HOMELESS SHELTERS IN ALABAMA: A STUDY OF WOMEN'S HEALTH SERVICES

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This is dedicated to my family
for all their support
throughout this project.

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In loving memory of my Dad, Willie Rayfus Hall, 1938 -2010, he was my father, my friend and my hero.

ABSTRACT

HOMELESS SHELTERS IN ALABAMA: A STUDY OF WOMEN'S HEALTH SERVICES

by Veta Robinson

Women and families are the fastest growing segments of the homeless population. Homeless women have been recognized as having a variety of unmet healthcare needs but only limited studies have been performed on adult homeless women. To determine what health related services are provided by homeless shelters for women in Alabama, a descriptive qualitative study was performed using a Homeless Service Questionnaire to gather data from shelter directors on the demographic information of the homeless population they serve. Categorical data from 15 homeless shelters in Alabama was collected, processed and summarized into decisive statistics. A lack of health service promotion and education by the shelters were noted which limited the exposure of health initiatives for many of the homeless individuals. There was a significant difference between the number of clients reporting barriers of a lack of money, lack of transportation, no childcare, and do not trust providers and those that did not report a lack of money, lack of transportation, no childcare, and do not trust providers. There was an implication of the need for additional shelters to support the growing homeless population. Furthermore, health promotion and education should be developed in the context in which homeless people seek health care. Homeless individuals must be educated regarding sources of care, encouraged to seek health services and treated with dignity. Data from two identified benchmark shelters (Safe Haven Family Center and Gateway Shelter for Battered Women) were used as comparative data to recognize best

practices for recommendation of improvement for the Alabama shelters. The benefit of the study is to increase awareness of the health services available for the homeless; to improve health care services availability to the homeless; and to enhance awareness of the growing rate of homelessness in the United States.

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DEFINITION OF TERMS

Words	Definitions
Absolute homelessness	Describes the conditions of persons without physical shelter who sleep outdoors, in vehicles, abandoned buildings or other places not intended for human habitations.
Barriers	Defined as factors that impede health-promoting behavior.
Chronic shelter users	Those who use shelters as a form of relatively long-term housing.
Chronically Homeless	An unaccompanied disabled individual who has been continuously homeless for over one year
Couch surfers	Defined as individuals chronically staying with others.
Episodic shelter users	Those who move repeatedly in and out of the shelter system.
Food insecurity	Defined as having limited availability of nutritionally adequate and safe ford or the ability to acquire foods in socially acceptable ways.
Health care access	Defined as fit among personal, sociocultural, economic, and system-related factors that enable individuals, families, and communities to have timely, needed, necessary, continuous, and satisfactory health services.
Health promotion	Defined as the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health.
Homeless	A person who "lacks a fixed, regular, and adequate night-time residence; and has a primary night time residency."
Homelessness	Considered a state of deprivation in which existing social supports fail to provide essential resources in a crisis.
Housing instability	Defined as having difficulty paying rent, spending more than 50% of household income on housing, frequent moves, living in overcrowded conditions or doubling up with friends or relatives.
Relative homelessness	Describes the condition of those who have a physical shelter but one that does not meet basic standards of health and safety, such as access to safe water and sanitation, personal safety, and protection from the elements
Statutorily homeless households	Referred to as "Acceptances. Satisfied required criteria for assistance, unintentionally homeless and falls within a specified priority need group".
Transitional shelter users	Those who use shelters as an emergency service which they exit and do not return.

CHAPTER I

INTRODUCTION

Growing Rate of Homelessness

The growing rate of homelessness has reached crisis levels in many cities in the United States (U.S.). The economic crisis has caused many industrial companies to close or transfer overseas, leaving numerous workers unemployed and contributing to the continuous increase in the number of uninsured. An estimated 2.3 to 3.5 million Americans experience homelessness each year, 700,000 people are homeless on any given night, and 14% of the United States housed populations have been homeless in their lifetime. The majority of the homeless people are men. However, nationwide studies have found women and families are the fastest growing segments of the homeless population (Lewis, Andersen, & Gelberg, 2003).

The Stewart B. McKinney Act, 42 U.S.C. §11301, et.seq. (1994), defined homeless as a person who "lack a fixed, regular, and adequate night-time residence; and has a primary night time residency that is: (A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations, (B) an institution that provides a temporary residence for individuals intended to be institutionalized, or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings." The term "homeless individual" does not include individuals imprisoned or otherwise detained pursuant to an Act of Congress or a state law (National Coalition for the Homeless, 2009). According to the United Nations, "absolute homelessness" describes the conditions of persons without physical shelter who

sleep outdoors, in vehicles, abandoned buildings or other places not intended for human habitations. "Relative homelessness" describes the condition of those who have a physical shelter but one that does not meet basic standards of health and safety, such as access to safe water and sanitation, personal safety, and protection from the elements (Badiaga, Raoult, & Brouqui, 2008b).

Homelessness is considered a state of deprivation in which existing social supports fail to provide essential resources in a crisis. The state of homelessness represents one of the least desirable life circumstances one could imagine, presenting significant daily difficulties for the individual (LaGory, Ritchey, & Mullis, 1990; Hwang, 2001). Homeless people are usually described as transient, lack a permanent address, and are either unemployed or employed in a job that does not provide adequate income to provide basic needs such as food, clothing, shelter, and health insurance. The homeless are less likely to obtain preventive medical services and more likely to experience barriers to health care such as not knowing where to go for care, lack of transportation, long waiting times, mistrust of health care professionals and high costs (Lewis et al, 2003).

The National Coalition for Homeless (2009) documented that the National Law Center on Homelessness and Poverty in 2004 reported children under the age of 18 accounted for 39% of the homeless population, 42% of these children were under the age of five, and unaccompanied minors comprised 5% of the urban homeless population. The numbers of children experiencing homelessness varies with demographic location and the numbers are much higher in rural areas. The same study found that 25% of the homeless were ages 25 to 34 and 6% were between the ages 55 to 64. This same survey, performed

in 2006, found that families with children comprised 23% of the homeless population. The National Coalition for Homeless (2009) also documented that the U.S. Conference of Mayor in 2006 survey of 25 cities found that the sheltered homeless population is estimated to be 42% African-American, 38% White, 20% Hispanic, 4% Native American and 2% Asian. The ethnic makeup of homeless population varies according to geographic location (National Coalition for the Homeless, 2009).

Contributing Factors to Homelessness

There are many factors contributing to homelessness that can be as diverse as the population affected. Domestic violence was identified as a primary cause of homelessness. Studies show that battered women who live in poverty are often forced to choose between abusive relationships and homelessness. The National Coalition for Homeless (2009) reported on a national study performed by the National Coalition against Domestic Violence in 2001 that revealed that 50% of all women and children experiencing homelessness are fleeing domestic violence. Poor health is another major factor in becoming homeless. The study showed that 15% of the homeless surveyed stated that health was the "single most important" factor. Many are homeless due to economic setback, a lack of affordable housing, and the failure of the "social safety net:" which include physically disabled or chronically ill, the elderly on fixed inadequate incomes, or able-bodied single adults receiving general assistance who often find it impossible to maintain stable housing on their limited monthly grant. Many homeless people have experienced severe disruptions in their lives such as natural disasters, tragedies, divorce or severe depression. Many homeless people are linked to chronic

conditions such as alcoholism, drug abuse, mental illness or people with acquired immunodeficiency syndrome (AIDS) or AIDS-related conditions (ARC). Approximately, 30% to 40% of the homeless peoples are veterans where half are from the Vietnam era (Wlodarczyk & Prentice, 1988; National Coalition for the Homeless, 2009).

Health Related Issues Associated with Homelessness

The numerous behavioral, social, and environmental risks homeless people encounter exposes them to many communicable infections which may spread among the homeless and lead to outbreaks that can become serious health concerns (Badiaga, Raoult, & Brouqui, 2008a). The homeless population has a greater prevalence of illness and early death due to socioeconomic conditions such as poor diet, poor living conditions, inadequate sleeping locations, contagion from overcrowded shelters, limited facilities for daily hygiene, exposure to the elements, exposure to violence, social isolation, lack of health insurance, and limited access to healthcare systems (The Health of the Homeless- Living in Public: Increased Problems, 2011). The rate of acute and chronic illnesses is high, in many cases, surpassing those of the general population, increasing reliance on emergency departments and higher rates of hospitalization often of preventable conditions. The most widespread chronic conditions among homeless are substance abuse, mental illness, hypertension, gastrointestinal problems, neurological disorders, arthritis and other musculoskeletal disorders, chronic obstructive pulmonary disease, anemia and peripheral vascular disease. The most common infectious diseases are chest infections, bronchitis, tuberculosis (TB), AIDS, hepatitis B virus (HBV), hepatitis C virus (HCV) and sexual transmitted diseases (STD). Homeless people also

suffer from a wide range of other medical disorders including obesity, depression, physical and sexual abuse, skin diseases such as cellulites, impetigo, venous stasis disease, scabies and body lice (The Health of the Homeless- Living in Public: Increased Problems,2011; Hwang, 2001).

Homeless people are admitted to the hospital up to five times more often than the general population. Unfortunately, homeless patients are sometimes discharged to shelters, even when their ability to cope in such settings is marginal at best. Most of the homeless patients do not make their follow-up appointments and do not fill prescriptions they have received because they lack health care insurance benefits and have an inability to pay the cost of the medication. Many health recommendations regarding rest and dietary changes may be unattainable. Chronic illnesses such as diabetes that are related to diet are difficult to manage for homeless people because of the challenges of coordinating meals with medication (Hwang, 2001).

Homeless people also face competing priorities that may impede them from utilizing health care services. Many homeless adults' priorities are centered on their basic needs for food, shelter and safety which they perceive as higher needs than issues of health or illness (Gelberg, Gallagher, Andersen, & Koegel, 1997). The prioritizing demonstrated by homeless adults is best summarized in Maslow's hierarchical of needs which explains the lower the needs in the hierarchy, the more fundamental they are and the more a person will tend to abandon the higher needs to sufficiently meet the lower needs (Poduska, 1992).

Health Care Promotion

Homeless people often use the emergency department for their health care needs and are more likely to present with a disease rather than at prevention or screening stages (Power, 1999). Homeless mothers appear to have higher risk health behaviors, and higher rates of hospitalization and emergency department visits, but fewer outpatient visits and preventive screening compared to mothers in the general population. The greater use of hospitalization and emergency service reflect poorer access to appropriate and timely health care (Lim, Andersen, Leake, Cunningham, & Gelberg, 2002). Therefore, homeless people are often missed by primary care health promotion initiatives. Many volunteers such as outreach workers, general practioners, and community nurses have provided health provisions to shelters, clinics and day centers. These volunteers' aim was to provide direct services to homeless people and promote integration into mainstream health services. Research show that progress was made with direct services to homeless people but little success was made with the promotion of integration into health services. Most health care interventions have tended to concentrate on young homeless people. The elderly people and families living in temporary accommodations have largely been ignored. There are barriers to health promotion among homeless people such as; (a) little coordination or collaboration between health promotion agencies; (b) health promotions departments rarely set up initiatives aimed specifically at homelessness and housing; (c) homeless people can feel alienated from health promotion materials that often require high levels of literacy; and (d) low self-esteem and low expectations prevent them from engaging with health promotion activities (Power & Health Education Authority, 1999).

Budget cuts and the downsizing of state mental health institutions have contributed to homeless shelters along with jails and prisons becoming today's mental hospitals. People with mental illness and additional problems are guaranteed neither a home, food, health nor safety (Treatment Advocate Center, 2007). Adults living with serious mental illness cannot get adequate treatment or services; they often end up on the street. Addressing mental illness among homeless people requires "supportive housing", a combination of both affordable housing and mental health service (Homelessness, 2010).

Shelters

For many, homeless shelters are a temporarily safe haven for a shielded place to sleep while getting their life back on track. A great number of circumstances force people into homelessness such as a missed paycheck, health problems and unpaid medical bills. Many homeless people take advantage of homeless shelters, not only for a place to sleep but also for the numerous other services that might be offered, such as job training and soup kitchen services or other assistance programs. Assistance programs offered by the homeless shelters vary per shelter. Homeless shelters are organized at the State and county level into Continuums of Care (CoC). Continuums of Care are local networks that provide services appropriate to the range of homeless needs in individual communities. Continuums of Care usually rely on Federal Department of Housing and Urban Development (HUD) Supportive Housing Program (SHP), grant funding for a significant proportion of their budgets and report data to HUD. Individual shelters depend upon a

mixture of public and private (foundation and faith-based) funds to maintain operations. CoC agencies can be either nonprofit or governmental organizations (Agency for Healthcare Research and Quality, 2011).

Unfortunately, services for the homeless have focused on assisting households only when they are literally homeless (Culhane, & Metraux, 2008). In the United Kingdom (UK) and United States, homeless shelters are considered temporary residences for homeless people and usually located in urban neighborhoods. Most homeless shelters in the United States expect clients to stay elsewhere during the day and return to sleep or eat if the shelter provides meals. In the United Kingdom, most homelessness services fill the role of both daytime and nighttime shelters. Shelters develop empowerment based "wrap around" services in which clients are case managed and supported in an effort to become self-reliant (Homelessness, 2010). There is a wide spectrum of shelters that usually fit into six (6) categories: (a) day shelters which supplement homeless people for shelters only offering overnight stay; (b) emergency/homeless shelters which provide short term relief for the homeless and low-income in some areas up to sixty days of temporary housing; (c) transitional housing which helps the transition of individuals and families from shelters to permanent housing up to 9 months (6 months in some jurisdictions); (d) permanent affordable housing is a long-term solution for housing; (e) disaster shelters which are activated in schools, town hall, and other open-spaces and are often run by non-profit organizations such as Red Cross, Salvation Army and United Way working with State and local officials after an emergency and; (f) drug and alcohol rehab treat alcohol and/or drug dependency (Homeless Shelters Centers, 2011; Agency for Healthcare Research and Quality, 2011).

According to Kryda and Compton (2009), available health services are being underutilized or refused by the homeless due to general mistrust in health care workers and lack of confidence in the services. If the services are not being utilized, the value of the services available for the homeless is meaningless. Therefore, there is a critical need to understand the mistrust of the homeless toward the outreach workers and the lack of confidence in the available services (Kryda, & Compton, 2009).

In the year 2000, millions of Americans lost work, exhausted money they had saved during the boom years, and faced increased economic insecurity. These new hard times placed heavy demands on emergency social services. In 2001, over 25,000 people were sleeping in New York City shelters every night; over 600,000 New Yorkers were using soup kitchens and emergency food pantries every month; and 2 million made use of emergency food resources.

Public shelters in major cities throughout the United State faced severe overcrowding since early the 1990s. The huge increase in demand for emergency shelter means that care givers have little ability to make long range plans and policy initiatives are largely reactive (Marcus, 2003). A shelter in Atlanta, Georgia and Nashville, Tenneesee were identified for their best practicies for comparision with shelters in Alabama.

Atlanta

Atlanta is the most populous city and the third largest city in the Southeastern United States. In 2009, there were an estimated 5,475,213 people in the 28 county Atlanta

Metropolitan Statistical Area. Atlanta's demographic population consists of approximately 50.4% female and 49.6% male; 33.2% Caucasian, 61.4% Black, 1.9% Asian and 3.5% others (Atlanta Population and Atlanta Demographics, 2011).

An estimated 21,441 people experienced homelessness in Atlanta during 2009. On any given night at least 7,019 people sought shelter and support. Approximately, 18% of Atlanta's homeless population is families with children. The total number of homeless people in families was 1,238 of the 7,019 homeless on any given night. The adult female head of families were 28%, two parent (male and female) families were 5%, adult male head of families were 1% and children were 65.5% (The 2009 Metro Atlanta Tri-Jurisdictional Collaborative Homeless Census, 2009).

Many of the females experiencing homelessness are escaping domestic violence. Gateway Shelter for Battered Women works toward the elimination of personal and societal violence against all women and children. Gateway provides a comprehensive array of programs and services to violent families, including: 24 hour crisis line, emergency shelter and extended day program, individual and group counseling, community development with education and training, and services providers to increase the effectiveness of intervention and treatment of domestic violence incidents (Gateway Battered Women's Services, 2010).

Nashville

Nashville is the capital of Tennessee and an essential transportation, business and tourism center for North America. The U.S. Census of 2010 estimated the Nashville-Davidson population to be 601,222. Nashville's demographic population consists of

approximately 51.5% female and 48.5% male; 60.5% Caucasian, 28.4% Black, 3.1% Asian and 8.0% others which included American Indian and Alaska Native, Native Hawaiian and Pacific Islander and those identified by two or more races (Nashville Population and Demographics, 2011).

In 2004, the number of homeless individuals in Nashville counted by volunteers and Metro officials were 1,800 which included 900 individuals who met the Department of Housing and Urban Development's definition of chronically homeless (an unaccompanied disabled individual who has been continuously homeless for over one year) (Safe Haven Family Shelter, 2010). For cities like Nashville, recognized across the nation for its excellent quality of life, the plight of our chronically homeless population is especially poignant and problematic. In April 2004, Mayor Bill Purcell appointed a task force charged with making sure Nashville meets the federal goal of ending chronic homelessness within ten years (The Strategic Framework for Ending Chronic Homelessness in Nashville, 2004). The Safe Haven Family Shelter has accepted the challenge of ending chronic homeless through their mission to provide shelter and transitional services that empower Middle Tennessee homeless families with children to achieve lasting self-sufficiency (Safe Haven Family Shelter, 2010).

Alabama

Alabama is located on southern coast of the United States, with the state capital located in Montgomery. The state is divided into 67 countries. According to the Alabama Department of Industrial Relations, Alabama ranks 30th in size, covering 52,423 square miles. The U.S. Census Bureau showed Alabama as the 23rd most populous state, with

4,447,100 residents (National Network Libaries of Medicine, 2010). The Alabama's demographic population consists of approximately 51.9% female and 48.1% male; 70.9% Caucasian, 26.3% Black, 3.2% Hispanic or Latino, 1.0 % Asian, and 0.5% American Indian and Alaska natives (U.S. Census Bureau, 2011).

Alabama had an estimated 5,400 homeless with about 509 homeless families on a single night in 2009. Unemployment was cited by 29.8% of the homeless individuals surveyed in Mobile County as being the primary reason for homelessness in 2009. Nearly one-third (33.6%) of homeless women had no income and one-third (34.6%) of women with a source of income earned wages from temporary or day labor. Half (49.9%) of the 385 persons surveyed required job search assistance and had been unable to attain such services (National Survey of Program and Services for Homeless Families, 2010).

Women

More women, elderly and young people, particularly black women and members of other minority groups have slipped into a population of homelessness that was once dominated by older alcoholic white men. The burden of poverty falls disproportionately on families headed by women, children, young adults, and ethnic minority groups. The "feminization of poverty" has significance in the growing and shifting homeless population. Many women have no place to turn but to the streets. Research shows that women receive harsher judgment and less adequate services than men. Society can no longer neglect women as they continue to enter the ranks of the homeless as victims of the spousal abuse, economy, landlords, a depleted mental health system (Stoner, 1983).

Homeless women are considered one of the most vulnerable subpopulation among the homeless. They have weaker social networks and higher rates of mental and substance abuse (Lim et al., 2002). Poor women are at a higher risk for violence as poverty increases stress and lower a person's ability to take control of their own environment and seek protective care (Silver & Pañares, 2000).

Research Objective

Research data were collected to address the following questions: "What health promotion and education are provided by the shelters in this study?", "what health related services are provided by the shelters in this study?," and "how do shelters in this study provide assistance with accessing other health related services not provided by the shelter?" A qualitative study was performed on the promotion and education of homeless shelters, available health related services along with the assistance in accessing services not provided by shelters. Health care promotion is defined as the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health (Power & Health Education Authority, 1999). Health care access is defined as the fit among personal, sociocultural, economic, and system-related factors that enable individuals, families, and communities to have timely, needed, necessary, continuous, and satisfactory health services (Hatton, Kleffel, Bennett, & Gaffrey, 2001). The data collected from the study provided valuable information on the needs of this steadily increasing homeless population. The research method consisted of a Homeless Service Questionnaire to gather data from shelter directors on the demographic information of the homeless population they serve, health promotion initiatives and

program assistance. Due to the decrease in funding for mental health services, misdiagnosis of mental illness among homeless people, and the difficulties in engaging the homeless population in mental health and substance abuse programs, specialty shelters such as substance abuse shelters and mental health clinics were not included in this study.

Previous studies on adult homeless women as well as health care promotion are very limited. The benefit of the study on homeless women in Alabama will be to recognize the needs of the homeless; to increase the awareness of the health services available for the homeless; to decrease the barriers of accessibility for health services for the homeless; to improve the health care services availability to the homeless; and to enhance the general populations' awareness of the growing rate of homelessness in United States. The data obtained were used to address the research questions.

CHAPTER II

LITERATURE REVIEW

Introduction to Literature Review

The purpose of the literature review chapter is to provide an in-depth evaluation from previous data collected in an attempt to support the research questions posed by this study. The literature review provided pertinent information on health promotion and education provided by shelters , health related services provided by the shelters, assistance with accessing other health related services through different shelters and agencies, in the United States and globally.

Available Research on Homeless Women

Women have been one of the most rapidly growing segments of the homeless population since the early 1980s (Lim et al., 2002). The National Center on Family Homelessness (NCFN) 2008 proclaimed that the United States leads all industrialized nations in the numbers of homeless women and children, and the incidence of homeless families in the United States is the highest it has been since the Great Depression. Studies show that homeless women comprise one fifth of the U.S. homeless adult population, where the research indicates that families, single mothers, and children make up the largest group of people who are homeless in rural areas (Silver & Pañares, 2000).

There are an estimated 20,000 sheltered and unsheltered homeless women in Los Angeles County on any given night. Los Angeles has one of the largest concentrations of homeless women in the country. Those who are homeless are significantly more likely to be affected by substance abuse, HIV/AIDS, and violence. An exploratory study was

conducted to examine the composition of homeless women's personal networks in order to understand the social context of risk behavior in this vulnerable population. The study consisted of 28 homeless women residing in temporary shelters in Los Angeles County who provided detailed information about their extended personal networks. Homeless women's personal networks are not well understood. Results indicated that about one-third of women's relationships were with high-risk individuals. High risk individuals were defined as those perceived to drink heavily, use drugs, or engage in risky sex. Most women also reported having relationships that could be characterized as both "low risk" (e.g., involving individuals perceived as not drinking heavily, using drugs, or engaging in risky sex) and "high quality" (e.g., long-term, emotionally close, or supportive). The results suggest a need to assist homeless women in strengthening these existing low-risk/high-quality relationships, and extending the diversity of their networks, to increase women's exposure to positive role models and access to support and other needed resources (Tucker et al., 2009).

The places a homeless person goes for help when they first become homeless is poorly understood yet extremely important in trying to reduce the consequences of homelessness. The state of homelessness is associated with earlier mortality, significant morbidity and a substantial cost to families and society with worse health indices associated with longer time spent homeless. The most common causes of death among homeless individuals are related to substance abuse, trauma, and infectious diseases such as HIV/AIDS. Homeless individuals have a much higher incidence of morbidity and rate of acute-level health services utilization with much of their care concentrated in accident and emergency departments and hospitals. The many U.S. municipalities have enacted

anti-homeless ordinances (laws prohibiting sleeping in public places, panhandling/begging) while limiting access to basic necessities (public access bathrooms, conveniently located soup kitchens) by this population. The longer the individual is homeless the more likely the person will experience poor health and be placed at higher risk for premature death. Therefore, early intervention in one's homelessness is an important prevention strategy. A cross-section survey was conducted on 230 homeless individuals in the US cities of Pittsburgh and Philadelphia to find out where someone goes for help when they first become homeless and how well those sites are prepared to address the multitude of issues facing a homeless person. The majority of respondents in this survey actively sought help from social service agencies and healthcare providers upon becoming homeless. Many first-time homeless individuals did not pursue housing supports, case management, or referrals to addiction treatment services because they did not expect those options to be available based on pre-homeless experiences at those sites. The study concluded that most homeless individuals sought assistance for concerns less directly associated with their reasons or cause for homelessness; instead they pursued services more specific to an immediate subsistence needs of food, housing and health security with more long-term vocational, mental health or substance abuse treatment services (O'Toole et al., 2007).

The study of mortality among homeless women is a clarion call to our society and our health care community. The 10-fold disparity in mortality rates between Toronto's homeless and housed women aged 18-44 is complemented by data from 7 other cities, which showed that the risk of death among young homeless women is 5-30 times higher than the risk among their housed counterparts. Homeless people in Boston and Toronto

have reported overall mortality rates 3-5 times higher than those among the general public. Homelessness is a prism that refracts the failures of society's key sectors; housing, welfare, education, health care and corrections.

There are excessive reported mortality in seven cities and four countries: England, Canada, Denmark and the United States. Shamefully, the United States still has over 40 million citizens without health insurance, whereas three other countries have had universal health insurance. The universal insurance coverage does not appear to be sufficient to prevent premature death among homeless people. Caring for the homeless poses an uneasy ethical dilemma. Women and men without homes bear an undue and unacceptable burden of illness and they are dying prematurely in our streets (O'Connell, 2004).

Data from the University of California Los Angeles (UCLA)/Research and Development (RAND)Homeless Women's Health Project was used to determine how much perceived unmet need for medical care there is among homeless women, what homeless women perceive to be barriers to health care, and how barriers and other factors are associated with unmet needs. Homelessness causes increased risk of having health problems and encountering barriers to care. The study shows there was a significant unmet need for medical care among homeless women and having a regular source of care was more important than health insurance in lowering the odds of unmet need. Also, homeless women must be educated regarding sources of care, and clinics serving the homeless must decrease wait times (Lewis et al., 2003).

Although, homeless women represent a rapidly growing population of at risk for poor health outcomes , relatively little is known about the differences in the health status, victimization profiles, and health services utilization of homeless women who reside in emergency or sober living shelters as compared with those who live in alternative, unsheltered places, such as the streets. Literature has shown that homeless persons have higher rates of physical morbidity, are sicker, and are less likely to use outpatient health services than those of the general population. A cross-sectional survey was performed on one thousand fifty-one homeless women to contrast sociodemographic characterics, physical and mental health status, substance use, sexual behaviors, victimization, and utilization of health services between homeless women residing in sheltered and nonsheltered environments. The results showed that homeless women living on the streetss were more likely than sheltered women to be white and longer-term homeless. Unsheltered women have over three times greater odds of fair or poor physical health, and over 12 times greater odds of poor mental health than sheltered homeless women. The study also showed that unsheltered homeless women are more likely than sheltered women to report using alcohol or noninjection drugs, to having multiple sexual partners, and have a history of physical assault. The overall sample reported utilization of a variety of health services, but unsheltered homeless women were less likely to utilize all the health services that were accessed, including drug treatment (Nyamathi, Leake & Gelberg, 2000).

According to Finfgeld-Connett (2010), the primary factors contributing to this rise in homelessness included a growing shortage of affordable housing and a simultaneous increase in poverty. The other causes of homeless women are domestic violence, mental

illness, and substance abuse. The number of families experiencing homelessness continues to rise as affordable housing becomes scarcer, and women and children are subject to much greater dependence on the social service system (Finfgeld-Connett, 2010).

Finfgeld-Connett conducted a qualitative meta-synthesis study to comprehensively articulate the experiences of homeless women, with or without children, and make evidence-based inferences regarding optimum supportive services. The finding from the study showed that homeless women were ill prepared to prevent and resolve homelessness. The resolution of homelessness involves overcoming complex interconnected stressors and occurs in progressive-regressive-progressive stages. Homeless women exist within a world of complex interconnected problems that continuously tend to propel them toward more of the same. A successful resolution of homelessness results in the acquisition of stable housing as well as multiple other improvements in women's lives (Finfgeld-Connett, 2010).

Violence against homeless women is another relatively underdeveloped investigated area. Recently, Congress called for an increase in knowledge and control of violence against women with a special focus on needs of underserved (e.g.,. homeless) women. A study was performed in Los Angeles County on 974 homeless women between the ages of 15-44 to document the association of rape with health and substance use or abuse characteristics of homeless women. In this study, homeless women were defined as those who had spent any of the past 30 nights in nontraditional housing. The results of the study showed that thirteen percent of the women reported rape during the previous year and half of these women were raped at least twice in that year. The mean

age of the study group was 32.9 years with 56% being African American, 16% white, 14% Hispanic, and 14% other ethnicities. Women who reported rape had worse general health, had one or more physical functional health limitations, were more likely to report two or more gynecologic symptoms and conditions, had two or more serious physical health symptoms, and were less likely to see a physician (Wenzel, Leake & Gelberg, 2000).

The first published reports of increasing numbers of homeless women began to appear approximately 15 year ago. Studies have documented major contributors to the causes and course of homelessness among women, generally, and their unique service needs, including histories of childhood sexual and physical abuse. Women are also highly vulnerable to violence and exploitation once they become homeless. Homeless women with children face the additional threat of losing their children to involuntary foster care placements. Compared to homeless women accompanied by minor children, unaccompanied women have been shown to be older, more likely to have histories of mental illness and substance abuse, to have been homeless longer, to have served time in jail or prison, to be poorer, and to have more health problems. It is important to understand fully the nature of the needs of women without, and with children, in order to understand the different implications for policy and specific programs (Page & Nooe, 2002).

A survey was performed in Knoxville, Tennessee addressing a range of issues including residential stability in childhood, maltreatment experience, reasons for homelessness, prior homeless episodes, current family status, formal social supports, employment history and skills, health history, alcohol and drug problems, psychiatric

problems, basic nutrition, income sources, crime victimization, informal social supports, recent residential stability, receipt of public benefits and family resources. There were several significant vulnerabilities in the lives of those women that probably contributed to the cause of their homelessness, and that certainly serve as significant obstacles to exiting homelessness. Both groups, those who had recent residential stability and those with residential stability in childhood, had high rates for history of mental illness and incidents of prior homelessness. High percentages of both groups had previous incarcerations and histories of serious substance abuse. The study also found that several serious problems tended to cluster together, including alcohol and drug problems crime victimization, health problems, homeless chronicity, childhood risks, and mental illness, indicates an urgent need for sophisticated, well-integrated, and long-term services (Page & Nooe, 2002). As previously stated, research indicates that families, single mothers, and children make up the largest group of people who are homeless in rural areas.

Rural Homeless

Rurality is defined based on the population density and proximity to metropolitan areas such as those developed by the U.S. Bureau of the Census, the Office of Management and Budget (OMB), and the U.S. Department of Agriculture (USDA). Rural areas are delineated to constitute all "territory, population, and housing units not classified as urban." Rural homelessness requires a more flexible definition of homelessness. Rural areas have far fewer shelters than the urban areas. People experiencing homelessness are less likely to live on the street or in a shelter and more likely to live in a car or camper, or with relatives in overcrowded or substandard housing.

Therefore, limiting the definition of homeless to those that are on the streets or in shelters does not fit the rural reality, and may exclude may rural communities from accessing federal dollars to address homelessness (National Coalition for the Homeless, 2007).

Research performed in 2005 indicated that families, single mothers, and children make up the largest group of people who are homeless in rural area. Native Americans and migrant workers are also largely represented in the homeless population of the rural areas. Research also showed a higher rate of domestic violence and lower rates of alcohol and substance abuse among the rural homeless compared to homeless in non-rural areas. The research also showed that the odds of being poor are between 1.2 to 2.3 times higher for people in nonmetropolitan areas, than in metropolitan areas. Rural homelessness is more pronounced in rural regions that are primarily agricultural (National Coalition for the Homeless, 2007).

In 2007, the National Alliance to End Homelessness examined the distribution of homelessness by geographic type. Little has been known about how many people experience homelessness in urban, rural and suburban areas. The geography type consisted of rural, urban-rural mix, mostly urban and mostly rural (see Figure 1). The subpopulations by geography were categorized as non-chronic individuals, chronic individuals, and person in families with children (see Figure 2).

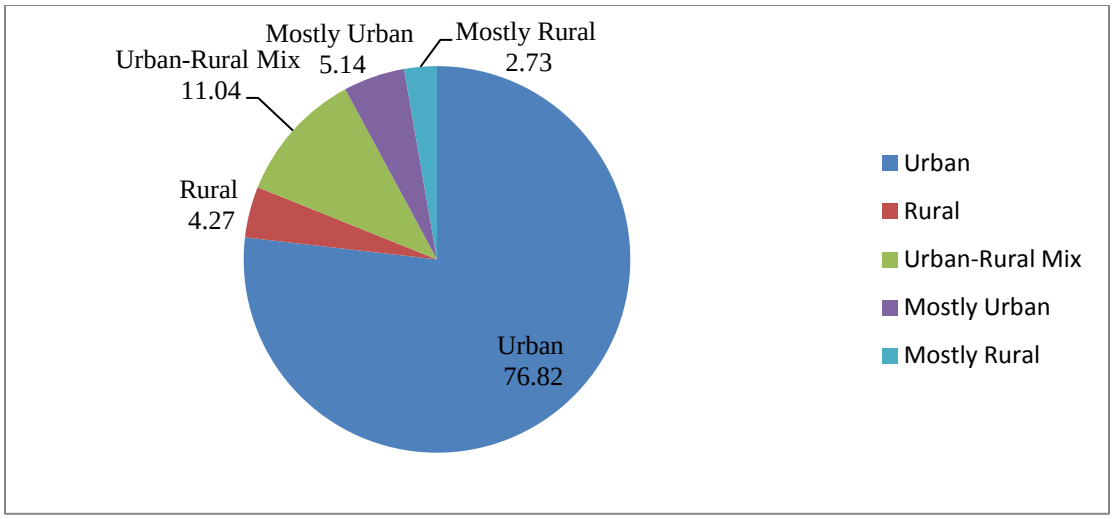

Figure 1. Percent of Total Homelessness in 2007 by Geography
Source: National Alliance to End Homelessness, 2010

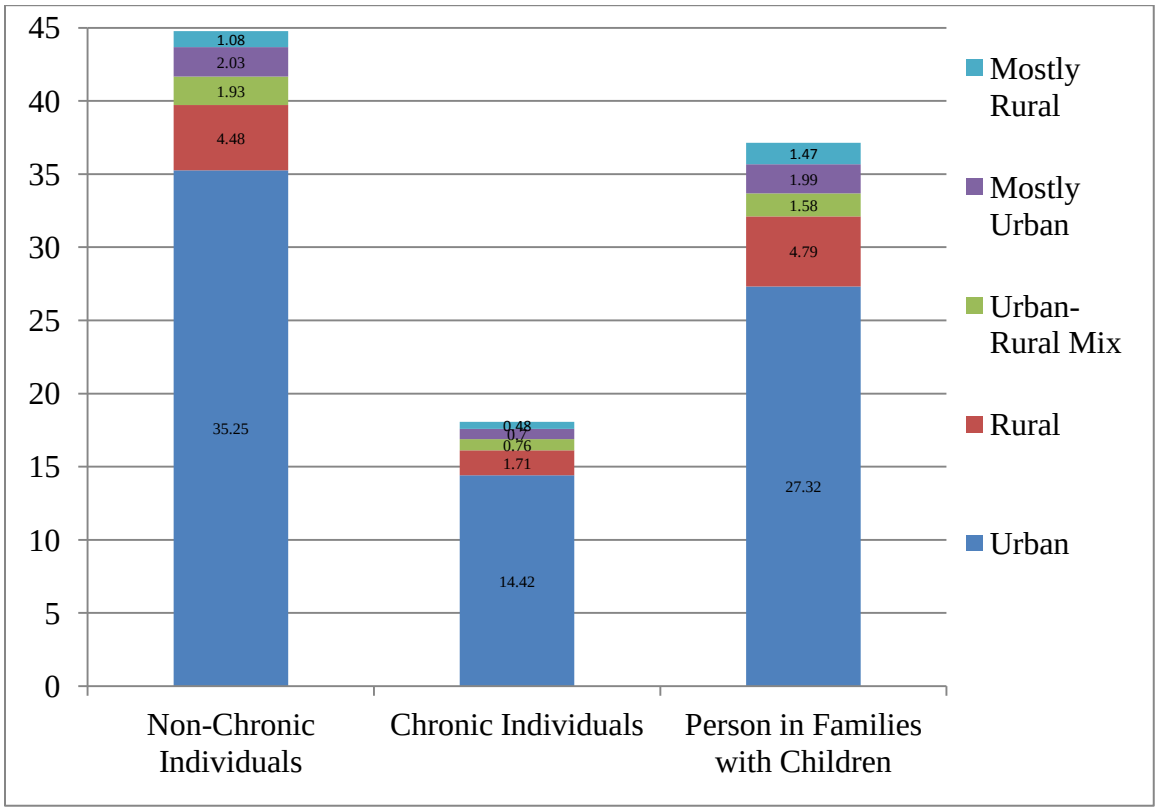

Figure 2. Subpopulations by Geography 2007
Source: National Alliance to End Homelessness, 2010

The health of urban homeless individuals has been studied for over a decade; little is known about the health of rural homeless people. Rural homeless people have been so elusive that they have been labeled as "Americans lost nations." The rural homeless are hidden because they live with relatives, friends, live in cars, abandoned buildings, parks, tent cities and woods. Data on the health of rural homeless people are limited, which contributes to isolated and haphazard health services. Rural and small-town homelessness is rising, with the numbers of women and children growing at the fastest rate. The scope of health problems for rural and homeless people is unclear due to the lack of reliable and valid data. A study was conducted in a Midwestern community on a group of rural homeless women and children to describe the health status and health resources. This data was needed to identify, develop, and test interventions for improving the health of rural homeless women and children (Craft-Rosenberg et al., 2000).

Difficulty in locating and counting rural homeless people has led to the use of generally crude estimates in their numbers. Five (the five states were not listed) out of seven states (Colorado, Delaware, Maryland, Minnesota, Ohio, Pennsylvania, and Washington) reported higher percentages of females in the rural homeless population than in the urban homeless population. Rural homeless people were reported as more likely to be younger than urban homeless, with their ethnicity being predominantly Caucasian, compared with higher ethnicity diversity in urban areas. Family units have reported higher proportion of rural homeless people than urban homeless people, and the number of homeless families has been estimated to be increasing in rural populations. Rural homeless people were more likely to be residing in their county of birth and to be homeless a shorter period of time (Craft-Rosenberg et al., 2000).

In this study, the population studied was defined as rural because the women lived in adjacent rural counties or counties adjoining a metropolitan statistical area (MSA), a city of 50,000 or more residents. A group of 131 rural homeless women in a shelter participated in the study by answering interview questions. The findings revealed higher than expected rates of illness, accidents, and adverse life events, with the incidence of substance abuse and mental illness being comparable to data from other homeless populations. Many mothers reported their children were in foster care, had been adopted, or were being cared for by others. The inability to access needed health and dental care was reported by half of the participants (Craft-Rosenberg et al., 2000).

Rural homelessness occurs due to a multitude of structural and individual factors including poverty, a shortage of affordable housing, inadequate mental health and substance abuse services, and domestic violence. Rural homelessness differs in important ways from urban homelessness: (1) rural homeless individuals tend to be less educated but are more likely employed to be; (2) rural homeless individuals are less likely to receive government assistance but more likely to have higher average monthly incomes and more likely to receive cash assistance from friends; (3) rural homeless individuals experience shorter episodes of homelessness, and are two to four times more likely to live with friends or family; (4) rural homeless individuals are as likely as other homeless individuals to report having a mental health, alcohol, or drug problem during the past month, but six times more likely than their urban counterparts to report an alcohol-only problem during the last year; and (5) rural homeless individuals are less likely to have health insurance or access to medical care (Housing Assistance Council, 2008).

Access

Health care access is defined as the "fit among personal, sociocultural, economic, and system-related factors that enable individuals, families, and communities to have timely, needed, necessary, continuous, and satisfactory health services" (Hatton et al., 2001). Abdul-Hamid and Cooney (1996) summarized that the medical literature on homeless people tends to concentrate on their biographical characteristics or clinical problems without granting enough attention to the social and environmental contexts which the homeless have to survive. Although, the homeless have an increased need for health care, they underutilize traditional health services. Abdul-Hamid (1996) reported that in 1983 Shanks described the establishment of separate primary care services for the homeless population. This study took place in Manchester, England where it was concluded that the mode of delivery of care to the homeless population was crucial because they did not use the mainstream medical services. There was a lack of cooperation between various health and social services which impacted health care intervention (Abdul-Hamid & Cooney, 1996).

Abdul-Hamid (1996) also reported that in 1988 that Shanks described a three-year prospective study to assess the morbidity of homeless people in Manchester, England. The study showed low consultation rates for cardiovascular and musculoskeletal disorders. The information collected in the study did not give the full picture of the levels of chronicity and unmet needs that are due to homeless people's restricted access to health care. Shanks concluded the services that work with homeless people should; incorporate outreach community services, address the complicated social problems of the homeless people, and adopt a multidisciplinary approach (Abdul-Hamid & Cooney, 1996).

Mostly single women with children, make up the fastest growing subgroup of the homeless population. Projections showed the number of homeless, female-headed families will increase, a phenomenon attributed to a combination of welfare reform increasing housing cost, lack of low-skill jobs, and food stamp cuts. Homeless women experience more severe physical and mental problems than the general population due to the under-utilization of health services. A qualitative field study was performed to explore how homeless women access health service especially within the context of shelter living and managed care. The interviewer conducted in-depth interviews with 19 homeless women, 6 staff from agencies serving homeless women, and two community health nurses. Findings from the study revealed that homeless women usually had circuitous rather than direct routes to health services. They typically found a social network opportunity structure where brokers could assist them into the health care system. The first tiers of access included a domestic violence shelter, shelter for single homeless women, and a café offering low-cost meals to inner city homeless population. The needs of impoverished women access are still complicated with these opportunities, the conditions of managed care and. Access requires policies that address not only availability of health professionals, but also tiers of access that include a social network opportunity structure where women can interact with advocates who broker their entry into the health care system (Hatton, 2001).

The extent to which the homeless are able to obtain health care across the spectrum is largely unknown. Homeless people experience poor access to health care leading to delayed clinical presentations, increased reliance on emergency departments,

and higher rates of hospitalization, often for preventable conditions. In most studies of homeless people, access to health care is based on studies of single cities or single types of unmet need; very few national surveys have adequately captured this difficult-to-reach population (Baggett, O'Connell, Singer, & Rigotti, 2010).

Recent history and current etiologies of homeless in the United States, present information regarding homeless persons and their health problems, and describes steps healthcare providers can take to care for homeless patients to try to overcome the social problem of homelessness. Most issues relevant to homelessness affect both men and women, but homeless women have unique circumstances and health problems. Homelessness is largely ignored by the mainstream press and the general public, and the numbers affected continue to grow. Over 7% of persons living in the United States have been homeless at some point in their lives. Approximately, 20% of homeless persons maintain full-or part-time jobs, but only 5% are privately insured. Because of the lack of health insurance, homeless persons tend not to get adequate preventative care and appropriate routine management of such chronic illnesses as hypertension, heart disease, diabetes, and emphysema. Other barriers to health care include denial of health problems, the pressure to fulfill competing nonfinancial needs and misconceptions, prejudices and frustrations on the part of health professionals. According to previous studies, the average length of stay in the hospital of a homeless individual was 4.1 days, or 36% longer that of low-income, non-homeless individuals, even after adjustment for differences in the rates of substance abuse and mental illness and other clinical and demographic characteristics. The average life span of the homeless is shorter than 45 years (Donohoe, 2004).

A descriptive phenomenological study was performed to look at the health care experience through the eyes of the homeless person. The literature review showed growing data about the health problems of homeless people and issues of access to care. Little is known about the experience of being ill while homeless and the experience of receiving health care services from the perspective of homeless people particularly in the United States. The survey sample consisted of interviews with homeless adults. Four major themes emerged: (1) living without essential resources compromises health; (2) putting off health care until a crisis arises; (3) encountering barriers to receiving health care to include, social triage, feeling labeled and stigmatized, nonsystematic for health care for the homeless, being treated with disrespect, and feeling invisible to health care providers; (4) developing underground resourcefulness. The study concluded that being homeless is difficult enough but accessing health care while homeless is even more daunting. Homeless people experience higher rates of poor health. Worse than poor health itself is the barriers to accessing even minimal health care (Martins, 2008).

The United States adopted a national priority to attempt to reduce or eliminate disparities in health and health care. Health care is not equally financially available to all individuals in the United States. The potential for delaying or missing needed care is intensified, particularly among vulnerable populations. Vulnerable populations are defined as persons at greater risk for poor health and lack health care access. The vulnerable population group can be categorized by diseases (e.g., HIV), age groups (e.g., the elderly), and demographics (e.g., homeless individuals). Health care initiatives to reduce barriers rarely recognize the common overlap of risk factors, and few studies have examined the combined influences of multiple risks of obtaining needed health care

services. Shi and Stevens (2005) revieed the 2000 National Health Interview Survey analyzed data from 32,374 adults to present a profile of risk factors for poor access based on income, insurance coverage, regular source of care, the association of the profiles with unmet health care needs due to cost. The results of the study showed that whites were more likely than any other racial/ethnic groups to report unmet needs. Individuals who were low income, uninsured, and had no regular source of care were more likely to miss or delay needed health care services due to cost. Hispanics were more likely than other groups to have 2 or more risk factors (36.0%) compared to African Americans (19.7%), Asians (17.7%), and whites (9.66%). The survey concluded that without attention to co-occurring risk factors for poor access, it is unlikely that substantial reductions in disparities will be made in assuring access to needed health care services among vulnerable populations (Shi & Stevens, 2005).

Women are disproportionately affected by the escalating problem of homelessness. Homeless individuals experience serious barriers to obtaining health care and homeless women face an additional burden by virtue of their sexual and reproductive health needs. Homeless women experience higher rates of unintended pregnancy than other women. A qualitative/quantitative study was performed to investigate homeless women's access and barriers to family planning and women's health care. Forty-seven homeless women were interviewed for the study of diverse ages and ethnic backgrounds. The purpose of the study was to determine the barriers homeless women uniquely face, by virtue of the fact of being poor and homeless, in obtaining reproductive and gynecological health care; and to use this information to suggest interventions to enhance homeless women's ability to use birth control, family planning, and general gynecological services.

Findings showed that women in this study generally knew where to go for women's health services. The fact that health services were available did not mean they were used. Health is not a priority for homeless women. Access was impeded by cost, limited clinic hours, difficulty or inability to get appointments, and transportation. Another serious concern is the acceptability of available health service. Women repeatedly talked about the negative attitude of physicians and other providers that lead them to avoid health care all together. The study showed that having children was extremely important to the women in this study, despite being homeless. The study concluded with suggested interventions that would make general, gynecological, and reproductive health care more accessible to homeless women. Issues associated with providing care to homeless women should be included in the education of health care professionals and in continuing medical education courses for providers of health care to this group (Gelberg, Browner, Lejano & Arangua, 2004).

Reproductive health care is especially challenging for clinicians serving individuals who are homeless. Unprotected sex is associated with high rates of sexually transmitted diseases among homeless adults and youths. According to research, HIV infection has been reported to be at least three times more prevalent among homeless people (3.4%) than the general population (1%). A recent study found that 92% of homeless women surveyed had experienced severe physical and/or sexual assault at some time in their lives (60% before age of 12), and 39% suffered from posttraumatic stress disorder. Ninety-five percent of homeless women are sexually active, yet less than one

percent of homeless women currently use condoms. Primary care providers who serve homeless people recognize the need to take living situation and co-occurring disorders into consideration when developing a plan of care with the homeless (Bonin et al., 2003).

Homeless individuals and families are sicker and die faster than those who are housed. The realities of homelessness contribute to poor health and poor health may lead to and sustain homelessness when individuals are unable to obtain access to preventive care.

Disproportionately more studies have focused on mental health, substance use and risky sexual behaviors of the homeless population. Also, there is evidence that homeless individuals suffer from chronic medical conditions at higher rates than their housed counterparts. In 2003, a national survey was conducted using almost 200 U.S. Health Care for the Homeless (HCH) clinics with a response rate of approximately 71% to examine the health status of its users. The study employed the HCH User Visit Survey's cross-sectional data set to evaluate health indicators of individuals using HCH Services with the US population, and compare individuals who reported they routinely used HCH clinics to those who did not. The survey concluded that homeless adults exhibited much higher prevalence rates in many health problems when compared to the general population. Only 12.3% of the general population in the United States reported their health status as fair/poor, compared to 44.0% of homeless people using the HCH clinics. Many homeless individuals have difficulty gaining access to health care services and receive little or fragmented health care (Zlotnick & Zerger, 2008).

The first nationally representative survey of individuals using clinical services was conducted as a secondary analysis of the 2003 Health Care for the Homeless (HCH). The purpose of the study was to assess the prevalence and predicators of the unmet needs for five types of health care service in a national study of homeless adults. The five types of health care services were defined as medical or surgical care, prescription medications, mental health care or counseling, eyeglasses, and dental care. The data from 966 adult respondents to the 2003 HCH survey represented more than 436000 individuals nationally. The results showed that 73% of the respondents reported at least one unmet need, including the inability to obtain needed medical or surgical care (32%) prescription medications (36%), mental health (21%), eyeglasses (41%), and dental care (41%). Significant predicators of unmet needs included food insufficiency, out-of-home placement of a minor, vision impairment, and lack of health insurance. The study concluded that there were substantial unmet needs of the homeless for multiple types of health care (Baggett et al., 2010).

A study was conducted in 2005 on secondary data analysis of the National Survey of American Families to determine the association between housing instability and food insecurity and access to ambulatory health care and rates of acute health care utilization. Research showed persons experiencing hunger generate more cost per diagnostic-related group. Diabetics with insufficient food supply have increased hypoglycemic episodes and increased health care utilization. Housing instability and food insecurity represent more widespread forms of homelessness and hunger. Housing instability is defined as having difficulty paying rent, spending more than 50% of household income on housing, frequent moves, living in overcrowded conditions or doubling up with friends or

relatives. Food insecurity is defined as having limited availability of nutritionally adequate and safe food or the ability to acquire foods in socially acceptable ways. It is estimated annually that 39 million people experience food insecurity. The study concluded housing instability and food insecurity are associated with poor access to ambulatory care and high rates of acute care. The competing demand of housing and food may lead to delays in seeking care and predispose to acute care (Kushel, Gupta, Gee & Haas, 2006).

Given the opportunity, homeless people are willing to obtain health care for chronic conditions if they believe such care is important. Homeless people are dependent upon acute care, such as hospital-based services. Homeless individuals have fewer encounters with ambulatory care than non-homeless people, despite having a higher burden of illness. The state of homelessness has proven to be a long-lasting problem in diverse regions of the country, creating a large toll of human suffering as well as a complex burden on the safety-net health care system. A study was performed by the National Survey of American Families on homeless people interviewed through homeless assistance programs throughout the United States. The purpose of the study was to describe factors associated with use of perceived barriers to receipt of health care among homeless people. The study concluded that homeless people reported high levels of competing barriers of health care needs and used acute hospital-based care at high rates. Some provision of insurance may improve the substantial morbidity experienced by homeless people and decrease their reliance on acute hospital-based care (Kushel, Vittinghoff, & Haas, 2001).

Social Determinants

Homelessness has been a significant public health concern for the past 20 years. Broad social processes, such as changes in economic opportunities, and institutional factors, such as fragmentation of social services, have been associated with a rise in prevalence and incidence of homelessness. In a national representative survey, 7% of respondents said they had been homeless at some point in their lives. Homelessness has been associated with high levels of all-causes mortality, mental health disorders, and prevalence of infectious disease such as tuberculosis. Illicit drug users (IDU) make up a significant proportion of the homeless in the United States; approximately 10-20% of the homeless people are drug abusers. A survey conducted in New Haven, identified drug use as the primary reason for homelessness in one-quarter of homeless people (Galea & Vlahov, 2002).

Illicit drug use is a significant risk for poor health and high-risk behavior among homeless adults. Homeless people tend to practice few risk-reduction behaviors, and tend to engage in high-risk behaviors, such as trading sex for drugs and money. Lack of appropriate living arrangements has been associated with higher prevalence risky behaviors by women. Mental illness, high among the homeless, compounds high-risk drug use behavior by homeless IDUs and by drug users with few socioeconomic resources. High frequency of drug injection and use of crack cocaine are predictors of HIV infection in homeless IDUs. These HIV risk behaviors are associated with the severity of homeless circumstances. Cohabitation in overcrowded homeless increases the risk of airborne infections. Homelessness limits users' access to appropriate drug treatment and medical care (Galea & Vlahov, 2002).

Determinants of first-time homelessness were evaluated in Sacramento, California and Lehigh Valley, Pennsylvania. Homeless women comprise an ever-increasing proportion of the homeless population. This study provided information about risk factors for homelessness in women, such as childhood and adult exposure to violence, pregnancy, and substance abuse. The distinction between first-time and repeated homeless women is crucial to understanding the causes of homelessness. Figure 3 illustrates a model of homelessness specifying that housing and economic instabilities are the primary causes of first-time homelessness, although family instability and personal risk factors also contribute to increased risk. Housing instability include eviction, unsafe housing, overcrowding, relocation, and a tight housing market; examples of economic instability are employment loss, underemployment, and inadequate welfare benefits; family instability are divorce, domestic violence, and the lack of a support network; and personal risk factors include substance abuse, low education, parenthood, and physical or mental health problems (Lehmann, Kass, Drake, & Nichols, 2007).

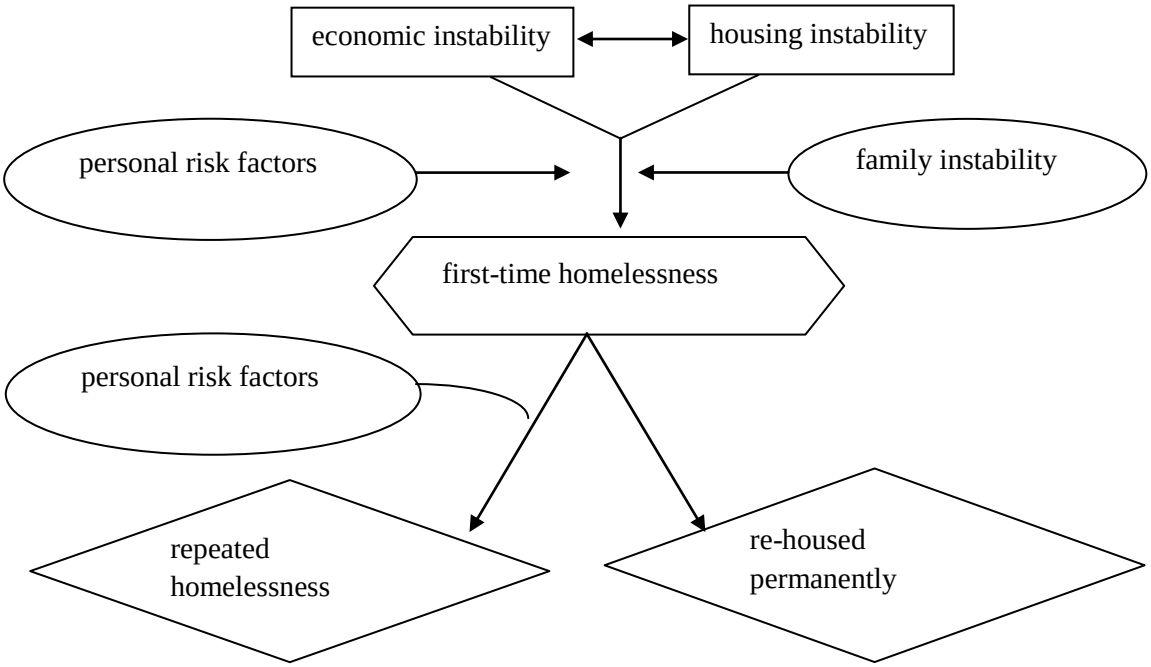

Figure 3. First-Time Homelessness in Low-Income Women
American Journal of Orthopsychiatry, 2007

According to this model, prevalence studies indicate that personal risk factors such as substance abuse and mental illness cause homelessness. The goal of the Stanford Center for the study of Families, Children and Youth (1991) was to (a) compare the personal and situational characteristics of newly homeless women and never-homeless housed women, and (b) to create a model of risk factors associated with first-time homelessness. The study showed that women under the age of 35 appeared to face unique risks for homelessness. Younger women were more likely to have young children, which had been previously reported as a risk factor for homelessness. A higher number of women in this study had been employed, a lower proportion had never married, and a lower proportion was pregnant or had recently given birth. Homeless women had higher levels of education than housed women even when age was analytically controlled. The risk of homelessness increased substantially with an increase in the number of risk

factors. Risk factors were predominantly similar for women at opposite ends of the United States (Lehmann , et al., 2007).

Results from the study supported the model of first-time homelessness. Service providers should be made aware that the majority of first-time homeless women require primary economic and housing assistance, and screening should be provided to identify those requiring more intensive service to prevent repeated homelessness. The study indicated that the trajectory from employment loss to homelessness generally occurs over several months, but the transition from eviction to homelessness was rapid (Lehmann , et al., 2007).

Mental Health

Homeless women show disproportionally high prevalence rates of lifetime mental health problems. The National Survey of Homeless Assistance Providers and Clients (NSHAPC), a data set comprising a nationwide sample of homeless adults, found that only 28% of women living with children had never had any problem with alcohol, drugs, or mental health in their lifetime. Of the remaining 72% of women living with children, 54% had a mental health problem, 40% had an alcohol problem and 46% had a drug problem. With high rates of psychiatric and substance use problems, homeless women need a wide variety of services, including behavioral, medical, and human services. The study was performed focusing on homeless women with and without symptoms of mental illness which examined the association of predisposing, enabling, and need factors (based on Aday-Andersen's health services utilization model) with use of behavioral, medical and human services (Tam, Zlotnick, & Bradley, 2008).

In some studies utilizing the health services model, need factors were the best predictors of service utilization among homeless individuals. In other studies, need for services was more strongly related to obtaining physical or mental health care services for adults without substance abuse problems compared with those with problems, indicating that substance abuse may be a barrier to needed services. The study findings illustrated that homeless women with symptoms of mental illness showed higher rates of service use in behavior, medical and human domains, which indicated that there are stronger service linkages for this group than for women without symptoms of mental illness. Mental illness may be a trigger for receiving additional services once homeless women gain entry into a service system. There was a negative association between symptoms of mental illness and use of behavior services among homeless mothers, which may have resulted from the fear of loss of child custody. Unfortunately, homeless adults who self-identified as belonging to ethnic-racial minority groups are less likely to obtain needed services (Tam et al., 2008).

The profile of homelessness has shifted dramatically in the recent decade to an increasing proportion of women and racial/ethnic minorities without stable housing. Homeless women are more likely than their housed counterparts to experience mental health problems ranging from generalized depression and anxiety to more serious diagnoses such as schizophrenia and post-traumatic stress disorder. The study found a homelessness rate of 15% in a sample of individuals receiving treatment for bipolar disorder, schizophrenia, or major depression. However, a higher proportion of homeless individuals experience general mental distress or “demoralization” as they struggle to meet their daily needs for food and shelter (Austin, Andersen & Gelberg, 2008).

This study explored ethnic differences in homeless women's metal health using a short inventory of mental distress administered to homeless women in Los Angeles. The sample individuals have been identified by social service agencies or the courts as needing care of mental health or substance abuse problems. Psychiatric hospitalization is often used as a measure of mental health in this population. Homeless individuals are often hospitalized for issues misdiagnosed as psychiatric problems, including substance abuse or assault. Psychiatric hospitalization may be reasonable proxy for severe mental illness; it is also a measure of access to medical care which makes it unsuitable for identifying general mental distress in this population (Austin et al., 2008).

The homeless population is a major challenge for service providers and policymakers. It suffers from multiple risk factors, including disproportionately high rates of mental illness and substance use and abuse. The study was performed in an attempt to understand the risk factors of the homeless and their changing roles which are essential for the development of effective policies and programs that addressed the public concerns of the homeless population. The study examined the prevalence of psychiatric illness among three homeless populations in St. Louis, Missouri in approximately 1980, 1990 and 2000. The comparison of the homeless population over time has been impeded by methodological difficulties, including an inconsistent definition of homelessness, varied sampling strategies and locations and disparate measurement instruments. The results of the study showed the prevalence of mood and substance use disorders dramatically increased, and the number of minorities with these populations has increased. Service systems need to be aware of potential prevalence changes and the impact of these changes on service needs (North, Eyrich, Pollio & Spitznagel, 2004).

A total of 821 women were included in this study. Sample population surveyed consisted of 67% African American, 16% Hispanic and 17% White. White women reported the greatest mental distress, followed by Hispanics. White women had been homeless longer on average and experienced more lifetime episodes of homelessness and African American women were older on average when they first became homeless. Hispanics were more like to have stayed at a shelter or institution and less likely to have spent time on the streets. Almost half of the women in the study had a mental distress score suggesting the need for further evaluation and possible clinical intervention. The role of physical and sexual abuse is underestimated in the lives of homeless women and the consequent mental distress that they experience. Hispanic women (especially mothers) seem vulnerable to the stress associated with living on the streets. Hispanic women also are less likely to seek out services due to fear of deportation because of language barriers (Austin et al., 2008).

Migration

Some commentators have described the labeling of homeless people as ‘tramps’, ‘drifters’ or ‘transients’ as misleading, arguing that these titles over-exaggerate the stereotype of the homeless as an excessively migrant population. Research shows that the migrant homeless individual was more likely to be young never married, White, mentally disordered, and either newly or cyclically homeless. The migrancy of homeless people is important when planning and targeting appropriate health and social service to address their varying health, social and psychological needs. This study was conducted using the inner-city health center for the homeless in the north of England to see if there was a link

between the differences of health problems and migrancy of homeless people. The study identified statistically significant differences for the migration of homeless people from their place of birth for age, problematic drug use and problematic alcohol use (Tompkins, Wright, Sheard, & Allgar, 2003).

Despite the categorization of homeless people as transients, there has been very little research on migration among the homeless. Based on the available research, two patterns are evident; (a) many homeless have strong social ties with "homed" as well as homeless family and friends and (b) many recent homeless are not migrants but rather native to the area or long term residents. Studies document a consistent pattern of stability among the homeless since the 1980s, with the majority being long-term residents of their current location. The demographic factors of age and race have been identified as correlation factors of migration among the homeless with younger homeless and Whites more likely to be migrants. Migration is also a result of lack of employment, residential opportunities, and social support. The migration status of homeless persons is one of the most consistently used criterions in typologies to differentiate homeless groups. The study was performed to examine differences in the social and psychological well-being of migrant and non-migrant homeless. The study showed there was a significant interaction effect between migration status and mastery (control over events in life), with mastery being a more salient resource for the mental health of migrants. Table 1 demonstrates the differences in the characteristics of migrant and non-migrant homeless people comparing demographics stressors and psychosocial resources variables (Lindquist, LaGory, & Ritchey, 1999). The climate is another environmental factor that has a significant effect on the migration of the homeless.

Table 1. Characteristics of Migrant and Nonmigrant Homeless on All Variables

	Migrant (n = 63)	Nonmigrant (n = 98)
Demographics		
Mean age	35.4 years	38.2 years
Percent female	41%	33%
Percent Black	54%*	69%*
Mean monthly income (unlogged)	$418	$362
Education (categories)	3.8	3.4
Stressors		
Mean no. life events	4.0	3.7
Mean no. daily hassles	2.2	2.6
Perceived danger score	2.7	2.7
Percent victimized	25%	34%
Percent street user (vs. shelter)	21%	33%
Happy childhood score	2.2*	2.6*
Length of homelessness (unlogged)	71 weeks	114 weeks
From outside of Alabama	50%	–
Psychosocial resources		
Mastery of fate score	10.6	10.4
Social ties score	4.5	5.5
Outcomes		
Depression (CES-D score)	25.5	25.4

*Indicates differences between recent and long-term residents at the .05 level of significance.

Source: Sociological Perspectives, P700, 1999

The homeless are one of the most vulnerable groups impacted by climate change. Migrating homeless are more likely not to have access to or knowledge of available shelters in the areas, or do not utilize shelter facilities. The impacts of climate change can be addressed by adaptation and migration. The change in climate is associated with high rates of poorly controlled chronic disease, smoking, respiratory conditions, mental illness, exposure to extreme temperatures, and vector populations. Heat waves increase the risk factors for mortality and morbidity of homeless individuals. Research has shown the risk of death from extreme heat triples with pre-existing psychiatric illness. There are other

risk factors associated with death during heat waves including cardiovascular disease, pulmonary disease, advanced age, living alone, being socially isolated, not using air conditioning, alcoholism, using tranquilizers, and cognitive impairment. About 91% of the homeless populations in the United States live in urban or suburban areas, where they are at an increased risk for heat waves due to the heat island effect (Ramin, & Svoboda, 2009).

There are an estimated 800,000 deaths related to air pollution per year. Air pollution is found to disproportionately impact those suffering from cardio-respiratory conditions, ischemic heart disease, peripheral vascular disease, chronic obstructive pulmonary disease (COPD) and asthma. The homeless are particularly susceptible to illness and death from climate change related to an increase in air pollutants due to their high levels of exposure to outdoor air pollution and underlying respiratory and cardiovascular conditions which are often poorly controlled (Ramin, & Svoboda, 2009).

Floods, storms and natural disasters affect everyone in area. Homeless people occupy marginal areas that are more vulnerable to environmental hazards. The urban homeless are not often considered in disaster planning. There are high risk factors for adverse health outcomes after disasters due to baseline poor health. Research has associated the warm dry summers resulting from climate change with West Nile Virus. Individuals sleeping outdoors are at increased risk of exposure to mosquito bites. The homeless individual is vulnerable to vector-borne infectious diseases that may compromise the immune system affecting chronic conditions such as diabetes, heart disease, or alcoholism, that are highly prevalence amongst the homeless (Ramin & Svoboda, 2009).

Health Care Promotion

Health promotion emphasizes the concepts of lifestyle, risk and preventive health behavior with the broader societal concerns of the environment, public police and culture. There have been extensive reviews on homelessness and health, but little attention has been paid to the health promotion needs of homeless people (Power et al., 1999).

Homeless people are often considered 'unpopular patients' because of their non-compliance with medical treatment, which make their treatment time consuming and difficulty to discharge from the hospital. There are several barriers to health promotion for homeless people including limited access, lack of support and advice for those working with homeless people, lack of collaboration between agencies, limited resources, lack of national or local strategies, negative attitudes and stereotypes, social marginalization of homeless people and lack of evidence-based health promotion practice. These barriers must be addressed for health promotion to be successful. Evidence shows that homeless people in established shelters are still unable to access health care services, particularly when there is poor literacy and mental health problems. Homeless people past experiences make them reluctant to approach services (Power & Health Education Aurthority, 1999).

The Report of the Health Education Authority (1999) defined health promotion as the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health. The immediate health promotion needs for the homeless begin with the supply of food and shelter. These are the most essential needs to be met to eliminate competing priority for enforcing more abstract

interventions. Most health promotion interventions are categorized into one of five recognized approaches: educational, behavior change, client-centered, medical or social change (Power & Health Education Aurthority, 1999).

The educational approach is usually effective when using peer interventions for targeting health promotion activities of hard-to-reach groups. The benefits of peer intervention include: 1) the greater trust, credibility and acceptability of peers; 2) peers are often better positioned to identify target groups and access them through social networks; 3) the good knowledge or personal experience which peers have of the target group; 4) shared interests and similar language; and 5) the additional benefit of empowering the peers themselves. Behavioral change approach is aimed at risk reduction in the fields of substance use and unsafe sex. Individual risk taking decisions represent a balancing act in which perceptions of risk are weighed against propensity to take risk. Homeless people's perception of risk and the ability to control or balance their behavior is relative norm to their peer network, environmental and social factors. Figure 4 demonstrates the risk thermostat for balancing behavior (Power & Health Education Aurthority,1999).

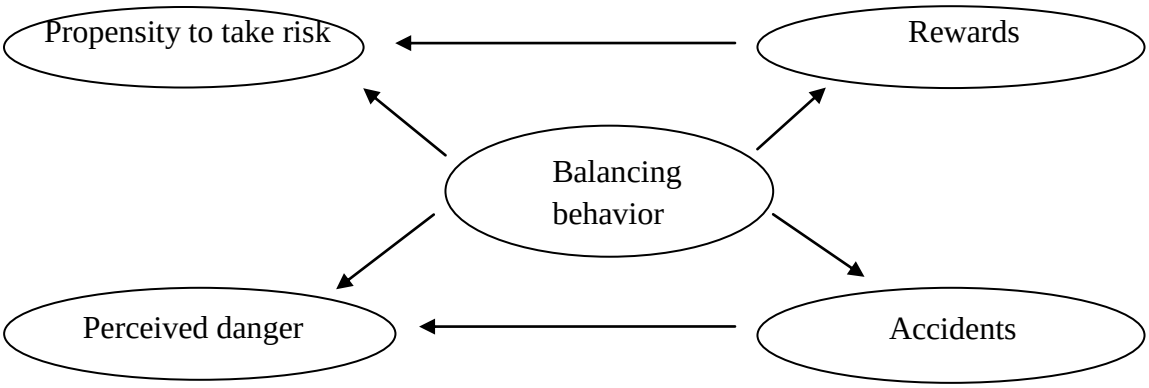

Figure 4. The Risk Thermostat
Health Education Authority, 1999

The client-centered approach focuses on the 'bottom-up' activities where the client sets the agenda; it's the concept of social capital. Social capital stems from the needs of the target population. Homeless people often isolate themselves from traditional health care services and look for information to be passed on through sub-culture which exists through necessity rather than choice. The outcomes of social capital should be measured by community change such as accessibility of services, policy development, liaison between statutory organizations and community groups and how information is passed on (Power & Health Education Aurthority, 1999).

Medical approach focuses on promoting preventative medical procedures such as screening programs or health services defined by medical professionals. However, homeless people are striving to meet their basic physiological needs and; medically defined problems may not be considered a priority. The social change approach focuses on altering what is perceived to be the norm within a group. General knowledge of who the homeless are and what causes homelessness can change the public perceptions and attitudes towards homeless people (Power & Health Education Aurthority, 1999).

A descriptive study was performed on sheltered homeless women to describe sociodemographic and personal characteristics, health practices, and health-promoting behaviors in a specific Midwest geographical region to increase awareness, understanding, and provide further insight into the complex area of homelessness and health. Homeless people often delay seeking medical treatment until their symptoms become intolerable or severe, waiting up to 3 months before seeking treatment. Homeless women health status is generally more likely to be reported as poor or fair. Data analyzed in this study from the Pender's Health Promotion Model indicated that homeless women

were noted to practice health-promoting behaviors in all areas (health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, and stress management) but scored lowest on physical activity and nutrition. The sample chosen for the study was limited to homeless women, well educated, single, mostly employed, and homeless due to relationship problems/conflict per self-reported. The sample represented a special population of well-educated homeless women which does not represent the norm for most of the homeless population (Wilson, 2005).

Because of the need for targeted health promotion aimed at homeless populations, a survey of 100 *Big Issue* newspaper vendors was conducted along with in-depth interviews and focus groups to identify health promotion needs. It is a challenge to develop and deliver health promotion initiatives to a heterogeneous population of homeless people. Compared to the general population, the health status of homeless people is extremely poor concerning health issues such as diet and malnutrition, sexual health, substance misuse, and mental health. A wide range of physical problems have been associated with the living conditions and lifestyles of the homeless, ranging from cardiovascular disease to accidents and hypothermia. The study of the health-seeking behavior showed that forty-four percent of the homeless had been to a hospital emergency department and twenty percent to a drug and alcohol service. The study also reflected the complex nature of the condition of being homeless. The Likert scale was used to measure "worry", which ranged from 'often' to 'not at all'. Approximately, 53% often worried about money, 39% often worried about their families, 36% often worried about accommodation and 30% often worried about their health. The results also showed how health problems may be perceived as less important than more immediate concerns:

"If you're homeless and penniless, the big problems don't really matter. It's the day to day problems. Where is the next meal or where you're sleeping…..basic things just add up." (Power & Hunter, 2001, p. 596).

The key to implementing health care promotions is to identify the needs of the target groups and ensure the most appropriate venues necessary to reach the targeted population. The use of social mapping is a method of formative evaluation to assist in the development of community based health promotion interventions. Generic and targeted health promotion activities are recommended, and the role of health advocacy and peer education should be further explored (Power & Hunter, 2001).

The study performed showed homeless childbearing women are at greater risk for cancer, violence, outcomes such as preterm labor and preterm birth. Preterm labor and preterm birth occurs when an infant is born before 37 completed weeks of gestation and is associated with signficant neonatl morbidity and mortality. Recent data showed pretem birth rates are highest in the United States for Black/African American (18.1%) infants. Homeless women and those with insecure living situations were at significant increased risk of delivering early. Researchers found that more life-long episodes of homelessness significantly increased homeless women's risk of delivering prematurely, and this association was most pronounced for Black and Latina mothers. Homeless women reported challenges in securing prenatal care, negative provider attitudes, drug use, and lack of support from the baby's father (Stringer, Averbuch, Brooks & Jemmott, 2011).

In a collaboration with personnel at women's shelters, researchers studied homeless childbearing women's knowledge, attitudes, and beliefs about general health promotion, healthy pregnanacy promotion and preterm labor prevention. Three themes

were identified during the study: things you do to stay health during pregnancy, where you learned about staying healthy, and women's knowledge about preterm labor and general health promotion. The participants stated that attending prenatal classes was important for staying healthy during pregnancy and identified barriers to attending care to include transportation and lack of insurance. Homeless women face challenges with eating healthy foods during pregnancy. Many women stated they learned about ways to stay healthy during their pregnancies from their mothers, doctors, and in health class at school. The participants expressed little knowledge related to preterm labor, they believed that preterm labor is related to stress or disease. The women were very interested in learning more about reasons for and prevention of miscarriages. They were also interested in the discussion of family planning, including methods, effectiveness, and availability. The participants wanted to continue to attend learning sessions if they were healthy at the shelters where they were currently living and would consider attending sessions at a community center, library, or health fairs (Stringer et al., 2011).

Underserved women face numerous barriers in their pursuit to adopt healthy eating behaviors. In order to develop effective health-promotion interventions barrieres, specific for the underserved women need must be addressed. The National Institutes of Health has prioritized research that develops knowledge about underserved populations and training minority researchers about strategies toward eliminating heath disparities. Research was performed to examine how different types of barriers influence healthy eating in underserved women, how individual characteristics, eperiences, and culture influences barries, and what approach could be used to address these barriers. "Barriers" were defined as factors that impede health-promoting behavior. Barriers are an important

component of conceptual frameworks used to facilitate lifestyle change. There are three different types of barriers, internal, interpersonal and environmental that are influced by individual characteristics, experiences and culture and can overlap to impede healthy eating in underserved women. Figure 5 shows the relations among the types of barriers (Timmerman, 2006).

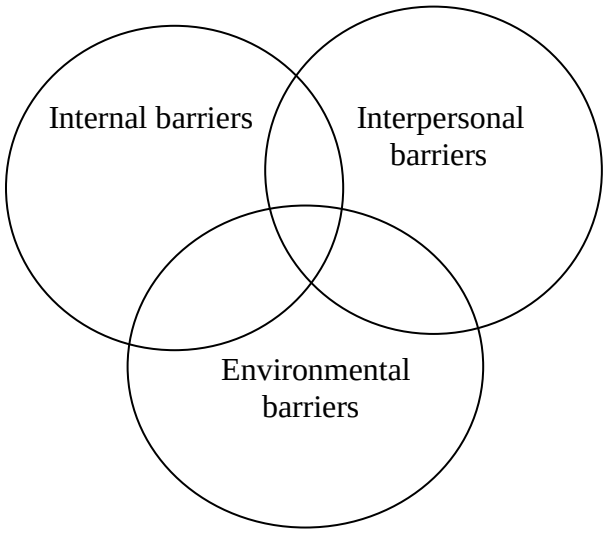

Figure 5. Relationships among Types of Barriers
Source: Timmerman, 2006. p. S35

Internal barriers include a variety of interal thoughts and emotions that interfere with the individuals choice to make behavioral changes. Internal barries include lack of time and motivation, lack of knowledge, enjoyment of the "bad" behavior, inconvenience, fatigue, boredom and disbelief in change making a difference. The key to overcoming internal barrieres to behavior change takes resolving the conflict between one's intellectual self and one's emotional self. Interpersonal relationships are barriers that encourage unhealthy behaviors or discourage behavior change. Reseachers found that women in caretaking roles in families may indirectly pose a barrier to behavior

change. Environmental barriers are those factors in the environment that make if difficult to change behavior. The environment needs to include access to sufficient quantities of high-quality fruits and vegetables at affordable prices. Individuals from low-income households are less likely to have access to supermarkets with the same variety of affordable fruits and vegetables available to people living in surburban areas. Environmental barries are more problematic for underserved women because they may influence internal and interpersonal barriers (Timmerman, 2006).

Four potential approaches for addressing barriers to health promotion were identified: (1) indivdualizing interventions; (2) developing collaborative partnership within the community; (3) using positive deviance inquiry to build on community assets; and(4) changing public policy. This study revealed that reserachers, healthcare professionals, healthcare consumers, and health policy experts need to focus attention on a variety of ways to deal with barriers so that multiple, innovative solutions can be developed. Figures 6 shows the approaches to dealing with barriers to health promotion (Timmerman, 2006).

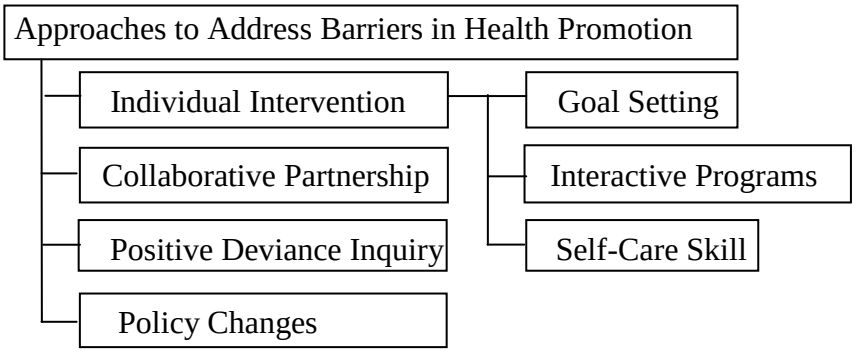

Figure 6. Approaches to Dealing with Barriers to Health Promotion
Source: Timmerman, 2006. p. S38

Comprehensive plans to overcome different types of barriers need to be an integral component of health –promotion interventions. As researchers and healthcare professionals rally forth in their attempt to eliminate health disparities, creative solutions are needed to address barriers to lifestyle changes (Timmerman, 2006).

The concept of Internet application for health promotion is the notion of Interactive Health Communication (IHC) as an adjunct to clinical practice that can be useful in disseminating quality health information, facilitating informed decision-making, offering peer support, and providing expert consultation to clients. IHC is defined as "interaction of an individual-customer, patient, caregiver, or professional – with or through an electronic device or communication technology to access or transmit health information or to receive guidance and support on a health-related issue. IHC is not the usual health support mechanism to address the chronic health issues of the homeless population. The homeless population has limited or misinformation about their health condition and its treatment, with difficulty in managing chronic conditions. Emerging evidence suggests that having access to the Internet and a well-designed interactive health communication program can provide significant benefits to economically disadvantaged populations. The homeless population has a large number of people with chronic health conditions and disabilities and typically limited access to computers and knowledge of how to use them. The Center for Collaborative Research and the Department of Occupational Therapy and Physical Therapy in the Jefferson College of Health Professions has been involved in a project to improve the lives of homeless individuals in city housing programs. Three computer labs were created in three housing programs designed to help homeless individuals make the transition to sufficiency. There were two

major goals: 1) design and implement an effective and relevant e-health promotion website for homeless individuals with chronic health conditions and the staff serving this population; and 2) train interdisciplinary teams of students in the use of interactive health communication technology as a part of community health initiatives. The preliminary results suggested that this underserved population, who was making the transition to self-sufficiency, was highly motivated to have access to health care information (Miller, Cornman-Levy, & Lyons, 2002).

Shelters

According to Mandell (2009), the number of homeless people has increased dramatically during the Reagan Administration due to the federal government's cut back on building houses and subsidizing housing for low-income people as well as social assistance programs. A study performed by Harvard's Joint Center for Housing documented that as housing costs have risen, wages have declined, increased numbers of people cannot afford housing (including the middle class), and more jobs pay lower wages (Mandell, 2009).

Emergency public shelters for the homeless began opening in 1983 and over the next couple of decades, shelters grew from being a temporary emergency response to become a permanent shelter industry. There were 62,000 homeless shelters in the United States in 2002. Most homeless shelters for individuals allow people to stay at night only. Many shelters do not provide space for personal belongings. Many homeless individuals will not go to a homeless shelter until the weather becomes an issue because the shelters are crowded and dangerous (Mandell, 2009).

A study by Means (2001) showed that one becomes homeless either suddenly or gradually. Women who suddenly lose their homes through fire, flood, or nature disaster are quickly channeled into relief efforts, given emergency assistance and emotional, support, and often regain their homes within months. Women who lose their homes through poverty tend to lose their homes slowly. Women with children who are unable to make ends meet may qualify for Transitional Aid to Needy Families (TANF). However, the benefits for TANF have not kept up with cost of living expenses. Women who impulsively flee abusive relationships face a myriad of government agencies and demands for "proof" of their poverty in order to receive service. Shelters for women were not established until the 1970s. Moving into a shelter often means separating from one's familiar places the neighborhood, church, children's schools and friends, and medical facilities. Nationally, there are more homeless women than beds, which mean that women without homes have no predictable guarantees of safety or protection (Means, 2001).

Public shelters have become institutionalized over time, drawing in vulnerable and marginally housed people. The residential programs for homeless families and single adults almost tripled between 1984 and 1988, and again more than doubled between 1988 and 1996.

Emergency shelter has accounted for smaller proportions of the overall shelter beds, with transitional housing programs (featuring longer stays and expanded availability of services) increasing over 60% since 1996. A cluster analysis was performed on shelter episodes in New York City and Philadelphia to monitor the shelter utilization patterns. The analyses provided an empirical means for sorting shelter users into three type of homelessness: transitional, episodic, and chronic. Data from

Philadelphia's public shelter system show that transitional shelter users represented 80% of the sheltered adult population, while episodic represented 9% and chronic subgroups 11% of shelter users. These findings indicated that the vast majority of people use the shelter system for brief periods of time. Most people used the shelters system as designed (transitional), as an emergency service which they exit and do not return to. Some people are episodic users, who move repeatedly in and out of the shelter system. The final group contains the chronic shelter stayers, who use shelters as a form of relatively long-term housing. Chronic users of homeless shelters and episodic shelters users who spend time on the streets and other locations, remain homeless because they have health-related barriers which combined with insufficient residential support from the community treatment system and their low incomes, make it difficult to avoid occasional homelessness. Research shows that the annual cost of a single adult shelter bed ranges from $4,100 in Atlanta, to $19,800 in New York City, a median cost per bed per year being $9,300 (Culhane & Metraux, 2008).

Health care access in the United States is "undeniably inequitable" and homeless families have more problems accessing health care than other families who are poor. Hatton et al. (2001) conducted a qualitative study on homeless women and children to explore how shelter staffs manage health problems among their residents and assist them in accessing health services, and to identify clinical strategies for community health nurses working with this population. Participants were Directors of shelters identified by the United Way Directory as serving women and children in a Southern California county. Data showed a paradox where homeless shelter staffs tried to gain access to health care for their residents through a system designed to keep them out. Most homeless people do not

possess the necessary documentation (identification, permanent address, and proof of being unemployed, etc.) to qualify for the services available. The study found a need for increased community health nursing services in homeless shelters (Hatton et al., 2001).

Atlanta

The 2003 Metro Atlanta Tri-Jurisdictional Collaborative Homeless Census and Survey is a comprehensive look at homelessness in the Tri-Jurisdictional Collaborative area (City of Atlanta, Fulton County, and DeKalb County, Georgia). An estimated 6,956 persons at any point-in-time and 16,625 persons annually have experienced homelessness in the Tri-Jurisdictional area during 2003. Of the 6,956 homeless people identified, 70% were in shelter facilities and 30% were unsheltered. At least 14% of the homeless persons on the streets were females and 10% were in families. The homeless respondents named alcohol or drugs (38%) as the primary cause of their homelessness followed by unemployment (29%) and inability to pay rent or mortgage (12%). Most respondents (59%) indicated that job, job training, or employment assistance would be the greatest help to getting them out of homelessness (The 2003 Metro Atlanta Tri-Jurisdictional Collaborative Homeless Census and Survey, 2003).

Homeless mothers face some of the most discouraging economic circumstances of any segment of the U.S. population. Research has shown that teen mothers are at much greater risk of being unemployed and of becoming a long-term welfare dependent. The plight of homelessness offers an even greater threat to these young women and their children. The Family Development Center (FDC) is a transitional housing program in Atlanta, Georgia, designed to provide young homeless mothers an opportunity to emerge

from desperate circumstances and begin the journey to economic self-sufficiency. The FDC program is operated by Families First, a nonprofit family and children's agency based in Atlanta. The program targets families that meet the following criteria: (a) young unmarried mothers (17-26 of age) caring for a first child up to 1 year of age; (b) families that are truly homeless, that is "lacking housing, other options for temporary housing, and lacking resources or skills to permanent housing; and (c) women who must not be substance abusers and must be motivated to benefit from the program (Fischer, 2000).

Fisher (2000) performed a descriptive study on the programs for homeless families and presents the results of a comprehensive look at the operation and effectiveness of the FDC program during its first five years. The survey participants consisted of 98 families who entered the program between March 1991 and December 1995. Data were collected on three main categories; program entry or intake, exit from residence, and follow-up. The study showed that many families were able to effect notable positive changes in their lives during and after taking part in the housing program. However, for some the recovery from homelessness was extremely difficult. Even for the most successful formerly homeless families-those that secured employment, housing, and other social supports- the escape from welfare dependence and poverty proved very difficult (Fischer, 2000).

One of the benchmark shelters identified for their best practice was Gateway Shelter for Battered Women of Atlanta, Georgia. Gateway Shelter offers emergency shelter for battered women and their children. The shelter also offers some transitional housing of clients.

A group of concerned community leaders in the Atlanta Metro area took notice of incidents of domestic violence across the country and decided to act locally. They founded Gateway House in October 1982. Through crisis intervention, comprehensive support services and community collaboration, Gateway helps create an environment for safe, healthy, self-sufficient growth and violence prevention. Gateway will meet all the basic needs of domestic violence survivors in the community. Gateway offers several programs such as; "Women Seeking Change" which teaches participants about the dynamic of domestic violence and allows participants to seek support from peers, emotional support groups, and "Life Skills Training." There are also innovative programs for children ages 4-11 that help children who have witnessed abuse at home. These programs teach children about safety and give them an outlet to express their fears and concern. There are also teen groups. Occupational Therapists are used to help victims of domestic violence thrive. The therapists help with the things that "occupy" their time like job skills, parenting and communication skills (Gateway Battered Women's Services, 2010).

Nashville

Nashville has joined 170 other U.S. cities in a nationwide campaign to eliminate chronic homelessness by 2015. About 2,300 homeless Nashvillians will be trying to find shelter on any given night. The current approach to solving homelessness is not working and with the increase in bankruptcies, the threat of home foreclosures, daily reports of layoffs and job reductions, and personal debt at an all-time high, and the homeless situation looks to get worse before it gets better. A cultural shift has occurred in the

Nashville community in which whole families can fall prey to one economic event that takes them over-the-edge and into the population of homeless. Nashville's homeless now look a lot like you and me - displaced victims of economy living from one paycheck to the next with women and children being the fastest growing of the homeless population, which has increased 32% in the past two years (Baker & Frey, 2009).

Homelessness has climbed to the top of the national agenda of social issues over the past decade. Demographic trends in homelessness are often based on repeated surveys of shelter operators, welfare administrators, activists, and other knowledgeable informants. Research studies have produced the over-time observational data needed to draw valid conclusions about changes in urban homeless populations during the 1980s. A series of emanations lend little support to Nashvillians' perception that the number of homeless in their city is growing rapidly.

Homeless people tend to be mobile, with many changing locations on a frequent basis, the distinction between the street and shelter portions of the population is difficult to maintain. The number of homeless fluctuates with the season. The most straightforward explanation of the seasonal ups and downs is that they reflect the climate-sensitive migrations of people exposed to the elements (Lee, 1989).

Nashville's homeless population is not mushrooming in size but it is changing in composition. In recent years, there was a decline in the number of traditional skid row residents, most of who are male, white, and older and a rise in the representation of women, blacks, children, and other now homeless groups. Data from the Nashville enumerations support the conclusion that the homeless population will be considerably

lower than estimates based on the opinions of experts. There were no great surges in the number of homeless groups in Nashville over the past 41/2 years (Lee, 1989).

In 2003, Safe Haven Shelter merged with Nashville Family Shelter allowing Safe Haven to serve 11 families throughout Nashville. Safe Haven Shelter is dedicated to empowering homeless families. Safe Haven is the only shelter program in Middle Tennessee that serves homeless families as an entire unit. The residents are comprised of married couples with children, and single mothers and fathers with children. The average length of stay is 65 to 85 days. The shelter can accommodate 11 families at a time through a main shelter campus and six transitional homes. The basic needs of the residents are provided as well as baby food, diapers, clothing, and toiletries. Once the parents are employed, they are required to save 75% of their income. The funds are placed into a savings account for families to build a financial safety net in preparation for program departure. The Save Haven Family Shelter was awarded the Marvin Runyon Leadership Award on Tuesday, September 21, 2010 (Safe Haven Family Shelter, 2010).

Alabama

Alabama has been known as one of the nation's poorest states. According to the 2000 U. S. Census Bureau, Alabama was the seventh poorest state, with 16% of its residents living in poverty compared to a U.S. national average of 12%. Alabama's root of poverty was found in its social, political, and economic policies. Alabama's history of slavery, segregation, and racial discrimination explains the high rate of poverty among African Americas. The enacted property-tax limitations made it difficult to raise property taxes, placing tax burden on state sales taxes and other regressive levies that continue to

fall disproportionately on the poor. The insufficient tax revenues starved the state's education and public health programs which might have helped poor people rise out of poverty (Flint, 2007).

According to the Statewide Data Report (2007), there are approximately 5,400 homeless Alabamians on any given night. The demographic structure is 64% Black, 34% White, 1% Native American, 1% other and composed of 70% men and 30% women. Figure 7 shows the demographic structure of the homeless in Alabama.

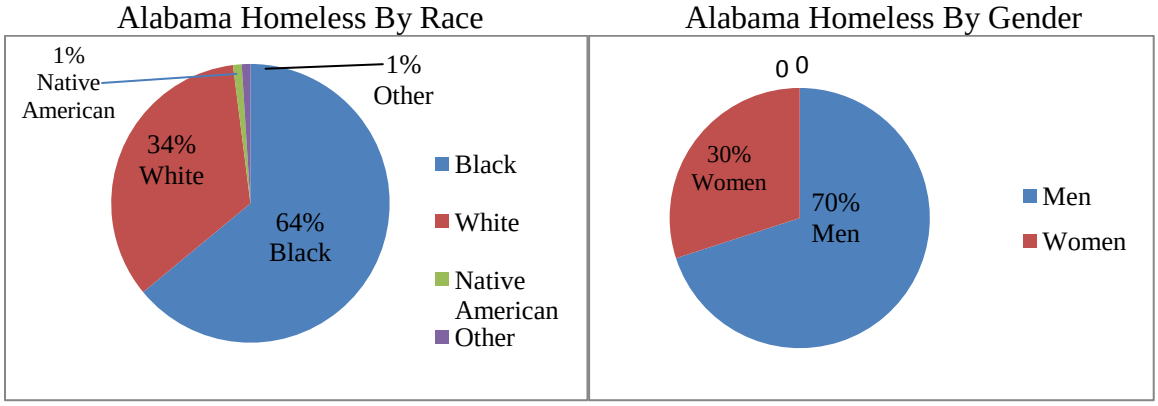

Figure 7. Demographic Structure of the Homeless in Alabama
Source: Homeless in Alabama Statewide Date Report, 2007

Of the homeless Alabamians 1,027 are chronically homeless, 2,177 are chronic substance abusers, 1,077 are in families with dependent children, 205 are persons with HIV/AIDS, 1,494 are severely mentally ill, 57 are unaccompanied youth, 1,659 are unsheltered, 974 are veterans and 403 are victims of domestic violence. The subpopulation data above were calculated using regional data. The actual numbers of homeless Alabamians in certain subpopulations may be higher than reported because Tuscaloosa and Russell Counties did not report certain data. The state of Alabama reports homelessness data by the state's regional continua of care (CoC). There are nine

established regions Gulf Coast (Baldwin and Mobile Counties), Metropolitan Birmingham (Jefferson, Shelby, and St. Clair Counties), Mid-Alabama (Bullock, Elmore, Lowndes and Montgomery Counties), North Alabama (Limestone, Madison, and Morgan Counties), Northeast Alabama (Calhoun, Cherokee, DeKalb, and Etowah Counties), Northwest Alabama (Colbert, Franklin, Lauderdale, Lawrence, Marian, and Winston Counties), Rural Alabama (Balance of State), Russell County and Tuscaloosa County (Homeless in Alabama Statewide Date Report, 2007).

A study in Birmingham Alabama looked at the complex changes in the safety net to examine whether access to health care has improved or declined for homeless people from 1995 to 2005. Studies suggest that lack of insurance and competing priorities limit homeless individuals' access to care when needed which may contribute to high mortality and excess hospital utilization. Survey data showed that 24.6% of homeless people reported an inability to obtain care when needed which is four times higher than contemporaneous national samples. Homeless people depend disproportionately on the health safety net, including public hospitals and community health centers, as well as the Veterans Health Administration, volunteer clinics, and academic teaching hospitals. Studies suggest strain on the health-care safety net because of the failure of resources to rise in tandem with demand. There are several possible safety net stressors to include: (1) rising numbers of uninsured adults, (2) restricted federal funds for safety net institutions, and (3) state and federally imposed restrictions to Medicaid program growth. The survey results showed that the unmet need for health care was more common in 2005 (54%) than in 1995 (32%), especially for non-Blacks (64%) and females (65%). Financial barriers

were more commonly cited in 2005 (67%) than in 1995 (42%). The survey concluded a rise in unmet health care needs among Birmingham's homeless from 1995 to 2005 (Kertesz, Hwang, Irwin, Ritchey, & LaGory, 2009).

The State of Homelessness in America (2011) consisted of four major sections to determine whether the nation's homeless problem has improved or worsened from 2008 to 2009. The primary measure of the state of homelessness is the total homeless population chronicles of annual change homelessness and homelessness among families and other subpopulations. The total nation's homeless population for the United States increased 3% from 636,324 in 2008 to 656,129 in 2009; for Alabama there was a 12.66% increase in 2009 from 5,387 to 6,080. Another indicator is economic risk factors such as poor households experiencing severe economic burdens, unemployed people, and income of the working poor and housing units in foreclosure. The average income of the working poor people in the United States decreased 2% from $9,353 in 2008 to $9,151 in 2009; for Alabama the average real income of working poor decreased 5.52% from $8,829 in 2008 to $8,370 in 2009. Table 2 shows the national percent change among economic indicators with the state of Alabama added to demonstrate comparisons (Sermons & Witte, 2011).

Table 2. National Changes among Economic Indicators

	National			Alabama		
	2008	2009	2009	2008	2009	2009
Poor households experiencing severe housing cost burden	5,398,379	5,886,293	9.00%	89,025	102,895	15.58%
Unemployed persons	894,000	14,265,000	59.90%	111,535	212,418	90.45%
Average annual income of working poor people	$9,353	$9,151	-2.16%	$9,345	$8,829	-5.52%
Housing units in foreclosure	2,330,483	2,824,674	21.20%	7,764	19,896	156.26%

Source: National Alliance to End Homelessness, 2011

The next indicator studied was the number of increased homelessness by doubled up people (people who are living with friends or family due to economic need), individuals discharged from prison and youth aging out of foster care. The nation's number of doubled up population increased 12% for 5,402,075 in 2008 to 6,037,256 in 2009; number of prison and jail release increased 2% for 669,194 to 679, 738; and the uninsured increased 1% to 47,151,404 in 2009. Figure 8 shows the national percent change among demographic indicators with the state of Alabama added to demonstrate comparisons (Sermons & Witte, 2011).

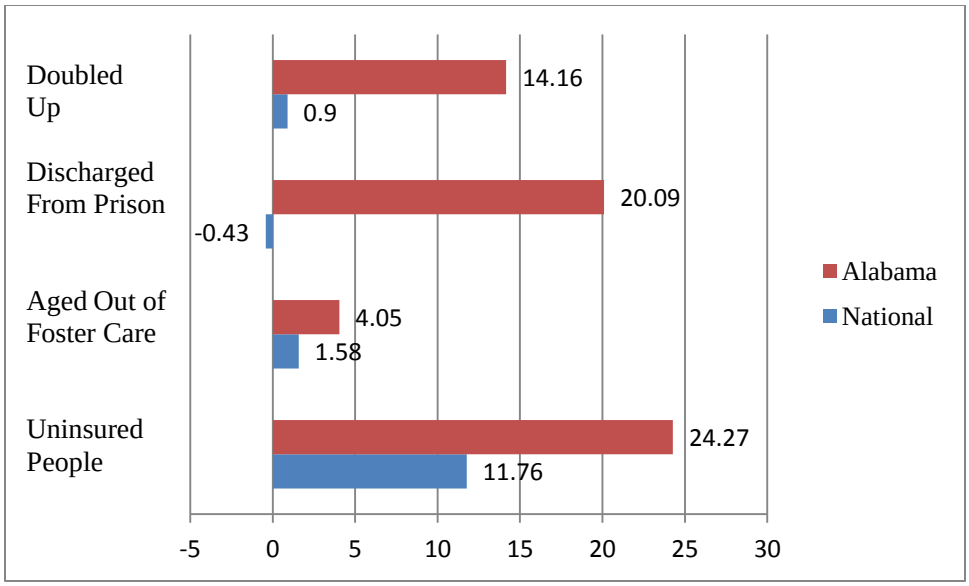

Figure 8. National Percent Change among Demographic Indicators
National Alliance to End Homelessness, 2011

The final indicator considered identifying states with multiple risk factors for increasing homelessness. These multiple risk factors for increased homelessness are identified by states with economic and demographic indicator rates worse than the national average and by looking at the eight economic and demographic indicators. The eight economic and demographic indicators were severe housing cost burden among poor households, unemployed, average real income of working poor, foreclosed housing, doubled up people, discharged from prison, youth aged out of foster care and uninsured people. Alabama and Nevada have fared worse than the national average on all indicators but one the uninsured (Sermons & Witte, 2011).

Literature Review Summary

The extensive literature review showed that there are limited studies on homeless women and health care promotion of the homeless population. With women and families becoming the fastest growing segments in the homeless population, it is pertinent to

increase the promotional awareness of health care services available and to ensure accessibility to these services. The health care needs of the homeless women population differ from the male population. There are numerous barriers that do not allow this homeless population access to health care services, as well as the competing priorities that are more important, health care services.

The literature review identified the causes of homelessness among the homeless women. It explained the over-exaggeration of the stereotype of who the homeless are and the labeling of homeless people as drifters or transients. Most of the homeless population utilizes homeless shelters at some time during their state of homelessness. The literature review validates that health care promotion by homeless shelters will probably increase health care awareness and the assistance offered by these shelters will increase access to health care services.

Some of the information used in the literature review is dated from the 1990s. Because of the changing economics and other social factors, data from the 1990s may not reflect the current situation.

CHAPTER III

METHODOLOGY

Research Objectives

The methodology section consists of a synopsis of the process employed in this study. The research questions this study will seek to support are "What health promotion and education is provide by the shelters in this study?", "what health related services are provided by the shelters in this study?," and "how do shelters in this study provide assistance with accessing other health related service not provided by the shelter?" The purpose of the study is to determine what health related services are provided by homeless shelters for women in Alabama. This study focused on homeless women because they are a steadily increasing proportion of the homeless population with a variety of unmet healthcare needs, and for the reason that only limited studies have been performed on adult homeless women.

Design

This study utilized a qualitative method using the principles of descriptive research. Qualitative research focuses on the attempt to interpret the social phenomenon in terms of the perspectives and worldviews of the people involved. Qualitative methods are a growing interest in health research. Data collected in qualitative research focus on talk and action rather than numbers. The qualitative research method in this study will exploit inductive, interpretative and historical data to answer the research questions by

utilizing survey and benchmarking techniques (Pope & Mays, 2009). Descriptive research is performed to describe the data and characteristics of the phenomena being studied as accurately as possible and formulating this information into conceptual categories (Cooper & Schindler, 2008).

Data were collected through a self-administered survey tool utilizing the Homeless Service Directory Questionnaire for selected shelters in Alabama. This survey was mailed to the shelters and picked up by the primary researcher upon completion. Data from the two identified benchmark shelters were collected through individual surveys and follow up questions. Benchmarking is the process of comparing organizations in order to identify the best practice (Heery & Noon, 2001). This process was employed to identify shelters that have recognized the needs of the homeless population and implemented successful critical factors in promoting health care awareness, offered a variety of health care services at the facility, participated in health promotion and education, recognized for their excellence, participated in the national effort to end homelessness in 10 years, has an English speaking representative, increased population of women being serviced, and accessibility and assistance to ensure health care services are available.

Study Research Samples

Cooper and Schindler (2008) stated that one general sampling guideline exits for qualitative research: "Keep sampling as long as your breath and depth of knowledge of the issues under study are expanding and stop when there is no new knowledge or insights" (p. 169). Cooper and Schindler (2008) also stated that sample sizes for

qualitative research vary by technique but are generally small. For the purpose of this study, homeless shelters are defined as the temporary residences for homeless people seeking protection from the devastation of homelessness. This study used the total population of the shelter directors or their designee to include all 45 homeless shelters identified within the 67 counties in Alabama. The specialty shelters such as substance abuse shelters and mental health clinics were not included in this study. The best source of data regarding the promotion of health care awareness and the assistance available for the homeless women are the directors or their designee due to their responsibility and obligation for the overall management to the shelter. Designee must be someone assigned by the director with overall working knowledge of the managerial operations of the shelter.

An in-depth internet search was performed per county in Alabama to identify all shelters registered on the Homeless Shelter Directory for the State. Shelter information was collected and compiled from three websites Alabama Homeless Shelters and Social Service for the Needy, the National Coalitions for the Homeless Directory, and the United States Department of Housing and Urban Development. There were 20 counties in the state of Alabama that did not have a shelter listed within a 30 mile radius and several adjacent counties shared shelters.

Instrumentation

A "Homeless Service Directory Questionnaire" was utilized as a survey tool to collect information from homeless shelter's directors on the population the shelter serves, housing program type, services provided by the shelter and assistance program services offered. The Homeless Service Directory Questionnaire is a survey tool developed by the

Coalition for the Homeless of Houston/Harris County, Inc. to assist those entities that serve the needs of the homeless through information exchange and accurate data relevant to homeless issues (Coalition for the Homeless, 2011). Whitney Fleming, Coordinator of the Coalition for the Homeless of Houston/Harris County in Houston, Texas, verbally approved the use of the survey on Friday, February 18, 2011. This survey is being used by the Coalition for the Homeless for informational purposes only. The information obtained from the surveys will be used as comparative data to answer the research questions from the shelter's directors' perspective on health care services promotion and access to services for homeless women. The survey has been amended to include health care related questions such as (1) the general health status of the population served; (2) types of health care services offered by the shelter; (3) the promotional efforts of preventative health care services by the shelter; and (4) assistance offered by the shelter to the homeless to access available health care services.

The survey consists of 11 questions divided into five sections: (I) general information, (II) population severed, (III) program awareness, (IV) program assistance services and (V) additional information. Section I General Information: identifies the category of services offered, days and hours of operation and hours of intake of the shelter. Section II Population Served: recognizes the primary populations served by the shelter. This section also categorizes the general age of and health status the population. Sections I and II also consist of demographic characteristics of the population and will be used as comparative data. Section III Program Awareness: identifies the medical services promoted through the shelter, types of medical services offered, barrier that prevent the population for getting health care services, and services the shelter uses for referrals.

Section IV Program Assistance Services: lists the available assistance services provided by the shelter. Section V Additional Information: is composed of two open-ended questions to allow the shelters to communicate problems they have encountered with the homeless women; how people for your shelter identified; and what are is the process of following up on refers. An Open-ended question is defined as a measurement question in which the participant chooses the words to frame the answer (Cooper & Schindler, 2008). Section II question 4 on general health is rated on a likert scale of 1 to 5: (1) poor, (2) fair, (3) good, (4)very good, and (5) excellent. Descriptive statistics were used to describe the sample characteristics from the data collected from the questions. The two open-ended questions in section V were added to encourage the survey participants to share experiences and any problems might have been encountered. The data collected from these questions were coded and analyzed.

Data Collection Procedure

This research was approved by the Institutional Review Board (IRB) at Central Michigan University) prior to submission of the surveys (see Appendix A). Formed consent forms were obtained from each participant agreeing to be interviewed (see Appendix G). Interview letters (see Appendix E) were submitted to the select participants along with the interview protocol (see Appendix D). The interviews were not performed due to an inability to correlate interview time frames. The selected benchmark shelters were emailed the follow-up questions and backed-up with written responses. The results from the questions were coded and analyzed.

A survey packet was submitted to the shelter directors of the identified shelters registered with the Homeless Directory Service consisting of a letter requesting their participation (see Appendix C) in this research study along with the self-administered homeless shelter questionnaire (see Appendix B) to be completed as accurately as possible and consent form (see Appendix G) for approval of participation. The survey packet was mailed to each shelter and arrangements was made by the researcher to pick up by the surveys in person or emailed or faxed. Each shelter with internet accessibility was emailed the participation letter and survey from a secured site to be forwarded back upon completion. The directors were asked to fill out the survey completely and as accurately as possible. Validity of the study depends on the accuracy of the information received.

The benchmark clinics received the same questionnaire survey (see Appendix B) administered to the homeless shelter directors or designee in Alabama. The follow-up questions were submitted in the same format as the questionnaire survey. The purpose of the benchmark is to collect data from the directors of the shelters identified as the best practice to identify their critical success factors, acknowledge problems encountered, and resolutions enforced. The benchmarking survey results were compared and contrasted to the survey results from the homeless shelters in Alabama. The data from the completed surveys will be analyzed to gain knowledge related to the director's perception of the promotion of health care for homeless women and accessibility of services provided by the shelters. The quantitative questions will be statistically analyzed and the open ended questions will be coded and analyzed.

Data Analysis Methodology

The demographical data and general information were used to compare and contrast the data collected the shelters. The quantitative data collected were analyzed using the Predicative Analytics Software Statistics (PASW), Version 18.0. PASW is a comprehensive system for the analyzing statistical data. A chi-squared test was used to identify any significant associations between the participating shelters by comparing data identifying the barriers that prevent getting health care and the services patients are referred for. The open-ended questions used a comparative method of qualitative data analysis to code the data. The follow up questions were stated verbatim and the same comparative method of qualitative data analysis was used to code this data. It is the essential task of the researcher to study the raw data, recognize and refine the concepts and code the data (Pope & Mays, 2009).

Validity and Reliability

Validity is defined as a characteristic of measurement concerned with the extent that a test measures what the researchers actually wish to measure (Cooper & Schindler, 2008). Reliability is paramount and perceived as the standard measure of research quality (Lomband, Snyder-Duch, & Bracken, 2004). The Homeless Directory provides information on Homeless Shelters and Homeless Service Organizations. The Homeless Services Directory Questionnaire consists of general information about the shelter, services offered, population served and assistance provided. This information is listed on the Homeless Shelter website for public knowledge by states and counties. Each state and or county completes an informational survey or questionnaire about their shelter which is

posted on the website (HDS Helping the Needy, 2006). For this study, the Homeless Service Directory developed in 2007 by the Coalition for the Homeless of Houston/Harris County, Inc. was utilized. This questionnaire was edited in 2009 and 2011 and was used for informational purposes only (Coalition for the Homeless, 2011).

For this study, the questionnaire was amended to include health care related questions that were helpful in answering the research questions. The amendments included questions to access: (1) general health status, (2) types of health care services, and (3) the promotional efforts of preventative health care services. These survey questions were taken from the Personal History Form developed by the researcher of "Health-Promoting Behaviors of Sheltered Homeless Women." The Personal History Form measured sociodemographic and personal characterizes. The readability was assessed below 5^{th} grade level using the Flesch-Kincaid Grade Level measurement computed by Microsoft Word software (Wilson, 2005).

External validity occurs when an observed causal relationship can be generalized across persons, settings, and times (Cooper & Schindler, 2008). All identified homeless shelters in Alabama as defined in this study were invited to participate in the study. The researcher utilized the same tools for all survey and benchmark data collection. All of the data collected from the open-ended question were coded using the same technique. The goal of content analysis was to identify and record relatively objective characteristics of messages.

CHAPTER IV

DATA ANALYSIS AND RESULTS

Summary of Key Findings

The research questions in this study were answered by a combination of survey results and benchmarking data assembled into units of information. This information was categorized, processed, compared and summarized into decisive data.

The health promotion and education provided by the shelters in this study are limited. About 53% of the shelters stated they offer education through counseling, information and referrals. Health promotion was initiated through information from the shelter workers, word of mouth from other residents, and brochures with 7% of the health promotion presented by the shelters. Health related services provided by the shelters in this study consisted of physicals, dental exams, HIV testing, blood pressure checks, eye exam, cholesterol screening, and diabetic screening. The health related services were only accessible in 33% of the shelters.

According to the data collected from the shelters, health services and education were promoted by the workers at the shelters. However, 87% of the homeless did not seek medical attention because of lack of money while public clinic offer free health care services and 47% were unsure where to go when the shelters stated services are referred to public clinics and emergency rooms. The survey showed that 93% of the shelters did not encounter any problems reaching the homeless women population. There is a constant need for additional rooms in the shelters. Most of the people in the shelters are walk-ins. One shelter only takes referrals for transitional living.

A chi-squared test will be used to identify any significant associations between the participating shelters by comparing data identifying the barriers that prevent getting health care and the services patient are referred. Where alpha (α) equals 0.05, there was a significant difference in the shelter population served that attended public clinics, community mental health centers and emergency rooms who reported lack of money and those reporting no lack of money. There was also a significant difference in the shelter population served that attended emergency rooms who reported lack of transportation and those reporting no lack of transportation.

The benchmark shelters provided data to include critical success factors that distinguished them from other shelters. Gateway Shelter listed critical success factors which they accredited for the accomplishments as comprehensive programming; volunteer program, resource development, community support, and advocates that offer referrals, safety planning, crisis intervention and emergency services. Safe Haven Family Shelter of Nashville Tennessee identified comprehensive programming, family goals, the use of a trauma-Informed Care Model, great community support; and great programming partner as their critical success factors.

Survey Data

Survey Response Rate

All identified homeless shelters in Alabama as defined in this study were invited to participate in the study. The survey participants were instructed to answer the questions to the best of their ability and that the answers to this survey are related to women. There were 63 homeless shelters identified from the Homeless Shelter Directory.

Eighteen of these shelters were considered homeless agencies and do not offer shelter. An attempt was made to contact the reminding 45 via phone. There was no answer at 12 of the shelters after numerous calls and messages were left; no return calls. Survey packets were mailed to these shelters with self- addressed stamped return envelopes. Four of the shelters phone numbers were no longer in service. Four other shelters had combined and renamed; two shelters in north Alabama and two shelters in east Alabama. The remaining surveys were mailed, faxed or emailed. At the request of the directors or designee, 18 packets were mailed, 14 emailed and 1 faxed. There were a total of 15 surveys completed and received for processing; representing a 33% response rate of the 45 identified shelters in Alabama.

Shelter Respondents Data

The general information section of the questionnaire was used for comparison of the shelters in Alabama. There were six shelters that had been in operation an average of ten years, five other shelters for approximately 45 years, two shelters have been in operation 146 years, and two shelters did not respond to that specific question. All the shelters utilized volunteers and 93% of the shelters employed a combination of full-time and part-time employees. One shelter utilized part-time employees only. The shelters were categorized into five types and an "other" category: emergency, transitional living, assistance program, special housing, permanent housing and other. The category "other" represented data submitted by five shelters (33%); two shelters that provided substance abuse centers within the transitional living shelter, one shelter director identified their shelter as a "shelter for homeless people" and did not categorize the shelter type, one

shelter was considered a homeless center with no immediate entry (an application process), and another shelter is consisted a day shelter. Sixty percent of the shelters provided emergency shelter and transitional living (see Table 3).

Table 3. Category of Services Offered (N=15)

Type of Shelter	Shelters Response	Percent of Total
Emergency Shelter	9	60
Transitional Living	9	60
Assistance Program	5	33
Special Housing	2	13
Single Room Occupancy	0	0
Permanent Supportive Housing	3	20
Other	5	33

All participating shelters operated seven days a week, nine of the shelters operated 24 hours per day, the remaining shelters daily operation time frame ranged from 7 to 18 hours. However, the intake hours varied only four of the nine shelters operating 24 hours had 24 hour intake. The other 11 shelters intake hours ranged from 6:00AM to 11:59PM daily. The average number of women per daily occupancy ranged from 4 to 164 with a mode of 15. The mode was reported instead of the mean because of the 164 daily occupancy outlier reported by one shelter. Three shelters declared a seasonal increase of approximately 10% during the winter months. Eight of the shelters reported that 5 - 30% of their clients' utilized services but did not sleep in the shelter and one shelter (day shelter) reported 100% service utilization by clients. All participating shelters confirmed their facility accommodated people with disabilities.

Population Served

The primary population served by the shelters in this study consisted of 87% single females, 47% single males, 80% children and 33% families (see Table 4). A crosstabs analysis was performed to compare the percentage of shelter types that served single females with children. This analysis illustrated that 53% of the emergency shelters served single females with children and 53% of transitional living shelters served single females with children. There were an estimated total of 1383 women reported by age group of all the participating shelters. The ages of the homeless in the shelters were sorted into five groups comprised of 23% less than 18; 22% age 18 to 24; 33% age 24 to 44; 18% age 45 to 64; and 4% age 65 and older (see Table 5). Three shelters did not report estimated numbers; one shelter stated they did not report stats by ages. Forty-seven percent of the shelters reported the general health of the population served as good, 40% fair, and 7% of the shelters did not submit data.

Table 4. Primary Population Severed (N=15)

Population Served	Shelters Response	Percent of Total
Single Females	13	87
Single Males	7	47
Children	12	80
Families	5	33

Table 5. Age of Population Severed (N=15)

Age Groups	Shelters Response	Percent of Total
Less than 18	322	23
18 to 24	308	22
25 to 44	452	33
45 to 64	250	18
65 and older	51	4

Program Awareness

Program awareness is the process of creating consciousness of accessibility and disseminating information for the selected population to improve their wellbeing and increase their knowledge. Only 7% of the health services promoted through the agency was actually offered by the agency, 73% information from workers, 13% brochure and 47% word of mouth from other residents (see Table 6). Twenty percent of the shelters provided some type of health related services. One shelter (7%) offered physicals, 2 shelters (13%) dental exams, and 2 shelters (13%) HIV testing, 4 shelters (27%) blood pressure checks, no shelters offered Pap test, 2 shelters (13%) eye exam, 1 shelter (7%) cholesterol screening, no shelters offered mammogram, and 3 shelters (20%) offered diabetic screening (see Table 7).

Table 6. Promotion of Medical Services by Agency (N=15)

Promotion of Medical Service	Shelters Response	Percent of Total
Offered by Agency	1	7
Information from Workers	11	73
Brochure	2	13
Word of Mouth from Other Residents	7	47

Table 7. Medical Services Provided (N=15)

Medical Services	Shelters Response	Percent
Physical	1	7
Dental	2	13
HIV	2	13
Blood Pressure Monitoring	4	27
PAP	0	0
Eye Exams	2	13
Cholesterol Screening	1	7
Mammogram	0	0
Diabetic Screening	3	20

Even with the health promotion and education provided, there are several barriers that continuously prevent the shelter population from getting health care such as lack of money lack of transportation, unsure where to go, and no child care (see Table 8). Most shelters referred patients to public clinics 80%, emergency rooms 73%, community mental health clinics 67%, doctor's office 40%, and in-house physicians 20% of the time (see Table 9).

Table 8. Barriers in Prevention of Service (N=15)

Barriers	Shelters Response	Percent of Total
Lack of Money	13	87
Lack of Transportation	11	73
Don't Trust Healthcare Providers	1	7
No Childcare	3	20
Language Problems	0	0
Unsure Where to go	7	47
Nothing	1	7

Table 9. Referred Patient Services (N=15)

Referred Services	Shelters Response	Percent of Total
Doctor's Office	6	40
Not Applicable	1	7
In-house Physician or Nurse	3	20
Public Clinic	12	80
Community Mental Health Centers	10	67
Emergency Room	11	73

The chi-square tests whether two categorical variables forming a contingency table are associated (Field, 2009). A chi-squared test of independence was performed to examine the relation between the barriers that prevent getting health care and the services of referred patients in the participating shelters. The relation between lack of money and public clinics was significant, $\chi^2(1, N=12) = 8.333$, $p < 0.004$. The relation between lack of money and community mental health centers was significant, $\chi^2(1, N=10) = 6.400$, $p <$

0.011. The relation between lack of money and emergency rooms was significant, $\chi^2(1, N=11) = 7.364$, $p < 0$ .007. The relation between lack of transportation and emergency rooms was significant, $\chi^2(1, N=11) = 4.455$, $p < .035$.

Assistance Services

There were numerous assistance services provided by the shelters. Sixty percent of the shelters offered counseling, 33% advocacy, 73% clothing, 93% food, 33% job training, 47% day shelter, 20% drop in center, 13% job placement, 60% information and referrals, 53% education and training, 60% transportation, 33% furniture and 27% offered legal assistance. None of the participating shelters offered detoxification services (see Table 10).

Table 10. Assistance Services Offered by Shelters (N=15)

Assistance Services	Shelters Response	Percent of Total
Counseling	9	60
Advocacy	6	33
Clothing	11	73
Soup Kitchen/ Food	14	93
Job Training	6	33
Day Shelter	7	47
Drop-In Center	4	20
Detoxification	0	0
Job Placement	2	12
Information and Referrals	10	60
Education and Training	8	53
Transportation	9	60
Furniture	5	33
Legal Assistance	4	27

Additional Information

An open ended question was asked to allow the shelters directors to communicate problems they encountered reaching the homeless women population. Nine of the shelters

stated no problems with reaching the homeless women population. Most of the shelters have a waiting list and some are currently overfilled and seeking other shelters or services in the community for assistance. One shelter continually networked through community resource programs. Another shelter noted the need for more emergency shelters and health services in the Birmingham area. There was no response from three shelters for this specific question. The people are identified for the shelter mostly through walk-ins and referrals. Thirteen of the 15 shelters accepted walk-ins and referrals and two shelters take referred clients only.

The final question on the survey was another open ended question asking about the follow-up process used by the shelters for patients referred to health care services. Five of the shelters replied not applicable (N/A) and three other shelters were unclear on the question. The other seven shelters submitted a variety of responses such as: "none at present", "we generally request documentation so that we can make sure follow ups are done in a timely manner," and "services provided/admitted to program based on availability or referred to appropriate resource."

Benchmark Data

Gateway Shelter for Battled Women

National survey reveals that 50% of all women and children experiencing homelessness are fleeing domestic violence. Gateway has been a leader in the field of domestic violence throughout the community, state and nation. Gateway was established in 1982 and was the first shelter in the community to establish a comprehensive counseling program for nonresident women and children. Gateway was one of the fires

shelters in the nation to establish a Court Advocacy Program, designed to organize and coordinate the criminal justice and domestic violence service systems. Their mission is to work toward the elimination of personal and societal violence against all women and children by empowerment through education, support service, and by actually promoting social change within the community. Gateway Shelter employs five full-time employees, eight part-time employees and the shelter does utilize volunteers. The shelter offers both emergency shelter and transitional living. Gateway operates seven days a week 24 hours per day and the intake hours are 24 hours per day. The estimated average women occupancy was reported as nine with an annually estimated occupancy of 70. Gateway did not report seasonal changes in the population estimated average number of women occupancy. A reported 80% of the clients that utilized the shelters services did not sleep in the shelter. The shelter accommodated people with disabilities.

The primary population served by Gateway Shelter is single females with children and single females. The age group of shelter was reported as 0 for age less than 18; 28 for age 18 to 24; 31 for age 24 to 44; 11 for age 45 to 64; and 0 for age 65 and older. The general health of the population served was reported as fair. Gateway reported that medical services are promoted through the agency by information from workers and word of mouth from other residents. The barrier identified by the shelter that prevents the population served from getting health care was the lack of money. Gateway refers patients to public clinics, community mental health centers, emergency room and the county local free volunteer clinic. Gateway also provided assistance services to include counseling, advocacy, clothing, food, information & referral, transportation, furniture and legal assistance.

People are identified for the shelter through crisis calls and the court house. The follow up process for referrals consisted of telephone calls and follow-up appointments. Gateway Shelter accredited five critical success factors that distinguished them from other shelters as: (1) comprehensive programming; (2) volunteer program, which allows Gateway to continue to provide quality care and programs; (3) resource development that grow fundraising efforts to build awareness of domestic violence; (4) community support; and (5) advocates that offer referrals, safety planning, crisis intervention and emergency services.

Safe Haven Family Shelter

Safe Haven Family Shelter was established in 1984. The goal of Safe Haven is to empower families so they can achieve long-term sustainability in independent living. Safe Haven was awarded the Marvin Runyon Leadership Award that recognizes a local non-profit organization that has sound management strategies in the heat of crisis. Safe Haven Family Shelter employs eight full-time employees and the shelter does utilize volunteers. The shelter offers both emergency shelter and transitional living. Safe Haven operates seven days a week 24 hours per day. Intake hours are from 10:00 AM to 6:00PM. The estimated average women occupancy was reported as eight with an annually estimated occupancy of 27. Safe Haven did not report seasonal changes in the population estimated average number of women occupancy. All clients that utilized the shelters services slept in the shelter. The shelter accommodated people with disabilities.

The primary population served by Safe Haven Shelter is single males with children, single females with children and families with children. The age group of

shelter was reported as 77 for age less than 18; 4 for age 18 to 24; 31 for age 24 to 44; 2 for age 45 to 64; and 0 for age 65 and older. The general health of the population served was reported as very good.

Safe Haven reported health services are promoted through the agency by brochures, information from workers, direct referrals, Tenncare (Medicaid) workers do presentations at the shelter, mobile clinic comes to the shelter, and local clinic opens on a Saturday. The shelter offered physicals, dental, HIV testing, blood pressure screening, Pap test, eye exam, cholesterol screening, mammograms and diabetes screening. The barriers identified by the shelter that prevent the population served from getting health care were lack of money, lack of transportation, no childcare and taking time away from job. Safe Haven refers patients to doctor's offices, public clinics and community mental health centers. Safe Haven also provided assistance services to include counseling, advocacy, clothing, job training, food, information & referral, education/training, transportation and furniture.

Safe Haven stated the problems encountered were reaching the homeless women population were it is hard to get women to take time away from work to see a doctor. It would be helpful if clinics were open later or on weekends and it would cut down on emergency room visits. People are identified for the shelter through phone calls and there is a long waiting list. The follow up process for referrals consisted of calling patients back but many times the phone is disconnected or the clients have moved and they can't find them.

Safe Haven accredited five critical success factors that distinguished them from other shelters as: (1) comprehensive programming to include therapy, financial education, employment readiness and parenting; (2) each family has different goals that may take longer or shorter depending on the family; (3) using a trauma-Informed Care Model; (4) great community support; and (5) great programming partners.

CHAPTER V

DISCUSSION

Implications

An assessment was performed on the homeless shelters in Alabama based on the director or designees responses to the Homeless Shelter Questionnaire. The study focused on health promotion, education and health service provided by the shelters to homeless women. Categorical information from participating shelters was compared during the survey data collection process. The data collected from these surveys were used to answer the research questions: "What health promotion and education is provided by the shelters in this study?", "what health related services are provided by the shelters in this study?," and "how do shelters in this study provide assistance with accessing other health related service not provided by the shelter?" Critical success factors were gathered from two benchmark shelters chosen for their best practices of promoting health care among the homeless population.

The shelters were identified through the Homeless Shelter Directory. From January 2011 until September 2011, there was a decrease in the number of shelters listed on the Homeless Shelter Directory by cities for Alabama. This decrease corresponds with the no longer in service numbers that were encountered during the process to contact the shelters identified on the directory and the number of shelters that had combined. Based on listed shelters information and respondents data, the overall number of available homeless shelters in Alabama appear to have decreased. Although, previous studies have shown that the growing rate of homelessness continues to increase in the United States

(Lewis et al,, 2003). Alabama homeless rate has reached record levels (National Survey of Program and Services for Homeless Families, 2010). The operational hours reported by the participating shelters seem to be substantial for the population served with the intake hours of 27% of the shelters operating 24 hours per day and the remaining 73% intake hours range from 06:00AM to 11:59PM. Shelters' intake process varies but generally, the intake process consists of assigning clients to a bed and performing some sort of needs assessment by trained shelter staff or social workers. The intake staff will collect basic identifying and demographic information on persons using the shelter services. Many of the emergency and temporary housing programs provide individuals with housing regardless of bed availability, in the form of hotel vouchers or floor space. Shelters may not log all arrivals into their system because no actual services are being provided beyond helping to fill a gap for a night or two (Agency for Healthcare Research and Quality, 2011). However, this process hinders the count of homeless individuals that are sheltered and the statistical data of the number of homeless.

Analysis of the primary population served by the shelters illustrated showed an increasing number of homeless women; where 87% of the results provided were single females compared to 47% single males. The participating shelters reported 40% more females occupying the shelters than males. The shelters also reported the primary population consisted of 80% children and 33% families. Fifty-three percent of the emergency shelters served single females with children and 53% of transitional living shelters served single females with children. These results support the data from nationwide studies that women and families are the fastest growing segment of the homeless population.

Health promotion campaigns should focus on the particular needs of the homeless groups identified (Power et al., 1999). Many of the homeless rely on health services provided directly by the shelters or soup kitchens they patronize. The lack of health service promotion and education by the shelters limit the exposure of health initiatives for many of the homeless individuals. Survey data showed that 73% (11 shelters) of health services promotions were offered by information from workers. Forty-seven percent (7 shelters) of health services promotions were offered from word of mouth from other residents. Individuals usually respond more affectively to their peers or someone in a likewise situation. Word of mouth between residents can be a good source of distributing information, based on the reliability of the information being disseminated. However, some of the homeless have developed underground resources for health care needs that are illegal, unsanitary, unmonitored and usually more harmful to the individual than receiving no treatment.

Only 33% of participating shelters provided some type of health related services. The lack of available health services by the shelters in Alabama can be considered a contributing factor to the numerous barriers that prevent the shelter population from getting health care such as lack of money, lack of transportation, unsure where to go and no child care. The homeless residents in the identified shelters were referred out to receive medical services at public health clinics, emergency room and the community mental health clinics. The shelter directors in the rural counties expressed a concern about the financial disarray of the state which has affected the funding of public services. Many of the hospitals and public health departments in these areas have closed or have been scheduled to close in the near future. The nearest health care facility for some areas is

about 50 miles away. This limits the homeless individuals' accessibility to public health services and overtaxes other available public services in the area.

Based on the chi-squared test results, there was a significant difference between the number of clients reporting barriers of a lack of money, lack of transportation, no childcare, and do not trust providers and those that did not report a lack of money, lack of transportation, no childcare, and do not trust providers. There was also a significant difference in the shelters that responded yes to patients that were referred to public clinics and emergency rooms and those that responded no to patients that were referred to public clinics and emergency rooms. A significant difference was noted in the shelter population served that attended public clinics, community mental health centers and emergency rooms who reported lack of money and those reporting no lack of money. A significance was also noted in the difference in the shelter population served that attended emergency rooms who reported lack of transportation and those reporting no lack of transportation.

The percentage of workers promoting medical services and the services the patients are being referred to appear disproportionate to the barriers preventing the population from getting health care. Most public health clinics are based on the patient's ability to pay and emergency rooms treat all patients. According the data collected from the shelters, health services and education were promoted by the workers at the shelters. However, 87% of the homeless did not seek medical attention because of lack of money while public clinics offer free health care services and 47% were unsure where to go when the shelters stated services are referred to public clinics and emergency rooms.

The additional information section of the survey showed that 73% of the shelters did not encounter any problems reaching the homeless women population. There is a

constant need for additional rooms in the shelter. Most of the people in the shelters are walk-ins. The response rate from the participating shelters were low to the open ended question asking about the follow-up process used by the shelters for patients referred to health care services. The responses or lack thereof denotes a misconception of this specific question. This question needs to be rephrased if used in future studies.

Critical Factors

Both shelters, Gateway Battered Women Shelter and Safe Haven Family Shelter contribute their success to great community support and comprehensive programming. Both shelters rely intensely on dedicated volunteers contributing numerous hours of service to support the missions of the shelters. The volunteers help create awareness of the programs and encourage gifts from corporations, churches and individuals in the community. Both shelters rely predominantly on donations and fundraising activities. Safe Haven's most successful fundraiser is "Dancing for Safe Haven" hosted annually in April generating more than $80,000 for homeless families. Gateway's most successful fundraiser is "Season to Share" where record-breaking funds were raised for low-income children, homeless, hungry or in need of medical care and women fleeing domestic violence.

Comprehensive programs allow the shelters to provide basic needs for the clients they serve as well as extensive education and training, therapy, and counseling. These programs will aid in the fight to end homelessness and assist in the transition of homeless to abode. The passage of President Obama's stimulus package, which earmarked $650 million for a Wellness and Prevention Fund, raises hope as an effective strategy to

improve health and prevent disease but it is also funded sufficiently to produce results. The benefits of a comprehensive prevention agenda, included suppression of ever-rising health care costs. Community-based prevention refers to a range of prevention interventions strategies to include upstream intreventions that address underlying social and ecomonic factors; public policies, regulations and legislation, and interventions directed at high-need, low-income neighborhoods (Goodman, 2009).

Social Implication

The present economic crisis has resulted in many people losing their jobs, mortgages have become cancerous and they can no longer pay the loan on their overvalued homes. These foreclosures have reached every area in almost every city in the country. Homelessness, domestic abuse, crime, violence and instability are rising in many communities as hundreds of thousands of home go into foreclosure (Homelessness: The Social Impact, 2008).

Homelessness impacts society in a number of different ways. The homeless individuals are forced to find alternate places to live and sleep due to lack of sufficient number of homeless shelters in their areas. Alternate places include sleeping in the streets, doorways of businesses, behind buildings, public benches, bus stations, under paths, parks and alley ways. There is an increased number of homeless digging through garbage cans and dumpsters in search of recyclable items, and an increased number of homeless panhandling. These incidents negatively affect the appearance of the community and city. A highly visibility ratio of homeless can adversely affect tourism (Homelessness: The Social Impact, 2008).

Another social impact of homelessness is the exposure to communicable infections. Homeless people encounters expose them to many communicable infections which may spread among the homeless and lead to outbreaks that can become serious health concerns. Epidemiologic studies of homeless populations have reported the following prevalence rates for infectious diseases: HIV infection, hepatitis B virus infection, hepatitis C virus infection, active tuberculosis, scabies, body louse infestation and *Bartonella Quintana* infection which is the most common louse-borne disease in urban homeless (Badiaga, Raoult, & Brouqui, 2008a).

Lastly, increased crime rate is a social impact of homelessness. The increase in the number of homeless individuals can be associated with the increase in the number of non-violent criminal activities such as vandalism, trespassing, panhandling, vagrancy, prostitution and burglary. Most of these non-violent crimes are committed by homeless individuals to fulfill their survival needs. Many crimes are committed by the homeless just to get off the street and have a place to sleep. Especially in the colder months, jail is better than facing the environmental elements. Violent crimes such aggravated assault and drug offenses are usually associated with homeless individuals that are substance abusers and those considered to have serious mental illnesses including schizophrenia and affective disorders (Fischer, Shinn, Shrout & Tsemberis, 2008).

Economic Implication

Homelessness has an enormous economic impact on society. Operating and managing homeless support services programs such as shelters, day centers and homeless medical services are costly ventures. Funding for these programs comes in the form of

taxpayer dollars and private donations. Most of these programs are generally unfunded, which means that only the most basic services can be offered (Homelessness: The Social Impact, 2008).

Another economic impact of homelessness is increased hospital admission and an increased limit of hospital stay for homeless people. Homeless people's hospital stay is about four days longer than average, which adds up to an additional cost to the public of about $2,400 per incident. Homelessness causes serious health-care issues, including HIV/AIDS, addiction, psychological disorders and other illnesses that require consistent, long-term care. Homelessness inhibits access to treatment and recuperation, making health issues more dangerous and more expensive. The rate of psychiatric hospitalization for homeless individuals is over 100 times higher than non-homeless people (Cassady, 2011).

Increased usage of emergency rooms is also an economic impact of homelessness. According to the study performed by Ku, Scott, Kertesz, and Pitts (2010), there were 234 million weighted emergency department visits in the United States in 2005 and 2006. These ED visits were made by homeless individuals from all age groups numbered 1.1 million or 0.5% of total ED visits. Homeless individuals made 550,000 ED visits annually, or 2 visits per 100 homeless individuals per year during 2005-2006 based on a count of 759,000 people homeless on a single night in 2006 (Ku , et al., 2010). A study performed by West Virginia University (WVU) showed that one-third of the homeless patients arrived by ambulance at an estimated cost of approximately $67 million. The analysis of almost a half million emergency room visits by homeless people found that

the homeless were more likely to receive more than two diagnostic tests. Homeless patients make emergency room visits four times more often than others and are among the most frequent repeat visitors (West Virginia University, 2009).

Another economic impact is the increase in municipal cost to clean up after the homeless because many businesses deny the homeless the uses of bathroom facilities. The homeless are forced to use whatever convenient location they may find to tend to those needs. The cost of the clean-up comes out of taxpayer dollars (Homelessness: The Social Impact, 2008). Homelessness affects the economic status of tourism. There are articles in the media documenting the struggles between merchants and homeless people and related public policy issues faced by local governments and police departments. Many cities enact legislation outlawing activity typical of homeless people, such as panhandling, sleeping in parks and loitering. These prohibitions often focus on tourist areas and retail centers after business persons express concern about loss of revenue. When a city gains a large event bringing in many thousands of visitors at once, authorities sometimes take drastic measures to get homeless people off the streets (Cassady, 2011).

Lastly, the underreporting of the number of homeless people affects society economics. The underreporting of homeless numbers hurts the distribution of federal funds to states to combat problems such as poverty and homelessness. The homeless population has been consistently underreported due to difficulties in obtaining accurate counts. Distribution of federal funds is greatly affected by census data (Bascom, 2011).

Public Health Implications

The health of homeless people is manifested by increased exposure to communicable diseases, increased risk for chronic disease, and increased prevalence of psychosocial problems. There are little access to personal hygiene and direct exposure to the elements that place individuals at risk for infections and episodic illness. The physical effects of communicable and chronic disease are often caused or exacerbated by psychosocial problems. There are also a high prevalence of mental illness, exposure to physical and sexual abuse, crime, and substance use, which can cause and perpetuate homelessness (Koon, Kantayya & Choucair, 2010).

The leading health indicators where health disparities exit in Alabama include: cardiovascular conditions and diseases, cancer, diabetes, HIV/AIDS, infant mortality, and mental health illness. Heart disease is the number one cause of illness in women in Alabama. The prevalence of cardiovascular disease in women was reported to have been diagnosed with high blood pressure, high cholesterol and obesity. Alabama ranked fifth in prevalence of diabetes in the US. More than one in ten Alabamians have been diagnosed with diabetes. According to the Alabama Department of Public Health (2009), females represented 30 percent of diagnosed HIV/AIDS cases. The highest proportion of new cases diagnosed was among females' age 25-34 years (Alabama Health Disparities Status Report , 2010).

Homeless people are treated in the emergency rooms more often for an acute injury, alcohol or other drug use or psychiatric issues than other people. The National Hospital Ambulatory Medical Care Survey-Emergency Department (2005-2006) reported the primary diagnoses for emergency department visits by homeless people consisted of 21% injury/poisoning, 14% psychiatric and mental disorder, 14% musculoskeletal system, 7% respiratory system and 27% other (Ku et al., 2010).

Emergency Operation Plan of the Vulnerable Population

The homeless population is vulnerable because they are at an increased risk for adverse health-related outcomes. Understanding the nature of homelessness and the relationship between resource availability, relative risks, and health status are critical in diagnosing and treating health-related problems in this vulnerable population. During a disaster the Centers for Disease Control and Prevention (CDC) Emergency Operations Center must respond effectively to support international, national, state, local, tribal, territorial, and private sector public health emergency response partners. The CDC's work during a public health emergency is to coordinate response activities and provide resources to state and local public health departments.

Each state is responsible for developing an emergency operations plan to include the vulnerable population. Both Georgia and Tennessee have briefly described vulnerable population under the Emergency Support Function Annex-6 of the Emergency Operations Plan. Annex-6 is titled "Mass Care, Emergency Assistance, Housing & Human Services Annex. The services include providing assistance required by

individuals, families, and their communities to ensure that immediate needs beyond the scope of the traditional "mass care" services provided at the local level are addressed. These services also include: support to evacuations (including registration and tracking of evacuees); reunification of families, provision of aid and services to special needs populations; evacuation, coordination with Agriculture and Natural Resources in regarding sheltering and other emergency services for household pets and services animals; support to specialized shelters, support to medical shelters, non-conventional shelter, management, coordination of donated goods and services; and coordination of voluntary agency assistance (Georgia Emergency Operations Plan, 2010; Tennessee Emergency Management Plan, 2010)). Alabama is deficient in its emergency operations plan. The Alabama emergency operations plan does not address vulnerable populations (Centers for Disease Control and Prevention, 2011).

Recommendations

This study will contribute to the existing research on promotion of health services and available health services in homeless shelters in Alabama. Based on the data collected, homeless shelters are utilized for food, shelter, transportation and as a source for information of other available services. With the increasing number of homeless people and communicable diseases, it is imperative that the shelters participate in health promotion, education and assist with health services for the population they serve in conjunction with the local community and health agencies.

Recommendations for future studies should include a similar study to be conducted on the entire homeless population in shelters in Alabama not just limited to women. This study of homeless shelters in Alabama should be extended to include critical success factors of the shelters in Alabama.

The challenge for health promotion is to develop and deliver appropriate initiatives to a heterogeneous population that is not always easy to categorize but has a wide range of needs. Health promotion should be developed in the context in which homeless people seek health care. This may involve moving away from traditional patterns of provision such as primary care services based in the general practice. Simple and practical assistance can sometimes be the most appropriate form of health promotions (Power et al., 1999). As stated, health promotion and education should be developed in the context of usage of health care by the homeless population. A study with a focus on the health care needs of the homeless by community can enhance the health promotion and education initiatives of the shelters in each county.

The Obama Administration recognized the need to address the health and well-being of the communities. In fiscal year 2010, $500 million of The Affordable Care Act's Prevention and Public Health Fund was distributed to states and communities to boost prevention and public health efforts, improve health, enhance health care quality, and foster the next generation of primary health professionals (Health Disparities and the Affordable Care Act, 2010). A study on the budgetary usage and funding receive per shelter should prove to be financial beneficial to heighten awareness of the monetary needs of the shelters.

The U.S. Interagency Council of Homelessness and more than 300 communities around the country have committed to ten-year plans to end homelessness. With

homelessness being based on what is known about how individuals and families use the current homeless serve system. The approach will be to deliberately couple housing and services with need and suggest reallocation resources to community programs that provide services regardless of housing status, rather than through residential institutions such as shelters. A reformed homelessness assistance system may not solve the housing affordability crisis but it can prevent involuntary shelter stays and reduce the time people spend as homeless, saving many people from the indignities and victimization of public destinations (Culhane & Metraux, 2008).

Health care access is the fit among personal, sociocultural, economic, and system-related factors that enable individuals, families, and communities to have timely, needed, necessary, continuous, and satisfactory health services. Recommendation for improvements of this paradox includes providing assessment, policy development, and assurance of health care for homeless women and children (Hatton et al., 2001).

A national prevention strategy is the improvement of education and employment opportunities. Education can lead to improved health by increasing health knowledge, enabling people to develop healthier behaviors and make better-informed choices for themselves and their families. Employment opportunities can provide sufficient income allowing people to obtain health coverage, medical care, health and safe neighborhoods and housing, health food and other basic goods. Employment can also influence social and psychological facts, including sense of control, social standing and social support (National Prevention Council, 2011). Studies have been performed on the educational

background of homeless individuals. A study on homeless individuals after receipt of educational training, health awareness and job training will be beneficial to the success rate and the need for continuous adjustments to fulfill the national prevention strategy to improve education and employment opportunities.

Study Limitations

There were a variety of limitations considered throughout this study. The study was validated through the use of previous studies employing the same comparative data. The open-ended questions presented in the survey and to the interviewees may have yielded problems with reliability and replication.

All identified homeless shelters in Alabama as defined in this study were invited to participate in the study. Two shelters were identified for their best practices to participate in a semi-qualitative interview. However, due to the restriction of one shelter on interviews the interview questions were emailed to both shelters and written responses were received from both shelters. The written responses to the interview questions did not allow the researcher to have direct contact with the respondents for clarification of their responses or to inquire about additional information that might have been important to this study.

This study is also limited based upon the number of completed surveys. As previously stated, there was only a thirty-three percent respondent rate of the identified shelters in Alabama. Survey results from this study are not a thorough representation of the selected population. Therefore, caution should be used when making broad inferences on study results to larger populations.

The results may be biased due to the fact the survey is dependent of the directors or designee's perspective of their shelter which might not agree with the perception of the homeless population. The directors were asked to respond to the survey questions to the best of their ability and estimated data were acceptable. Some of the information presented by the shelters was not precise data.

Additional study limitation maybe related to the survey instrumentation. The questionnaire format may not truly represent the experiences of the homeless women population. The survey questions were related to homeless women and do not reflect the data from the entire homeless population being served by the participating shelters. Therefore, the results of the survey are generalized for the homeless populations served by the shelters that completed the survey.

Lastly, three websites Alabama Homeless Shelters and Social Service for the Needy, the National Coalitions for the Homeless Directory, and the United States Department of Housing and Urban Development were utilized to identify homeless shelters in Alabama to participate in the survey. There is a possibility that some shelters may not be listed in either of these websites. Unfortunately, these shelters were omitted from the study.

Policy Development

Based on the results of the study completed on homeless shelters in Alabama, there is a lack of health promotion and education as well as health related services provided by the shelters. Alabama's population has been identified as having an increased rate of hypertension, diabetes, obesity, cardiovascular disease, HIV and TB. It

is proposed that the following services be provided by all shelters in Alabama: physical exams; blood pressure checks; diabetic, cholesterol, and HIV screening; and dental and eye examines. Health promotion and education information should include personal hygiene awareness, nutritional counseling, smoking cessations, and communicable and sexually transmitted diseases. The Homeless Shelters in Alabama: A Study of Women's Health Services showed an increased number of homeless females in the shelters in Alabama. Additional testing such PAP testing and mammograms should also be considered as part of the basic health related services available for women through public clinics. These services are available in the best practice shelter (Safe Haven Family Shelter, Nashville, Tennessee) identified in the study.

A policy to standardize health related services and health promotion and education provided by the homeless shelters should be considered by shelter directors and state and local governments. The strategy will be to co-ordinate the policy development process with the stakeholders involved in the shelters in Alabama. The stakeholders include the directors of the shelters in Alabama, state and county officials, the mayors to maintain a policy focuses on homeless shelters, federal officials to initiate joint enterprises and federal funding, United States Department of Housing and Development and Alabama Department of Rural Development.

The information on the health related services being provided and health promotion and education for all shelters in Alabama should be made accessible. A cost benefit analysis will need to be performed. Many of the shelters in Alabama are located in rural counties where local public health departments are the only access to medical facilities. The possibility of making provisions with the nearest county to share their

health care facilities should be considered. The rural areas may present a problem with lack of personnel trained to perform these health related services at the shelters. Communication with stakeholders is very important to ensure all sites understand and can convey the specific need of the shelters in their area to meet the expectations of the standardization of homeless shelters. Training sessions must be included to ensure organizations' personnel are fully informed and able to implement the policy. The suggested policy to be stated as: All homeless individuals should have access to health related services and health care promotions and educational material through homeless shelters in Alabama. The shelter directors will work closely with the state and local government as well as public health services to ensure theses services are available.

Conclusion

The purpose of the study was to determine what health related services are provided by homeless shelters for women in Alabama. The study focused on homeless women because they are a steadily increasing proportion of the homeless population and only limited studies have been performed on adult homeless women. The study sought to answer three research questions: "What health promotion and education are provided by the shelters in this study?", "what health related services are provided by the shelters in this study?," and "how do shelters in this study provide assistance with accessing other health related service not provided by the shelter?" These research questions were answered through the collection of data from participating shelters. Critical success factors were identified from two best practice shelters from two different states in an attempt to optimize the services provided by the shelters in Alabama.

The lack of available shelters and health related services provided by the shelters in Alabama raises the question about the distribution of federal, state of local funding for public assistance. The increasing number of homeless individuals in the nation has made the operation of homeless shelters a necessity. There are preventative services that can be offered by the shelters in conjunction with public health services and volunteers that will decrease the number of communicable diseases, emergency room visits, chronic illnesses and the severe delay in the homeless seeking health care.

The next step is to summarize the results for the study into a letter to be mailed to the participating shelters. The information from this study will be disturbed to registered shelters along with an expression of appreciation to those that participated for their contribution to the study.

APPENDICES

APPENDIX A

INTERNAL REVIEW BOARD APPROVAL

DATE:	August 3, 2011
TO:	Veta Robinson
FROM:	Central Michigan University Institutional Review Board 1
PROJECT TITLE:	[247265-3] Robinson, Veta, 375380, Homeless Shelters in Alabama: A Study of Women's Health Services
REFERENCE #:	
SUBMISSION TYPE:	Amendment/Modification
ACTION:	APPROVED
APPROVAL DATE:	August 3, 2011
EXPIRATION DATE:	August 2, 2012
REVIEW TYPE:	Expedited Review

Thank you for your submission of Amendment/Modification materials for this project. The Central Michigan University Institutional Review Board 1 has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on the applicable federal regulation.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require each participant receive a copy of the signed consent document.

Please note that any revision to previously approved materials must be approved by this office prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others (UPIRSOs) and SERIOUS and UNEXPECTED adverse events must be reported promptly to this committee. Please use the appropriate reporting forms for this procedure. All FDA and sponsor reporting requirements should also be followed.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this committee.

This project has been determined to be a More than Minimal Risk project. Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of August 2, 2012.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact the CMU IRB office at (989) 774-6401 or cmuirb@cmich.edu. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Central Michigan University Institutional Review Board 1's records.

APPENDIX B

SURVEY TOOL

Homeless Service Questionnaire

Instructions: Please answer the following questions to the best of your ability. The answers to this survey are related to women. If you do not have precise data, estimates are acceptable. Arrangements will be made by the researcher to pick up the surveys. All responses will be reported in aggregate and will remain confidential at the respondent and agency level.

Date: _____/_____/_____

Agency Code: _____

What year was your organization established: ____Number of years in operation: _____

Number of employees: _____

Part-time employees: _____

Full-time employees: _____

Does the agency use volunteers? Yes _____ No _____

I. General Information

Category of Services Offered (check all that apply)

___ Emergency Shelter ___ Special Housing (including room and board)

___ Transitional Living ___ Single Room Occupancy

___ Assistance Program ___ Permanent Supportive Housing

___ Other, please explain: _____

_____

Days of operation each week: M T W TH F Sat Sun (circle days)

Hours of operation each day: _____ A.M. to _____ P.M.

Hours of intake: _____A.M. to _____P. M.

The capacity of your facility: _____

Estimated average of the number of women occupancy:

Daily _____ Annually _____Seasonal _____

(specify) _____

Do you have clients who utilize services but do not sleep there? Yes_____ No _____

If yes, estimate the average percentage _____

Do you facility accommodate people with disabilities? Yes _____ No _____

II. Population Served

1. Primary Population (check all that apply):

___ Single Males Only ___ Single Females Only

___Single Males and Females Only ___ Couples Only, NO Children

___ Single Males with Children ___ Single Females with Children

___ Families with Children ___ Youth Males Only

___ Youth Females Only ___ Youth Males **and** Females

2. Languages Spoken by Staff (check all that apply):

_____ English ____ Spanish ___ Other, please explain: _____

3. Estimate the number for each age group:

___ less than 18 ___ 18 – 24 ___ 25 – 44 ___ 45 – 64 ___ 65 and older

4. General health of population served: Rate on the scale 1 to 5 (Poor to Excellent).

___Excellent (5) ___ Very good (4) ___ Good (3) ___ Fair (2) ___ Poor (1)

III. Program Awareness

5. How are medical services promoted through your agency?

___ Offered by the agency ___ Brochure

___ Information from workers ___ Word of mouth from other residents

___ Other, please specify: _____

6. Type of medical services offered (check all that apply):

___ Physicals ___ Pap test ___ Mammograms

___ Dental ___ Eye exam ___ Diabetes screening

___ HIV testing ___ Cholesterol screening ___ Blood pressure screening

___ Other, please specify: _____

7. What barriers prevent the population your agency serves from getting health care (check all that apply)?

___ Lack of money ___ No childcare ___ Unsure where to go

___ Lack of transportation ___ Language problems

___ Don't trust healthcare providers ___ Nothing

___ Other, please list: _____

8. What services do you refer patients (check all that apply)?

___ Doctor's office ___ Public clinic ___ Emergency Room

___ Not Applicable ___ Community Mental Health Centers

___ In-house physician or nurse (volunteer)

____ Other, please specify:_____

IV. Assistance Services Provided by Shelter (check all that apply):

___ Counseling ___ Day Shelter ___ Information & Referral

___ Advocacy ___ Drop-In Center ___ Education/Training

___ Clothing ___ Detoxification ___ Transportation

___ Soup Kitchen ___ Food ___ Furniture

___ Job Training ___ Job Placement ___ Legal Assistance

V. Additional Information

9. What problems have you encountered reaching the homeless women population?

10. How do you identify people for your shelter?

_____ Walk-ins

_____ Reach Out

_____ Other, please specify: _____

11. What is the follow up process for refers?

APPENDIX C

HOMELESS SHELTERS SURVEY LETTER

Veta Robinson, MPA, MT (ASCP)
3334 Dresden Drive
Montgomery, AL 36111
334.281.2541 – veeann1@bellsouth.net

Shelter Director Date [ ]
Name of Clinic
Address

Dear Shelter Director,

Homeless shelters offer critical contributions to homeless people seeking protection for the environment, shelter, food, information and health care services. Shelters provide temporary security and a place of emotional wellbeing. As a graduate student in the Doctor of Health Administration program at Central Michigan University I am conducting a research study attempting to determine what health promotion and education is provided, what health related services are provided and how shelters provide assistance with accessing other health related services to women not provided by the shelters. I am writing to ask your assistance in this important research.

Health care promotion is defined as the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health. In an effort to determine health related services are provided by homeless shelters, shelters across the state are being asked to complete the enclosed survey by September 1, 2011. Arrangements will made by the researcher to picked up by the surveys in person.

The study results will allow us to recognize the needs of the homeless; increase the awareness of the health services available for the homeless; decrease the barriers of accessibility for health services for the homeless; improve the health care services availability to the homeless in Alabama; and enhance the general populations' awareness of the growing rate of homelessness in United States. The study results can also pave the way for future donations from business, public, and private community by demonstrating areas of focus where donor dollars can have the greatest measurable impact.

Your participation in this survey is vital to the study success. Please take a few moments to complete the survey. Please contact either my doctoral advisor, Dr. James Johnson at 989,774.1351 or myself if you have questions about the survey. Thank you in advance for your contribution to this study and for your hard work, dedication, and commitment to the homeless in your community.

Veta Robinson, MPA, MT (ASCP), Principal Researcher

APPENDIX D

INTERVIEW PROTOCOL

Introduction

My name is Veta Robinson and I am a graduate student at Central Michigan University in the school of Health Sciences, Doctor of Health Administration Program. I am conducting a study on homeless shelters to determine what health related services are provided by homeless shelters for women. Your shelter has been selected as a benchmark because of your success in promoting health services.

This interview process will allow the shelter director or designee the opportunity to share their experiences and perception of the homeless population they serve. Your participation is vital in the study success. This interview will be recorded with approval of the shelter director and with the consent form being signed.

Questions:

1. What are your top 5 critical success factors that distinguish your shelter from other shelters?

Probe: (a) What makes your shelter successful?

(b) What do you recommend to other shelters to promote health care?

2. Do you have any concerns about the Homeless Shelter Directory Questionnaire?

The Homeless Service Directory Questionnaire should have been completed before the interview was scheduled. The questionnaire consisted of 11 questions on the shelter and population served.

3. Any additional comments.

Any information that the director or designee consider pertinent to improving health promotion and education provided, health related services provide and assisting homeless women in accessing other services not provided by the shelter.

After completion of the interview the recorder will be stopped and data stored in a secure area until the data is analyzed.

APPENDIX E

HOMELESS SHELTERS INTERVIEW LETTER

Veta Robinson, MPA, MT (ASCP)
3334 Dresden Drive
Montgomery, AL 36111
334.281.2541 – veeann1@bellsouth.net

Date [ ]

Shelter Director
Name of Clinic
Address

Dear Shelter Director,

Thank you for completing the *Homeless Shelters Survey*. Your responses are vital to the success of the study.

Follow up interviews are being scheduled with the shelters identified as benchmark shelters. The [*name of shelter*] has been selected to participate in the interview process. This interview will be recorded with approval of the shelter director and with the consent form being signed. I will contact you by phone in the next week to schedule a phone interview session.

After completion of the interview sessions, survey and interview data will be complied and the results will be analyzed, catalogued, and published.

Please contact either my doctoral advisor, Dr. James Johnson at 989,774.1351 or myself if you have questions about the survey. Thank you in advance for your contribution to this study and for your hard work, dedication, and commitment to the homeless in your community.

Sincerely,

Veta Robinson, MPA, MT (ASCP)
Principal Researcher

APPENDIX F

INTERVIEW CONSENT FORM

CMU
CENTRAL MICHIGAN UNIVERSITY

Consent Form for
Phone or informal "on-the-street" interviews

The purpose of this research study is to determine what health related services are provided by homeless shelters for women in Alabama. For that reason, we will be surveying homeless shelters directors. If you are willing to participate, our questionnaire will ask about critical factors that distinguish them from other shelters. There are 3 questions that will take about 10 minutes to complete. There are no foreseeable risks associated with this project, nor are there any direct benefits to you. There will be no financial compensation for participating in this study. This interview will be recorded with approval of the shelter director and consent form signed. All responses are confidential, and results will be kept under lock and key. Your participation is voluntary, and you may choose to stop at any time if you want. This study is being conducted by Veta Robinson, Department of Health Administration, who can be reached at (334) 281-2541, if you have any questions.

If you are not satisfied with the manner in which this study is being conducted, you may report (anonymously if you so choose) any complaints to the Institutional Review Board by calling 989-774-6777, or addressing a letter to the Institutional Review Board, 251 Foust Hall Central Michigan University, Mt. Pleasant, MI 48859.

APPENDIX G

ADULT CONSENT FORM

CMU
CENTRAL MICHIGAN UNIVERSITY

Adult Consent Form

Study Title: Homeless Shelters in Alabama: A Study of Women's Health Services

Research Investigator: Veta Robinson, MPA, MT (ASCP)
School of Health Administration
3334 Dresden Drive
Montgomery, Alabama 36111
334-281-2541 (H)

Advisor: James A. Johnson, PhD
School of Health Administration
Central Michigan University
1204 Health Professions Building
Mount Pleasant, Mich 48859
989-774-1351 (W)

Introductory Statement
This study is being performed to determine what health promotion and education is provided, what health related services are provided and how shelters provide assistance with accessing other health related services to women not provided by the shelter. The study will be documented in a final dissertation paper. Your participation in this survey is vital to the study's success.

What is the purpose of this study? The purpose of the study is to determine what health related services are provided by homeless shelters for women in Alabama.

What will I do in this study? You are being asked to complete a questionnaire by answering the questions to the best of your ability. If you do not have precise data, estimates are acceptable.

How long will it take me to do this? The questionnaire consists of 11 questions and takes about 10-15 minutes to complete.

Are there any risks of participating in the study? There will be no potential risks to you. You may benefit from this study by being able to take advantage of any improvements in health care delivery that might come about because of this study.

What are the benefits of participating in the study? Participation in the study can pave the way for future donations from business, public, and private community by demonstrating areas of focus where donor dollars can have the greatest measurable impact.

Will anyone know what I do or say in this study (Confidentiality)? The questionnaire does not ask for identifying information on the population being served at your facility. The name of your facility will be withheld. Your responses will only appear in statistical data summaries. All materials will be kept in a secure location until destroyed.

NOTE: For benchmark shelters, only the four benchmark shelters will be identified and not the individuals. Interviews will be conducted on the benchmark shelters. These interviews will be audiotaped with approval of the shelter director and the consent form being signed.

Will I receive any compensation for participation? No compensation will be available for participation in this study.

Is there a different way for me to receive this compensation or the benefits of this study? Not Applicable

Who can I contact for information about this study? All questions about research subjects' rights or in case of a research-related injury to the subject should be directed to the Institutional Review Board by calling 989-774-6777.

You are free to refuse to participate in this research project or to withdraw your consent and discontinue participation in the project at any time without penalty or loss of benefits to which you are otherwise entitled. Your participation will not affect your relationship with the institution(s) involved in this research project.

If you are not satisfied with the manner in which this study is being conducted, you may report (anonymously if you so choose) any complaints to the Institutional Review Board by calling 989-774-6777, or addressing a letter to the Institutional Review Board, 251 Foust Hall Central Michigan University, Mt. Pleasant, MI 48859.

My signature below indicates that all my questions have been answered. I agree to participate in the project as described above.

_____ _____

Signature of Subject Date Signed

A copy of this form has been given to me. _____ Subject's Initials

_____ _____

Signature of Responsible Investigator Date Signed

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