarify the nature of the barriers to service as it is likely that these barriers include eligibility criteria, stringent behavioral requirements, extensive waiting lists and difficulties engaging this marginalized population. It is currently unclear the extent to which these barriers are replicated in this suburban community.

The frequency of receipt of mental health services is also inconsistent with literature regarding mental health treatment usage among this population (Gelberg, Andersen & Leake, 2000). These results may be explained by several factors. The recoded variable Recoded Mental Health Treatment Receipt resulted in the loss of some detail regarding the type of mental health treatment received by individual cases. As a result of power issues, type of treatment was recoded into broader categories: inpatient,

outpatient and none. The sample size limited the analysis of the more specific categories and therefore cannot provide results regarding individual treatment modalities. The data indicates that chronically homeless adults were significantly more likely to receive inpatient/intensive treatment, but does not indicate the nature of this treatment.

Chronically homeless adults tend to utilize a disproportionate amount of emergency services and the use of inpatient services in this study may support this data. It remains unclear if more effective system integration would reduce the reliance on emergency service use by homeless people by increasing access and ensuring continuity of care. Given the willingness of many of the homeless people in this study to participate in treatment, future research should focus on the effectiveness of early intervention and other preventive measures on reducing overreliance on emergency service use within other samples of homeless people.

Chronically homeless adults in this sample were more likely than their episodically homeless counterparts to be denied mental health treatment services. The results indicate significant differences in denial of mental health treatment services between Chronically and otherwise homeless adults. The presence of significant differences between categories of Homelessness Status is consistent with research indicating difficulties accessing and maintaining mental health treatment services for chronically homeless adults. These results support previous literature regarding patterns of treatment denials among chronically homeless adults and they also expand the discussion to this suburban sample. As previously referenced, random sampling among homeless populations is not currently possible, yet this data represent a large majority of the homeless adults that entered emergency housing in this suburban community during

the time period under study. As such, this sample is likely representative of other homeless adults in this community and difficulties regarding accessing services within this sample may help to inform future research regarding similar communities and populations. For the purpose of this study, the reader should note the extent to which the results mirror difficulties experienced by other samples of chronically homeless adults.

These results support previous research regarding treatment denials but cannot contribute to the discussion regarding reasons for these denials. As with receipt of mental health services, the variable “Mental Health Treatment Denial” was recoded into another variable “Recoded Mental Health Treatment Denial” as a result of the small sample size and resulting power issues. The recoding process resulted in a loss of detail regarding the reason for denial and only indicated whether or not a respondent was denied mental health treatment services. Future research should focus on the reasons for mental health treatment denials among chronically homeless samples. Additional detail regarding denial causation will provide the practitioner, program administrator and policy maker with the data necessary to develop initiatives to address these barriers. As previously referenced, data about human service use among chronically homeless adults is often based on incomplete information and limited samples of homeless people and fails to consider the larger, systemic barriers to service use for this, and other, marginalized populations.

Chronically homeless adults were more likely to be referred to substance abuse treatment services than their episodically homeless counterparts. The data indicated the presence of significant differences in the numbers of substance use treatment referrals between Chronic and otherwise homeless adults. There were not, however, significant

differences between the type of substance use referrals based upon Homelessness Status. These data support existing research regarding the presence of substance use disorders among chronically homeless adults and expands this knowledge base to a suburban sample. Given the sample size, the data could not provide specific information regarding the nature of substance use referrals. The lack of specificity regarding the type of substance use referrals limits the understanding of the type of treatment referrals that is most effective with this population. Future research will benefit from expanding upon this knowledge base by examining potential differences between access to treatment within various types of treatment modalities.

The willingness of homeless people within this sample to seek substance abuse treatment mirrors the pattern seen previously regarding mental health treatment. Although it was beyond the scope of this research, these results suggest that the assumption that homeless people are resistant to seeking treatment for individual problems are not completely accurate nor do they fully explain the persistence of homelessness. Instead, these results suggest a willingness on the part of the homeless people within this sample to seek treatment and that their inability to integrate into treatment systems may, at least in part, be attributable to factors larger than individual problems or limitations. Future research should focus on categorical human service systems as a potential barrier to treatment for this population.

Homelessness status did not prove to be a determining factor in accessing substance abuse treatment services. The data indicated no significant differences between Chronic and otherwise homeless respondents with regard to substance use treatment receipt. These data are noteworthy given the significant differences in numbers

of referrals for treatment between these two groups. Despite the widely held understanding of substance abuse issues as a primary presenting problem among chronically homeless adults, these data demonstrate no increase in substance use treatment among this suburban sample of chronically homeless adults. These results initially support the argument that chronically homeless people are resistant or altogether unwilling to participate in treatment. Further discussion indicates that, for chronically homeless people, participation in substance abuse treatment is far more complex than their willingness to receive help.

The data also indicated that chronically homeless people in this study were more likely to be denied substance use treatment than their Episodic and Unknown status counterparts. The increased frequency of treatment denials is consistent with current literature regarding treatment barriers for chronically homeless people. As previously referenced, the lack of substance use treatment within chronically homeless adults in this sample seems to speak to increased rates of denial, not individual resistance to treatment. Because the sample size required that the original variable be recoded into a dichotomous variable, this process resulted in the loss of some specificity regarding the reason for treatment denial. Future research should examine differences in reasons for treatment denials between chronic and otherwise homeless adults. Similar to the results demonstrated for Mental Health Treatment Denials, these results regarding substance use treatment denials cannot contribute to an increased understanding of the reasons for these denials.

Homelessness status did not prove to be a determining factor in being referred, receiving or being denied medical services. The data indicated no significant differences

in the numbers of medical treatment referrals between Chronic and otherwise homeless adults. There also were not significant differences between the type of medical referral based upon Homelessness Status. These data support existing research regarding the presence of medical needs among chronically homeless adults and expands this knowledge base to a suburban sample. The recoded dependent variable, Recoded Medical Treatment Referrals, resulted in the ensuing loss of some detail regarding the type of medical referral, yet the results support existing literature regarding medical needs among the chronically homeless population.

The data indicated no significant differences between chronic and otherwise homeless adults with regard to medical treatment receipt. The results do not support the existing literature regarding the extensive use of medical, emergency and other medical services among chronically homeless adults. Notably, almost two-thirds of the entire sample utilized no medical care during the time period under study. Reasons for this limited use of medical care among this suburban sample may include inaccurate self-reports, unverifiable data by case workers, lack of access to resources necessary to secure medical treatment (health insurance, transportation) or an unwillingness to secure treatment. In addition, there were also no significant differences in medical treatment denials between chronically and otherwise homeless adults. While the reasons for this lack of significance may mirror those listed above, the reader should also note that there were only 19 reported cases of medical treatment denials within the entire sample. Future research should examine this lack of medical treatment denial among a suburban homeless sample to determine if this pattern is evident in other samples.

The reader should note that the results regarding medical treatment may not be easily generalized to another homeless population for several reasons. In particular, the program under examination is located next door to a full service medical clinic. Further, during the time period under study, this Drop-In Center had a Memorandum of Understanding with this Clinic regarding client service access. Clients were regularly referred to the clinic by program staff and these clients were often able to receive same day treatment, regardless of health insurance status. While these results cannot be easily generalized, it seems likely that this relationship between Drop-In Center and clinic staff had a positive impact on client access to medical treatment. Further, this example of coordinated services speaks to the potential efficacy of systems integration. The importance of systems integration will be discussed later.

Multiple analyses sought to examine differences in group means between chronically and otherwise homeless categories of the independent variable with respect to a variety of housing referrals. There were no significant differences between categories of Recoded Private Housing Referrals. This lack of difference between categories of Homeless Status may be indicative of the lack of affordable housing available to homeless people in general. There were significant differences for both Supported Housing Referrals and Other Housing referrals with respect to Homelessness Status. In both analyses, Chronically Homeless adults were more likely to be referred to these housing resources than both additional categories of the independent variable. In addition, there were significant differences between the numbers of housing referrals for chronic, episodic and unknown status respondents. Chronically homeless adults were far more likely to be referred to a variety of housing types than their non-chronic

counterparts. The increased frequency of referral breaks from the generally held belief that chronically homeless people are unwilling to apply or are eligible for fewer housing options. These data may reflect longer lengths of stay at the Drop-In Center, and increased knowledge of these clients and their service needs, thereby allowing staff additional time to make a variety of service referrals, but they may also indicate that a population which is frequently denied access to services is eager to receive them. The reader should note the prevalence of client referrals within each of the service categories discussed so far.

The data indicated only 39 instances of housing receipt for the entire sample during the time period under study. Analysis did not indicate differences between chronically and otherwise homeless adults on this variable. The limited number of instances of housing receipt is notable and merits future study. In addition, chronically homeless adults were denied housing significantly more than their Episodic or Unknown Status counterparts. In particular, chronically homeless adults in this sample were significantly more likely to be denied housing for “Ineligibility/Noncompliance” than Episodic and Unknown Status respondents. These results support other studies of chronically homeless people with regard to their difficulty complying or submitting to the demands of traditional supported housing programs. Given the lack of any programs utilizing a Housing First model in the county within which this study took place, it is possible that adults in this study did not meet housing requirements within the variety of programs to which they were referred. For example, supported housing programs in Suffolk County require specific time periods of sobriety, documented histories of consistent mental health treatment receipt and medical clearance. Because the

chronically homeless adults in this study have not met these standards in the past, it is unlikely that many of these individuals will successfully navigate the complicated systems required to secure these preconditions.

Homelessness status did not prove to be a determining factor in being referred, receiving or being denied benefits. The data did not indicate significant differences between categories of the independent variable with regard to Benefit Referrals. There also were not significant differences between categories with respect to the number of benefit referrals. Surprisingly, chronically homeless adults in this study were more likely to be in receipt of benefits than their counterparts. Further, there were not significant differences between categories of Homeless Status with regard to Benefit Denials. This data does not support the literature that indicates frequent dislocation from a variety of means tested and entitlement benefits among chronically homeless adults. These results, while initially encouraging, seem to indicate that even the presence of income supports cannot preclude the persistence of chronic homelessness in this suburban sample. The data seem to indicate that there are a variety of factors, inclusive of income and social supports, categorical human service systems, scarce affordable or supportive housing resources and demographic characteristics that prohibit chronically homeless adults from accessing these supports.

The presence of a dual diagnosis was also indicative of differences in human service utilization among the study sample. To demonstrate these differences, multiple bivariate analyses of group differences between categories of the independent variable Dual Diagnosis were completed. The data indicated significant differences in several areas. Regarding Mental Health Services, Dually Diagnosed adults in this study were

significantly more likely than their counterparts without a dual diagnosis to be referred, receive and be denied Mental Health Treatment. These data support the existing literature regarding difficulties associated with treating homeless people with dual diagnoses.

Dually diagnosed adults in this study were more likely to have some contact with substance abuse treatment systems than their counterparts that did not possess a dual diagnosis. The data indicated the presence of significant differences in the numbers of substance use treatment referrals between dually diagnosed and other homeless adults (those without known mental health and substance use diagnoses). Dually diagnosed adults in this study were significantly more likely than other adults to be referred, receive and be denied treatment for a substance use disorder. Similar to the results regarding mental health treatment referrals, the large numbers of receipt and denial of services may be reflective of the number of referrals for dually diagnosed adults rather than an increased ability to access substance use treatment. This possibility is supported by the fact that dually diagnosed adults were more likely to be denied these services than their non-dually diagnosed counterparts.

The data indicated no significant differences in the numbers of medical treatment referrals between dually diagnosed and other homeless adults. Similar to the results regarding Homelessness Status and Medical Treatment, it is possible that these results reflect the relationship between the Drop-In Center and the medical clinic located adjacent to the program. The lack of significance between categories of Dual Diagnosis speaks to the effectiveness of coordination between human service systems. In this instance, coordination occurred between homeless services and medical care. As

previously discussed, the coordination between the Drop-In Center and a clinic within walking distance from the center is very likely a factor that contributed to this effectiveness.

Multiple analyses sought to examine differences in group means between dually diagnosed and other categories of the independent variable with respect to a variety of housing referrals. There were no significant differences between categories for Recoded Private Housing Referrals. There were significant differences for both Supported Housing Referrals and Other Housing referrals with respect to Dual Diagnosis. In both analyses, Dually Diagnosed homeless adults were more likely to be referred to these housing resources than both additional categories of the independent variable. The data indicated no significant differences between categories of Dual Diagnosis with regard to Housing Receipt.

Dually diagnosed adults in this sample were denied housing more frequently than their counterparts without dual diagnoses. Dually diagnosed homeless adults were denied housing significantly more than their No Dual Diagnosis or Status Unknown counterparts. In particular, dually diagnosed homeless adults in this sample were significantly more likely to be denied housing for “Ineligibility/Noncompliance” than those without a known dual diagnosis. These results mirror those seen in the Homelessness Status and permanent housing analyses. Similar to the data regarding Homelessness Status and permanent housing, these results may be indicative of the lack of coordinated service provision or a Housing First model in the county under study. It is likely that adults in this study did not meet housing requirements within the variety of programs that they were referred to or that they were unable to obtain the documentation

that is required by supported housing providers as a result of their limited access to other service providers. It is also likely that the presence of a dual diagnosis created additional barriers to acceptance to housing programs designed for clients living with specific diagnoses (such as mental illness or substance abuse) but not both disorders. As previously discussed, supported housing programs in Suffolk County require specific time periods of sobriety, documented histories of consistent mental health and/or substance abuse treatment receipt and medical clearance. These requirements act as gatekeepers by keeping applicants with the most inconsistent histories of service receipt out of these programs. Chronically homeless people, those with the most severe housing need, are the most likely victims of this gatekeeping.

The data indicated significant differences between categories of the independent variable with regard to Benefit Referrals. Dually diagnosed clients were significantly more likely to be referred for both Means Tested and Entitlement Benefits than their counterparts. There were not significant differences between categories with respect to the number (t-test) of benefit referrals. Dually diagnosed adults in this study were also significantly more likely to be in receipt of Means tested benefits than their counterparts. There were significant differences between categories of Dual Diagnosis with regard to Benefit Denials. In particular, cases with No Dual Diagnosis were significantly more likely to have No Known Denials. Similar to the results evidenced in the Homelessness Status analyses, these results indicate that adults in this sample that possess a dual diagnosis are more frequently in receipt of means tested benefits, indicating the presence of at least some form of income support. As was seen in the Homelessness status

analyses, the presence of income supports does not act as a protective factor against the experience of homelessness.

The reader should note the prevalence of referrals for service within each of the service categories discussed regarding bivariate analyses. These results are inconsistent with much of the research regarding homelessness yet they are also encouraging regarding the willingness of homeless adults, chronic or otherwise, to participate in human service assistance. As evidenced in the research, homeless people are frequently marginalized from the very services that are most likely to assist them. Despite this marginalization, the previously discussed results speak to the ability of human service providers to modify their practice and to work within systemic constraints to increase access to necessary supports for this population. Access to supports may only be a partial answer to the categorical human service systems that currently characterize American social welfare, but it is a first step to creating a more inclusive system.

Multivariate Analyses

As indicated in the Results section of this document, the researcher conducted numerous multivariate analyses to determine if there were demographic characteristics in addition to Homelessness Status that could predict the likelihood of human service receipt and denial. As the bivariate analysis discussion indicated, human service usage among homeless people cannot be simplified into categories of homelessness status and there are a variety of factors that contribute to homeless people's access to these services. The multivariate analyses discussed here provide additional clarity regarding these factors. A discussion of these findings follows.

With regard to receipt of mental health treatment, Homelessness Status was not significant predictor of the likelihood of receiving Mental Health Treatment. The presence of No Social Supports significantly predicted two categories of the dependent variable: No Mental Health Treatment Receipt and ER/Inpatient Treatment. These results provide clarity regarding the importance of social supports to integrating individuals with multiple presenting problems into the mental health service system. Of particular importance is the fact that Human Service Professionals were included as an original category of social support. The initial social support variable was recoded into “Recoded Social Support” and, as a result, some specificity was lost with regard to the type of social supports available to the adults in this sample. Future research will benefit from increased specificity to determine if the type of social support has an impact on the receipt of mental health treatment. Further, it is generally believed that homeless people are frequent users of emergency services. Given these results, it seems that the presence of social supports may reduce emergency service usage and should therefore be studied further.

With regard to Mental Health Treatment Denials, several categories of two variables (Homelessness Status and Mental Health Diagnosis Type) negatively predicted the likelihood of being denied mental health treatment. The only variable that demonstrated a positive and significant prediction of the likelihood of being denied mental health treatment was Race. Specifically, identifying as Black/African American significantly predicted the likelihood of being denied mental health treatment. These results support research that indicates differential treatment services for non-dominant or otherwise underserved groups (Page and Blau, 2006). These results demonstrate the

importance of a continued emphasis on culturally competent practice within mental health treatment programs.

Two variables, Dual Diagnosis and Mental Health Diagnosis, were significant predictors of the likelihood of receiving two categories of the dependent variable, Outpatient Substance Use Treatment and Inpatient Substance Use Treatment. The presence of a Dual Diagnosis and the absence of a Mental Health Diagnosis (exclusively) significantly predicted both categories of the dependent variable. Giving specific attention to the presence of a Dual Diagnosis indicates the possibility that Substance Use treatment facilities in this sample seem to be capable or willing to incorporate the Dually Diagnosed client into their client base. This preliminary data may indicate progress toward system integration and an acknowledgement of the importance of integrating the unique treatment needs of the dually diagnosed client into at least one human service system. Future research will benefit from increased specificity to examine the impact of the type of substance use treatment receipt with regard to dual diagnosis.

The absence of a dual diagnosis (within the variable Dual Diagnosis) was the only variable that significantly predicted Housing Receipt. These results seem to support the previous assertions that categorical systems limit access to services for clients that present multiple problems, in this instance, clients that possess a dual diagnosis and need both substance use and mental health treatment. No variable in this study demonstrated a positive and significant ability to predict the denial of housing. Notably, the lack of social supports and absence of a mental health diagnosis negatively predicted this denial. Because these variables did not also predict the likelihood of receiving permanent housing, it seems likely that these results are indicative of reduced numbers of referrals

and the ensuing absence of denial for housing resources. The lack of affordable housing and the limited supply of supported housing units, particularly for clients with multiple needs such as dual diagnoses, may contribute to the limited number of referrals made for adults within this sample and, therefore, indirectly influencing denials resulting from these initial referrals.

Several variables predicted the likelihood of receiving some form of benefits or income supports. In particular, identifying as Black/African American significantly predicted the likelihood of receiving Means Tested (Public Assistance) benefits. Identifying as White or African American, Chronically Homeless or having a Thought Disorder significantly predicted the likelihood of receiving both Means Tested and Entitlement Benefits. These results demonstrate that even the presence of more than one income support does not prohibit the occurrence of homelessness, as is indicated elsewhere in this document. These results further indicate the importance of Race as a predictive factor regarding access to a variety of human service systems.

With regard to Benefit denials, both the presence and absence of a dual diagnosis (as compared to Unknown Status) were significantly predictive of having a Pending Application for benefits. These results are vague for several reasons. It is likely that program staff were simply more aware of the status of benefits for clients with a definitive presence or absence of a dual diagnosis. Those clients that were unwilling, unable or not at the facility long enough to meet with staff may also not have shared benefit status with program staff. These clients were categorized as “Unknown” and were the least likely to have a pending application for any form of benefits. For these reasons, the results do not provide sufficient clarity regarding factors that may predict the

likelihood of being denied any form of income support. Future research will need to expand upon these results.

Implications of Findings

Practice

This research represents a preliminary step toward quantifying the experience of homeless people in a suburban community with regard to human service referrals, receipt and denial. The experience of the adults in this sample may provide clarity regarding the extent, or lack thereof, of coordination and integration between human service systems within this suburban community. It is clear that differences exist with regard to service referral, receipt and denial within and between the human service systems examined in this study. It is notable that information regarding service referrals demonstrated no significant differences between service systems as a function of Homelessness Status. The literature regarding Chronic and Episodic homelessness indicates that chronically homeless adults are frequently difficult to reach, noncompliant or unwilling to accept professional intervention. Because the majority of human service referrals evident within this study were voluntary and involved the individual's participation, these results break from much of the research regarding an individual deficit model of chronic homelessness.

Research indicates "that one in ten poor people experience at least one night of homelessness in the course of a year" and that "such a high rate of homelessness definitely speaks to structural problems. Homelessness is not going to be solved without addressing those structural problems" (Burt, 2008). Structural barriers certainly limit the ability of many homeless people to escape homelessness yet this does not preclude the

ability of individual service providers to modify their practice to better address the needs of this population.

Physical and mental illnesses are implicated as both causes and consequences of homelessness for many individuals. While the shortage of safe, decent, affordable housing is the most fundamental cause of homelessness, untreated physical and/or mental health problems create vulnerabilities that can lead to loss of income and home (McMurray-Avila, Gelberg & Breakey, p. 2).

Some populations of homeless people, as discussed throughout this document, remain homeless for prolonged periods of time. These prolonged periods of homelessness speak – at least in part - to the current failure of our human service systems to see chronic homelessness as a structural, and not interpersonal, problem. Social workers can increase access to supports for homeless people by participating in efforts at both individual practice and program levels as well as by working for systemic policy change.

Efforts to meet the service needs of homeless people at the level of the individual practitioner or agency can occur in several ways. Specifically,

Homeless people face numerous barriers to access which can be overcome by adaptations to the structure of the delivery system, including extensive outreach, mobile sites and flexibility in policies and procedures. The nature of the homeless condition also calls for special adaptations to clinical practice in the areas of intake and assessment, clinical preventive services, diagnosis, follow-up to assure continuity of care, referrals to specialty care and linkages to other services (McMurray-Avila, Gelberg & Breakey, p. 1).

Developing mechanisms by which to effectively engage homeless people in human service systems should be a primary focus of social workers seeking to serve this population.

The results of this study support the concept that “homeless persons are willing to obtain care if they believe it is important” (Gelberg, et. al., 2000, p.1273). The high rate

of program referrals are encouraging and support practice models that embrace a strengths perspective and are willing to start where the client is. As in other research involving this population, “we also found that we can motivate the homeless to seek medical care even though they have mental illness, are abusing substances, and lack permanent housing” (Gelberg, et. al., 2000, p.1273). Although previous models have focused on medical care, it is clear that the outcomes found in this study also apply to other systems. “Clinicians providing care to homeless populations must pay attention to the unique aspect of living conditions and lifestyle that may affect the health outcomes of homeless persons and impede their utilization of care” (Gelberg, et. al., 2000, p.1299).

Effective practice with homeless and other marginalized populations will implement a radical theoretical foundation for this work. Suggestions for radical practice methods for this population include:

- social work action should be sensitive to relevant social causes;
- Practice must be constantly tailored to the situation in which workers practice [sic];
- Workers should be alert to contradictions between claimed low-level gains (such as client empowerment) and concomitant high-level losses (such as service disempowerment);
- Social work is concerned with inherent humanity, and no single political or theoretical position has a monopoly of values which support such objectives;
- Critical thinking should lead to action;
- It is important to preserve narratives about real life which explain and point up injustices;
- We should focus on things which are marginalized [sic] by conventional thinking. (Payne, p. 219-220).

An example of this theoretical foundation will include a shift in focus from ‘compliance issues’ with homeless clients to identifying “a shortcoming of the system of services – non-compliance with the approaches needed to effectively serve the clients” (McMurray-Avila, Gelberg & Breakey, p. 15). Further examples will include flexible interventions

that are delivered in a manner that homeless people can accept (with regard to location, immediate concrete needs, scheduling, safety, etc.) and continuous service monitoring and improvement.

The results also speak to the importance of expanding culturally competent practice for the sample and systems under study. In more than one instance in the results of this study, Race was a significant predictive factor regarding the receipt or denial of human service assistance. “Oppressive structures limit individuals’ ability to access and receive treatment that is relevant, culturally appropriate, affordable, and addresses structural oppression” (Page & Blau, 2006, p.103). Further, “homeless people with mental illness especially those who are unable or deemed unwilling to access traditional services, are a group particularly prone to oppression” (Page & Blau, 2006, p.105). It is unclear the extent to which each system offers culturally competent services but the varied receipt and denial rates evidenced here beg exploration that is beyond the scope of this document.

Anti-oppressive social work theory and practice provides the social work practitioner and policymaker alike a framework through which to improve our work with homeless and other marginalized populations. “Providing individual clients with adequate resourcing to pursue their claims, acknowledging their agency and validating their own knowledge base as a source of expertise, despite institutional and legislative powers that favor [sic] the professional, is crucial to anti-oppressive practice” (Dominelli, p. 96). The homeless people within this sample demonstrated the desire to change the course of their lives through their willingness to apply for a variety of services. The

burden now lies within the system of available services within this community to respond to this desire by developing programs that are accessible to this population.

Systems Integration and Social Policy

Perhaps the most notable outcome of this study is the lack of coordination between human service systems. This lack of effective coordination is not new to social work and, in fact, is has been studied for decades.

Over the past 30 years, efforts to achieve systems integration have been variously called: community integration, comprehensive services, comprehensive planning, coordinated services, systems of care, community support services, and continuum of care-to name a few. In theory, if multiple service agencies were dealing with the same clientele in a case-by-case and uncoordinated fashion, then perhaps gains could be realized and costs reduced if each agency broadened its core service approach to involve coordination with other providers serving the same clients. (Dennis, Cocozza, & Steadman, p.359).

Despite this emphasis within the literature, coordination remains one of the primary challenges facing 21st century social work.

Coordination among agencies to facilitate access is hampered because of different funding restrictions, service eligibility requirements, geographic boundaries, treatment or service philosophies, and administrative policies. As services are now organized in most communities, the burden of gaining access to services and integrating them often falls on the homeless person, who also has to overcome transportation barriers, complicated application forms, and long waiting lists” (Randolf, Blasinsky, Parker & Goldman, 1997, p.369).

For people experiencing specific barriers to service including, but not limited to homelessness, this burden becomes insurmountable. This research illustrates that these difficulties are replicated in the suburban community under study. In addition to bureaucratic barriers to systems integration, the structure of human services in this

suburban community provides few incentives for otherwise independent service modalities to collaborate.

Limited literature exists regarding human service system integration and coordination for homeless people in suburban communities. Existing studies involve large metropolitan and urban settings whose demographics vary from this suburban community (Calloway & Morrissey, 1998; Hambrick & Rog, 2000; Morrissey, et. al., 1997). Further, at least one study discussed the example that “services for persons who are homeless and have serious mental illness are perceived as inaccessible and poorly coordinated”(Morrissey, Calloway, Johnson & Ullman, 1997, p.379). This study is the first of its kind to examine service system coordination within a suburban sample of homeless people.

These results do not demonstrate effective service coordination regarding the sample under study. A notable exception to this lies within medical treatment for the study sample. As previously mentioned, the program under study has a Memorandum of Understanding with a local clinic with regard to medical services for clients at the Drop-In Center. This example demonstrates the effectiveness of formal cooperative relationships between service providers from different systems. The shared desire to increase service access to the specific client base, and increase use of an underutilized medical facility, proved to facilitate coordination in this instance.

An important assumption underlying the concept of services integration is that categorically structured human service delivery systems are less able to address the needs of people with complicated problems. The goals of integration are to improve clients’ access to comprehensive services and continuity of care; to reduce service duplication, inefficiency, and costs; and to establish greater accountability (Randolf, et. al.,1997, p. 370).

Further,

Developing an integrated service system is a complex undertaking that requires interagency planning and consensus building, knowledge about how to make different integration strategies work, adequate resources, and substantial time. (Randolf, et. al.,1997).

The effort of the two agencies in this example demonstrate that it is possible to create integrated service systems in a sustainable manner.

Notably, the investment of time, resources and interagency planning has become increasingly scarce in an era of limited funding opportunities, commodified health care and increased interagency competition for limited program resources. Previous national efforts at coordination have provided us with a framework by which to improve efforts at coordination. Some of these lessons include:

- Commitment to change without adequate resources is not enough. Systems integration efforts can only impact client outcomes if the resources to meet their needs exist. Resources to meet specific needs may need to be increased or existing resources may need to be more efficiently allocated or organized.
- Three strategies are key to establishing the basic infrastructure to permit systems integration to occur: (1) having a designated leader responsible for systems integration, (2) getting the key players and decision-makers to the table (and keeping them there); and (3) using a formal strategic planning process.
- Current or former service recipients need to be involved at all stages of planning and implementing systems integration.
- Remember that while large-scale systems change may be the goal, incremental change is often the way in which most systems evolve. Systems change is a long-term commitment; incremental change is an interim goal, important in its own right.
- Seek advice from others. Too often communities ignore the need for an outside expert to identify what is making them stuck and to help them find a way through a difficult issue. Sometimes taking a team of enthusiastic and reluctant community members to visit another community that has already struggled with similar issues can be just what is needed to move beyond an impasse (Dennis, Coccozza, & Steadman, p.358).

Future efforts at coordination within this community will need to include these lessons in order to increase the likelihood of achieving greater levels of success.

These results support previous research that increased coordination between human service systems is possible although not common. The benefit to coordinating service systems include “more integrated service systems providing [sic] better access to a broad range of services; ...clients treated in more integrated service systems have better outcomes; and ...the resulting improvement in outcomes is mediated through increased accessibility and continuity of service delivery” (Rosenheck, Morrisey, Lam, Calloway, Johnson, Goldman, Randolph, Blasinsky, Fontana, Calsyn & Teague, 1998, p. 1610). Unfortunately, in the current residual social welfare system that characterizes U.S. human service delivery, increasing access to homeless and other underserved populations is unlikely. As providers attempt to do more with less and programs operate at or above capacity, those who cannot compete in the market for these services will be left behind by these providers.

In order to remain viable in an increasingly competitive market for human service provision, agencies will need to diversify the nature of the services they provide. “The restricted flow of resources from governmental agencies and federal campaigns has meant that larger numbers of agencies have competed for the scarce resources of foundations, corporations, and private donors”(Jansson, p. 114). This means that agencies whose mission remains narrowly focused on a single issue will be less likely to survive in the current social welfare system. For example, “most mainstream health care organizations are primarily single focused. They either provide medical care, mental health services or substance abuse treatment”(McMurray-Avila, Gelberg & Breakey, p.

15). This singular focus on a specific treatment or service modality is not limited to health care organizations. As service provision increasingly becomes the responsibility of the states and localities, coordination between systems will become increasingly difficult. Policy initiatives will need to focus on this lack of coordination and provide incentives to agencies, programs and communities to increase their efforts.

The concept of systems integration is not new to American social policy, specifically with regard to homelessness. The most comprehensive federal initiative designed to address homelessness, the McKinney-Vento Act, has attempted to address decentralized service provision by requiring agency participation in regional Continuums of Care. “A continuum of care utilizes a comprehensive approach to persons who need different types and intensity of services over time, depending upon changing issues” (Livingston & Miller, p.35). As discussed in the literature review, these Continuums are limited insofar as they can require participation only by funded agencies. The McKinney-Vento Act remains the most significant social policy designed to address homelessness. Despite the fact that “while federal policy did not adequately meet the holistic service needs of many homeless, increasingly substantial federal monies were spent on programs and the ideas of homeless scholars/advocates were integrated into some innovative policy initiatives”(Gabbard, Ford & May, 2006, p. 109). These efforts are mirrored in other human service systems.

Difficulties in developing integrated service systems are not unique to housing policy and the programs these policies impact. The inability to fully integrate mental health service systems are evident in attempts at providing streamlined services and

addressing multiple needs in programs such as the ACCESS demonstration projects of the 1990s. In particular,

...many of the problems with, and faced by, CMHCs stem from problems at the federal level that work to perpetuate the impasses in effective treatment of oppressed groups... fragmentation, overemphasis and research and training without financial support to implement the findings, and market-driven policy responses such as privatization and managed care have also impeded the development of better mental health policies (Page & Blau, 2006, p.104).

Efforts to adequately meet the needs of chronically homeless adults, or other underserved populations that possess multiple co-occurring needs, will need to reevaluate this emphasis on service integration.

These efforts, while noteworthy, fail to fully acknowledge the difference between service integration and system integration.

In services integration, services are coordinated, but relationships between agencies do not fundamentally change. Systems integration, by contrast, requires changes in the ways in which agencies interact with each other. There are fundamental changes in the ways in which agencies share information, resources, and clients. Such changes are difficult and time-consuming. Communities using similar strategies can vary greatly in the level of systems integration achieved (Dennis, Coccozza, & Steadman, p.359).

Service integration certainly requires coordination efforts at multiple levels to ensure streamlined and efficient human service provision – in the case of this research, between various human service systems.

Policy or strategy development can come in many forms. To the extent that national and state public policies can be revised, such as those that mandate that states and localities undertake specific integrating activities, systems integration [sic] will be enhanced but will not be complete... the department heads of independent human services departments or the top staff at the apex of a combined agency must meet on an equal footing and decide which organizational commitments--dollars, information, people--will be made to support an integrated effort. These commitments could be contracts for services, shared staff, automatic eligibility, a case-

management system, a joint taxonomy, or many other integrative tools (Agranoff, 1991, p. 536).

This model of system integration focuses not only on streamlined and efficient services but also on the development of a clearly defined agenda designed to increase service access for marginalized, underserved and non-dominant groups. Efforts to increase access to these groups will not succeed until a clearly developed policy agenda is developed taking into account the diversity of client needs outlined throughout this, and other, research regarding underserved populations.

These examples illustrate that social welfare policy in the United States does not adequately address the needs of homeless people and other marginalized populations. The fragmented and disorganized system of services mirrors our political system in many ways and, as such, it is unlikely that our political process will address the gaps in services within our social welfare system. Further, social workers have traditionally struggled to play an active role in policy making at many levels. The disconnect between individual need and social change lies at the very foundation of our profession; yet this disconnect is unnecessary and limits our ability to effect social change. The ambivalence of social workers with regard to our role in social policy initiatives limits our understanding of these processes. Within the field of social work, “social welfare policy has [sic] traditionally fallen into social welfare reform, historical, orienting and descriptive materials. Even the analytic, political, and implementation literature that supplemented policy literature in the 1970s and 1980s usually failed to discuss how people might actually try to shape policies” (Jansson, 1994, p. 24).

Our absence in the policy arena is notable given the many social issues and marginalized populations with which we work. Given the diversity of roles that social

work plays within agencies, advocacy groups and government, effective policy practice for our profession will need to consider the practical realities of our work. In previous decades, “theorists who examined political and implementation realities usefully expanded the boundaries of policy beyond the relatively narrow scope established by policy analysts. Their work implied that policy analysis must be coupled with knowledge of political and organizational realities”(Jansson, 1994, p.23).

As discussed earlier in this document, radical theory provides the reader with a framework to better understand not only homelessness, but also the mechanisms currently in place to manage homelessness and other contemporary social problems. Despite the frustration evident within homeless advocates, policy initiatives such as the Continuum of Care and Housing First Models represent limited progress toward more inclusive treatment of marginalized populations. “Radical incrementalism challenges the existing constraints on the politically possible, recognizing that the changes forthcoming will be in the form of concessions at best. Yet, such concessions can improve the lives of the oppressed and marginalized and create the conditions for further incremental challenges and improvements in the future” (Schram, 2002, p. 51). Perhaps the greatest challenge facing 21st century social work lies in our ability to navigate these changes while continuing to challenge institutional constraints.

Limitations of the Study

This study possesses several significant limitations to its design and external validity. Given that the design of this study consisted of retrospective chart reviews, it is unlikely that an intervention caused changes to the results. Threats to construct validity

with regard to design, as discussed in Bloom, Fischer and Orme (2006), consisted of the number of measures utilized for each variable under study and leading to the possibility of drawing inaccurate conclusions. In most instances, this threat was minimized by program staff that initially entered, de-identified and coded the data. Staff consistently looked for supporting information for all self-reports so as to ensure accurate measurement of client information.

This study possesses several significant limitations to its external validity and generalizability. As discussed at length in the Methodology section of this document, it is not possible to obtain a random sample of homeless people. As such, this study relied on purposive sampling methodologies. It is unknown if these results are unique to this sample of homeless adults from this suburban community, or if the data obtained can be generalized to a larger homeless population. Replication of this study would determine its external validity, but that is beyond the scope of this research. The included statistical tests therefore possess limited reliability for a larger homeless population however, it is important to note that the methodologies utilized in this study are consistent with those utilized on similar research involving homeless people.

This study possesses limited statistical power. Instead, these results serve as a model for future research regarding suburban homelessness or other ‘hidden’ populations. As is consistent with other research regarding homeless people, the greatest threat to generalizability of this study is the lack of a clearly defined population to which to generalize these results.

Directions for Future Research

Although not easily generalizable to other populations, the data contained in this study provides a wealth of information to direct future research. Perhaps most notably, this study can be replicated in other communities to begin to determine if the data contained here is in some way unique to this sample or if, in fact, the patterns discussed in this document are evident in other samples. Additionally, future research should begin to look at several of the variables in this study that, due to sample size and power issues, did not contain specific information. Specifically, several variables were recoded resulting in the loss of some detail regarding causal information (e.g. reasons for service denials) in the final analysis. This data may have proven to be meaningful and could provide clarity on the specific barriers that homeless people, chronic or otherwise, experiences in their quest for assistance.

Additional studies should examine small scale efforts at system integration in suburban communities as this has not been studied in these communities to date. It is unclear if there are differences, or perhaps successful smaller scale examples, in the integration of human service systems outside of urban communities. To the extent that it is possible, future research should also examine ways to minimize the impact of categorical funding, regulatory agencies and the lack of shared definitions with regard to these systems.

And finally, the author cannot overstate the importance of giving voice to the lived experiences of the people whose suffering we ultimately seek to alleviate. Studies that include qualitative narratives about what it means to be homeless provide invaluable insight into this invisible group of people. Their experiences shed light on how social

work can be most effective and, perhaps most importantly, provide us with a measure of how far we still have to go.

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