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ETHNIC MAKE UP OF INDIVIDUALS WHO RECEIVE SERVICES FROM SAN
BERNARDINO COUNTY'S MENTALLY ILL HOMELESS PROGRAM

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Cynthia Sophia Roth-Felter

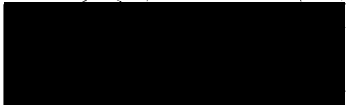
June 2001

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Approved by:



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6/12/01
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Dr. Rosemary McCaslin,
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ABSTRACT

The mentally ill homeless are a diverse population with varied needs. No one can assume that the experience of homeless is the same for all ethnic groups. This study examined the ethnic makeup of individuals who seek services from San Bernardino County, Department of Behavioral Health, Mentally Ill Homeless program. Differences in population regarding African American, Caucasian, and Hispanic underrepresentation and overrepresentation are addressed.

Data on the ethnic makeup came from reports submitted by San Bernardino County to the State of California, which documented information on the mentally ill homeless served by the County. Data were also obtained from 18 mentally ill homeless individuals who agreed to be interviewed. These data provided information about the ethnic makeup of the mentally ill homeless, and specifically, the unique characteristics, values, attitudes and help seeking behaviors.

Results showed that each individual experienced homelessness differently, regardless of ethnicity. However, there were differences in each group's responses, suggesting that there are cultural differences within the

"homeless culture." Implications for social work need to be geared at understanding the diversity of the homeless people. Social workers need to be culturally sensitive and aware of each ethnic group's unique differences. It is hoped that this information will enhance social workers understanding of homelessness and be utilized to suggest appropriate case management services for the mentally ill homeless.

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CHAPTER ONE

INTRODUCTION

Homelessness has been prevalent since the beginning of civilization and has been experienced by a variety of people. The poor, disabled, and mentally ill have typically made up the core of those who are homeless. The word "homeless" has only been used roughly for the last 150 years (Baumohl, 1996; Caton, 1990). The definition of homelessness is important to consider because of the inconsistency in the use of the word throughout the literature. Depending on the study, the term "homeless" has different definitions. Some studies consider individuals who are living with friends and family to be homeless. They are considered the "invisible homeless". Other studies define "homeless" as only those individuals who are living in the streets and/or shelters. For this study the term, "homelessness" refers to people who have no permanent address or nighttime shelter other than that provided by a private or public agency. Rossi, Wright, Fisher, & Willis (1987) have termed this the "literal" homeless.

Best estimates suggest that on any given night, up to 600,000 people are literally homeless. Of these 600,000 homeless, about one third suffer from severe mental illness (Task Force on Homelessness and Severe Mental Illness, 1992). Data taken from the National Institute of Mental Health Research indicate that in the three largest cities, New York, St. Louis, and Los Angeles, racial and ethnic minorities account for 65 percent of the mentally ill homeless (First, Roth, & Arewa, 1988). If this was generalized to San Bernardino County, more than half of the mentally ill homeless seeking services should be minorities. However, this does not appear to be the case. Minorities in general, are underrepresented in the homeless population.

San Bernardino County has a diverse population, although not as diverse as the three cities listed above. However, San Bernardino County is diverse enough to obtain meaningful data. The U.S. Census Bureau (2000) estimated 1,157,387 adults over the age of 18 lived in San Bernardino County. The number of homeless people in the City of San Bernardino was estimated at 5,700 people (The Salvation Army, 2000). The number of mentally ill homeless in San Bernardino County was estimated at 3,000 (San Bernardino

County, 2000). Generalizations to a larger sample of this population are not applicable. Homelessness is situational, with many people moving in and out of homelessness. The findings are only relevant to this particular time period and demographic area. This study addressed the issue of minority mentally ill homeless by looking at the composition of individuals who seek services from San Bernardino County's Mentally Ill Homeless program.

It was expected that different ethnic groups would be underrepresented and others overrepresented from the population of San Bernardino County. Once the population makeup was determined, this study looked at possible reasons for the inconsistencies in representation.

In order to understand the representation of each ethnic group, one has to look at their homeless experience. For example, members of minority groups may experience homelessness differently than that of any majority groups because the loss of self and community are compounded. When minority status is combined with mental illness and homelessness, the loss is more complicated (Molina, 2000). The Task Force on Homelessness and Severe Mental Illness (1992) notes that, "like the homeless population in

general, minority homeless mentally ill persons have varied needs because of their diversity".

The purpose of this study was to look at the ethnic differences, diverse characteristics, and unique service needs of the mentally ill homeless. By identifying the people who were served, we can improve our chances of helping them in the future. Cultural values and attitudes influence how individuals express problems, how they seek help, and how problems can best be resolved.

The definition of ethnicity that was used for this project came from Longres, J. (1995). He noted that an ethnic group is "a group of people in a national state who share a sense of common ancestry and identity based on perceived similarities in culture, language, or physical type".

The population was identified and compared with the general population. The comparison between the mentally ill homeless population and the general population shed some light on who is homeless in San Bernardino County and whom we are serving. The study also provided some insight into who is literally homeless and who is not.

It was expected that the number of literally homeless mentally ill individuals in San Bernardino County would not

constitute 65 percent of the minorities, which would contradict First, Roth, & Arewa, (1988) finding. The people who sought services from the Mentally Ill Homeless program were literally homeless and usually had a documented diagnosis. Information was limited, as literally homeless were the only ones who sought services. It was not possible to get a count on the invisible homeless, as they were not seeking services. The "invisible homeless" provide a multitude of information and probably threw the statistical data off. However, the researcher offers reasonable speculation about this group based on information the interviewees provided.

Cultural norms, values, and attitudes about seeking help were looked at for each ethnic group. Existence of differences in service use and patterns of homelessness between African Americans, Caucasian, and Hispanics are addressed more in depth since those are the three largest populations observed (Julia, 1988). The numbers for Native Americans and Asians were not high enough to incorporate into this measure but information on them was included when available. Deciphering ethnic differences were attempted in order to have a better understanding of homelessness and

provide the best way to reach each groups needs (Baker, 1992).

The results of the study are expected to contribute to social work practice by providing a look at the special and unique characteristics of African American, Caucasian, and Hispanic homeless mentally ill individuals. It was hoped that the study would provide useful information for the design of appropriate case management (North, 1992).

CHAPTER TWO

LITERATURE REVIEW

Literature on the ethnic diversity of the mentally ill homeless has been modest. For instance, the 320-page task force report on homelessness produced by the American Psychiatric Association devoted merely two sentences and no analysis to the disparity between the number of homeless people of color and homeless whites (Cohen & Thompson, 1992). There has been a tendency to neglect ethnic/cultural information in almost all literature obtained regarding the mentally ill homeless. The literature obtained for this study has come primarily from looking at three key issues separately. These issues are: (1) the general homelessness, (2) the mentally ill homeless and (3) differences in service use.

Characteristics of Homeless

Homelessness can be understood in terms of two broad, occasionally overlapping, categories of problems. The first category is experienced by people who become homeless because of a "crisis of poverty". Their homelessness tends to be temporary. Their use of shelters is one way of bridging a gap in resources. Their housing troubles are

generally due to some disruption in their lives such as unemployment, domestic violence or poor money management. Their persistent poverty can cause bouts of homelessness when setbacks occur (Interagency Council on the Homeless, 1994).

The second category consists of men and women with chronic disabilities. Their homelessness is more likely to persist, and for them, homelessness can appear to be a way of life. This group tends to be the most visible in the public eye. They are more likely to have problems that compound daily living such as alcohol and drug abuse (U.S. Conference of Mayors, 1988).

Members of the second category are more apt to have exhausted whatever family support they may have had and thus, resort to the streets. Their disability makes their situation more complex than those who are homeless because of a "crisis of poverty" (Interagency Council on the Homeless, 1994).

The composition of homeless consists of families with children, adolescents and adults. The majority of homeless are single, unattached (without children), adults. They make up about three quarters of homeless persons. Families with children make up another fifth. Of homeless families,

80 percent are headed by a single mother. The rest of the homeless people are adults accompanied with one or more adults (Burt, 1992).

Up to one-third of the adult homeless population have severe mental illnesses and at least half of the adult homeless population has a current or past alcohol or drug use problem. (Interagency Council on the Homeless, 1994). Homeless people also suffer from many health problems, such as HIV/AIDS and tuberculosis, although not as frequent (National Health Care for the Homeless, 1993).

Homeless persons tend to be very poor. In Los Angeles, the average monthly income among homeless persons was \$408. However, one half of the homeless with an income received \$285 and one quarter had an income of \$105 (Schoeni & Koegel, 1998). In a national sample, the average monthly income among homeless persons was less than \$200 (Burt, 1992).

Estimates of homeless individuals who spent time in foster care range from 9 to 39 percent (Blau, 1992). Mangine, Royse, Wiehi, and Nietzel (1990) found the rate of homeless adults with histories of foster care to be four times higher than in the general population.

A New York study found that unattached homeless women, twice that of males, have had an institutional or foster-care placement as their principal living arrangement while growing up (Crystal, 1984).

Approximately 30 to 45 percent of the adult male homeless has served in the military. Of the homeless veterans, approximately 98 are percent male and about 40 percent are African American or Hispanic. Homeless veterans tend to be older and better educated than non-veteran homeless adults. Approximately 10 percent of homeless veterans suffer from post-traumatic stress disorder (National Health Care for the Homeless, 1993). In order to understand these differences, a look at the causes of homelessness needs to be addressed.

Causes of Homelessness

Poverty is the common denominator of homelessness. Based on data from the 1993 US Census Bureau, the Interagency Council on the Homeless (1994) found that rates of poverty among African Americans are consistently three times higher than among whites (33 percent versus 11.6 percent in 1992); for Hispanic Americans, they are two and a half times higher.

Changes in the labor market have also contributed to the number of homeless. The shift of the American economy from goods production to services has changed the labor market and the demand for workers. The chances of obtaining employment for those who have limited skills or education have decreased. The changes in industry have increased the demand for highly educated people. The weakened value of the minimum wage has hurt the poor enormously (Interagency Council on the Homeless, 1994).

Young African American men have been drastically affected. Unemployment data and changes in work force participation suggests that there are many discouraged workers who have dropped out of the work force and are no longer counted in unemployment statistics (Interagency Council of the Homeless, 1994). Less than 45 percent of African Americans between the ages of 16-24 were working compared to about 65 percent for whites (Interagency Council of the Homeless, 1994).

Income assistance is another contributing factor. For families, state AFDC benefits have dropped. Since 1970 to 1992, a family of four with no income dropped from \$799 to \$435. The reason for the decline in cash benefits is attributed to food stamps, Medicaid and housing assistance.

For single people, their situation is harsh. The state "General Assistance" programs were severely cut in the 1980s. In 1991 and 1992, there were reductions in benefits that affected over a third of General Assistance recipients and more are to be considered (Interagency Council of the Homeless, 1994).

Lack of affordable housing is another factor. The poor compete for affordable housing. The poorest renters totaled nearly eight million households, but fewer than three million units were affordable to this group (Interagency Council of the Homeless, 1994). High interest rates and increasing energy costs also contribute to available housing. In 1990, there were 137,000 people living in hotels and other rooming houses with no permanent address. In 1990, 17.8 percent of renters devoted more than half their income to housing costs. However, only 25 percent of eligible low-income renters received rental assistance (Interagency Council of the Homeless, 1994 and Jencks, 1994).

Changes in family structure are considered another contributing factor. The single-parent families' accounts for 22 percent of all families. Single-parent African American families account for 53 percent and Hispanics

account for 32. Female-headed households accounted for 39 percent of the poor. These households are strapped for resources and any decline in finances puts them at risk for homelessness. In times of financial crisis, families have often resorted to resource pooling. The prevalence of doubling up increased substantially, especially among African Americans in the 1970s. But currently, for reasons still unknown, families have been less successful or able to aid additional family members (Interagency Council of the Homeless, 1994).

Drugs and alcohol are another factor to consider. Research studies (Baumohl & Huebner, 1990) found that about half of the single, unattached homeless adults suffer from substance abuse problems. Substance abuse eats away at resources and social supports.

The experience of homelessness is complex and deeply rooted. Described below are more characteristics that show the complexity of this issue.

Mentally Ill Homeless

The mentally ill homeless make up approximately one-third of the homeless population. Within this population, there are two distinct groups. One group comprises of

middle-aged adults who have been deinstitutionalized from psychiatric hospitals. The other group is younger from 18 to 35 years. They have been diverted from institutionalization and spend most of their time in the streets. The majority of both these groups suffer from Schizophrenia followed by personality disorders (Hagen, 1987). They are deficient in social skills, communication, and the ability to express themselves (Barker, 1990). This group of individuals remain homeless for longer periods of time and have less contact with family and friends. Disaffiliation from family, friends, and social roles is even more noticeable with the mentally ill homeless when compared to the general homeless. For example, Hagen (1987) found that 74% of the homeless had no family relationships and 73% had no friends to provide support. However, those homeless with a history of psychiatric hospitalizations were even more disconnected. More than 90 percent had neither friends nor family. They encounter more barriers to employment, tend to be in poorer physical health, and have more contact with the legal system than homeless people who do not suffer from mental illness (National Coalition for the Homeless, 1999). Less than 10 percent have families that were able or willing to provide

ongoing support and assistance (Rife & First, 1991). 54.4 percent of the whole homeless population did not complete high school. However, only 48.6 percent of the African American population did not complete high school. Many homeless persons, particularly African American homeless, were not and had never been married.

The mentally ill homeless who live in the streets are more severely impaired, have more basic service needs, are less motivated to seek treatment and take longer to engage. Findings further indicate that the mentally ill homeless are willing to use services that are easy to enter and that meet their perceived needs (Oskley & Dennis, 1996).

Age and Gender

The traditional image of the homeless person has been of an older, Caucasian male alcoholic living on skid row. However, the homeless population now includes women of all ages and younger men. The average age of single, unattached, homeless adults is in the late 30s. The average age of homeless mothers with children is in the early 30s (Burt, 1992). Most homeless people tend to be young (18 to 45 years of age), male, and from a minority group (Baker, 1994).

Women represented only 25 percent of the homeless population until the 1970s, but data indicate that women now make up one half of the homeless population (Slavinsky & Cousins, 1982). Other studies contradict this estimate. An early study conducted in 1979 in New York by the Vera Institute of Justice found that over half of the first time users of a women's shelter were under 40 years of age and 40 percent were Caucasian (Hagen, 1987). Nearly 50 percent of the women had lived in single-room occupancy residence before coming to the shelter, 25 percent had been evicted, locked out, or ejected from a household by family or friends, and 13 percent came to the shelter directly from the hospital (Stoner, 1983).

Findings from Hagen (1987) indicate that women and men experience homelessness differently, particularly in the reason they are homeless. Women report their reason for homelessness due to eviction, domestic violence, unemployment and difficult interpersonal relations. Women were in greater need for referral to the department of social service and for long-term counseling.

The number of homeless men vary from study to study. Burt, 1992 found that men outnumber women by a factor of five. Single men comprise 45 percent of the homeless

population, single women 14 percent. Men are usually alone. Only half of the homeless men have completed high school (Burt, 1992). According to Cohen and Sokolovsky (1989), the survival skills of homeless men are more advanced than those of women. Men were more likely to experience homelessness as a result of unemployment, alcohol abuse, and jail release. Three out of four homeless men have a history of institutional stay, hospitalization, jail or prison, or inpatient chemical dependency treatment (Burt, 1992). Homeless men were found to have a higher arrest rate than males in the general population. However, most arrests were for public intoxication, theft/shoplifting, violation of city ordinances, and burglary. Hence, homeless men were found to be in greater need for employment and alcohol/drug treatment (Snow, Baker, & Anderson, 1989; Johnson & Cnaan, 1995).

Mental illness is a contributing factor to homelessness for both men and women. But for women it is a major contributing factor. According to Hagen (1987), homeless women are somewhat more likely than homeless men to be mentally ill and to have experienced hospitalization previously for psychiatric reasons. A shelter study by

Crystal (1984), found that 27.7 percent of women reported previous psychiatric hospitalizations in comparison with 14.8 percent of the men. In a similar study, Bussuk, Rubin, and Lauriat (1984) found in a Boston shelter that 85 percent of the women were diagnosed as having chronic mentally illness, whereas, 61 percent of all the people utilizing services were diagnosed as having chronic mental illness. However, Hagan's (1987) study contrasted the above findings. Men more frequently reported previous psychiatric hospitalizations, 13.2 percent for men and 8.9 percent for women. Women found in the streets and shelters are much more likely than men to be homeless in the company of at least one other family member. Women are much more likely to use shelters and to use them more frequently. Single women demonstrated a nearly 50 percent higher rate of previous hospitalization for mental illness than did single homeless men (Baker, 1994). Women were slightly more likely than men to have a source of income and to be employed.

Ethnic Makeup

Studies have repeatedly shown that minorities are disproportionately represented among the homeless

population, especially among homeless families. African Americans, for example, form a larger fraction of poor people, 28 percent, and homeless persons, 40 percent (Burt, 1992; Burt & Cohen, 1989; Rossi & Schlay, 1992)

Rossi (1988) and Baker (1996) suggest that mental illness does not vary across racial and ethnic groups, but in today's homeless population, nonwhite ethnic groups are now heavily overrepresented. This is puzzling, considering that clinicians in a nationwide network of shelter based clinics were twice as likely to diagnose mental disorders for Caucasians as they were for African Americans or Hispanics (National Academy of Sciences, 1988). Baker (1996) found that African Americans are generally overrepresented and Hispanics are generally underrepresented. First, Roth and Arewa (1988) found that Native Americans were overrepresented.

Burr & Cohen (1989) showed the following ethnic distribution: 41 percent African American, 46 percent Caucasian, 10 percent Hispanic, and 3 percent other. In a similar study by First, Roth and Arewa (1988) found 51.9 percent African American, 33.3 percent Caucasian, 14.8 percent Hispanic, Native Americans, and Asian Americans. The rates of African American and Hispanic homeless are

highly disproportionate to their rates in the general population.

African Americans

The homeless population is estimated to be 49 percent African-American (The U.S. Conference of Mayors, 1988). On average, the African American share of the homeless exceeds the African American share of the metropolitan population by 25.5 percentage points (Baker, 1994). They tend to be younger with a mean age of 36.9 for males and 34.0 for females. Homeless persons under the age of 40 were more likely to be African American. This group also has a somewhat higher educational level, and represents a slightly greater proportion of Vietnam veterans than other homeless persons. Member of this group were homeless for shorter periods than the Caucasian respondents but were more likely to move in and out of homeless conditions. This suggests that African American homeless people may move from homeless conditions to living with family and friends for certain periods. However, African American respondents showed no greater support from family than Caucasian respondents, reported fewer friends on whom they could depend, and also were much less mobile. Differences in employment history and work patterns indicate that

African American homeless people suffer greater unemployment. The median number of days homeless for African American respondents is 30. The African American population appears to be more indigenous. Seventy-five percent of African American respondents indicated they were permanent residents of the counties in which they were interviewed or had lived there longer than one year. African American respondents primary explanations for their homelessness were economic. African American respondents were less likely to have had income from earnings in the last month and almost 20 percent had never had a job. These data support the contention that African Americans suffer more than Caucasians from unemployment even when they have more education and appear better prepared for work (Baker, 1994; First, Roth, & Arewa, 1988).

African American respondents reported more use of the social service system than did white respondents. African American respondents did not report as much psychiatric hospitalization, jail detention, alcohol problems, and physical health problems. Data (First, Roth, & Arewa, 1988) on homelessness in Ohio indicate that most of the African American homeless persons interviewed want to and can be employed if given access to the job market. Almost

30 percent of the African American homeless persons in the Ohio study were hospitalized previously for psychiatric reason. These rates are somewhat lower for homeless African American respondents compared with homeless Caucasian respondents.

Hispanics

On average, the Hispanic homeless are underrepresented relative to the Hispanic population by 3.5 percentage points (Baker, 1994). They tend to be younger and less likely to have completed high school compared to Caucasians and African Americans. Hispanics experience brief episodes of homelessness more often than Caucasians and are more likely to endure frequent spells of homelessness. They are more likely to be homeless with children compared to their Caucasian counterparts. Hispanics are more likely to be foreign born and less likely to speak English than both African Americans and Caucasians.

Hispanic people use shelters less frequently than other groups but they also experience longer periods of homelessness after seeking help. (Wong, Culhane, & Kuhn, 1994)

Cooperation, harmony, and sensitivity to the needs of others characterize the Hispanic family. A strong

interdependence between family members usually exists and decisions about family members are based on mutual aid (Delgado, 1995). It is the family's responsibility to provide support. Julia's (1999) study on Puerto Rican homeless noted that preservation of social appearances and family pride are highly valued. In order to maintain or preserve the family's reputation, behaviors that threaten it are avoided. Individual family members actions reflect the family. A homeless family member would stigmatize the whole family. The family would be viewed as abandoning their loved one and seen as uncaring. Therefore, the family would protect itself by supporting the homeless family member. Julia (1999) noted that all of the men interviewed at the Salvation Army shelter in San Juan reported having no family. It is suggested that Hispanic individuals end up homeless because they have no support system.

Caucasians

"The White population has often been used as the "standard" for comparison in most studies of racial/ethnic representation in service sectors" (McCabe, Yeh, Hough, Landverk, Hurlburt, Culver, Wells, & Reynolds, 1999). This practice of comparing Caucasians to other groups has been

beneficial in examining discrimination and differential treatment. But on the other hand, this practice has lead to a reduction of information about the Caucasian population relative to their representation (McCabe, Yeh, Hough, Landverk, Hurlburt, Culver, Wells, & Reynolds, 1999). Listed below are some known characteristics about this population.

Caucasian homeless tend to be older and male (mean age of 39.5 for males and 36.7 for females). More Caucasian men were working. Caucasian men more often cited psychiatric reasons as having led to their unemployment and homelessness. Caucasian homeless men reported more alcohol use than non-white homeless (North and Smith, 1994). Caucasian homeless tend to have larger social networks than African Americans or Hispanics. The median number of days homeless for Caucasians is 90 (First, Roth, & Arewa, 1988). Less than 60 percent of Caucasian homeless persons reported they were permanent residents of the counties in which they were interviewed or had lived there longer than a year. This indicates differences in patterns of homelessness and has implications for service delivery.

Attempts to Explain the Misrepresentations

The few attempts to explain the Hispanic underrepresentation and African American overrepresentation imply that social networks or rather "cultural differences" play a larger part. Rossi (1988) implies that kinship and support patterns may mitigate homelessness and this might account for ethnic differences. For example, minority social networks largely reflect family based ties whereas Caucasians include unrelated friends (Baker, 1994). These networks vary in each ethnic group.

Baker (1994) reports that the "Latino paradox" is likely to be "explained by the particular way they have adapted to their constrained opportunity structure by sharing housing as a material resource more frequently and in more varied ways than may be true of other ethnic groups."

Molina (2000) examined the informal networks of homeless Hispanic and African American men in Los Angeles. She found that social networks of Spanish-speaking Hispanics were not typically homeless. Their networks consisted of family and friends who were housed. This group tended to spend most of their day soliciting employment or working. Thus, their networks served as

channels of communication with the prospect of obtaining work. Their association with housed members appears to be beneficial in exiting homelessness.

Networks of English-speaking Hispanic homeless appeared to be closer to those of African American homeless than of Spanish-speaking Hispanics. Their networks consisted primarily of homeless people. These men tend to spend their day obtaining food, clothing, and shelter, and taking on odd jobs. The experiences of English-speaking homeless Hispanics suggest that many of them have become acclimated to street life.

The social networks of African American homeless are geared at survival. Their networks are geared at obtaining allies while in the streets. All of their networks contain a greater proportion of homeless people, which limits their access to housed individuals. This group tends to spend most of their day at shelters, meal facilities, panhandling, or engaging in activities with affiliates (Molina, 2000). It appears that the resources available and one's orientation toward those resources are important factors in understanding how and why one ends up on the streets (Baker, 1994).

North and Smith (1994) indicate that locus of control plays a part. Caucasian homeless are more likely to have an internal locus of control. Caucasian homeless relate their homelessness to alcoholism or psychiatric problems. Non-whites, on the other hand, are more likely to have an external locus of control. Non-white homeless relate their homelessness to socioeconomic reason such as not having a job (North and Smith, 1994). If mentally ill minorities view themselves as being homeless because they do not have a job, they are not going to seek services from a mental health program.

In regards to mental health service use, Caucasians generally tend to be overrepresentation and may reflect greater familiarity with and cultural acceptance of mental health and related services. A similar representation was found for African Americans. They were also likely to be familiar with services. However, African Americans did not use services to the extent that Caucasian did. The ethnic groups with underrepresentation across service use are those where higher proportion of immigrant families may be present (McCabe, Yeh, Hough, Landverk, Hurlburt, Culver, Wells, & Reynolds, 1999). In general, ethnic minorities seen in therapy have been reported to have more severe

forms of mental illness. This has been attributed to minorities seeking services only when their symptoms become severe. Beliefs about mental illness and treatment discourage use of mental health services (Flaskerud, 1986).

The reasons for underutilization of mental health service use by ethnic groups include stigma and shame, insensitive agency, inconvenient location, lack of knowledge of services, and use of alternative resources (Flaskerud, 1986).

Needs of the Mentally Ill Homeless

Billions of dollars have been spent on emergency services, but the government has made little progress in alleviating the problem of homelessness. That is because the one common need to all homeless people, housing, has been neglected. Low-cost permanent housing is not a national priority. The trend to assist homeless people is to provide temporary and less expensive solutions, such as shelters. Emergency shelters are not the solution to the problem of homelessness, and yet, they are the backbone of service delivery. Stoner (1989) suggested that shelters fail to reduce the incidence of homelessness and reinstitutions the poorhouse system. As a result of

ineffective emergency shelters, long-term, treatment-orientated transitional shelters have been developed. These transitional shelters are beneficial in helping homeless people secure permanent housing because they attempt to address the holistic needs of the homeless (Johnson, & Cnaan, 1995).

The needs of the mentally ill homeless are immediate, concrete services such as food, shelter, clothing, laundry facilities, lockers or space for personal items, and transportation. In order to lessen the impairment and disruption produced by homelessness, the mentally ill homeless also require access to services such as treatment counseling, alcohol treatment, medical and dental care, case management, housing options, long-term follow-up, support services, employment, education and meaningful daily activity. The care of homeless people is more technical than therapeutic. It involves spending much time on providing basic needs and linking them to existing services (National Coalition for the Homeless, 1999; Johnson & Cnaan, 1995).

Homeless people are often distrustful and fearful of mental health workers. This resistance toward mental health professionals is lessened through effective

outreach, engagement and case management. If the engagement process is not successful, there is little hope of the homeless person entering services voluntarily. Mentally ill homeless people who live on the streets or in shelters are often regressed and unstable. Levy (1998) recommends that the engagement process use a psychosocial rehabilitative model that seeks to empower people by focusing on goals and challenges, rather than problems and symptoms. The engagement process with the homeless person should be an attempt at forming a trusting relationship, while respecting and promoting client autonomy in order to build initiative toward positive change (Levy, 1998).

Once the mentally ill homeless are willing to accept mental health treatment, social workers must act more as advocates and less as clinicians to meet the needs of the homeless. Fellin and Brown (1989) suggest using a generalist practice and a task-centered model that includes advocacy, community coalition building, brokering services, and the development, coordination, and evaluation of services. Cohen (1989) recommends using an empowerment-orientated approach that increases clients control and supports self-determination.

Flaskerud (1986) recommended that a culture-compatible approach be used in treatment. This approach includes having therapists who shares the culture, language or language style of the clients. The location of the agency should be in the client community and provide flexible hours. Referrals to services for social, economic, legal and medical problems, including referral to clergy and/or traditional healers should be incorporated into the treatment plan. Whenever possible, family members should be included in the therapeutic process. A brief therapy approach should be used. Lastly, clients should be involved with determining, evaluating, and publicizing services. One of the most serious barriers to the homeless mentally ill client is having a case manager who does not understand them. One way to help break down the barriers is to know whom we are servicing (Levy, 1998).

CHAPTER THREE

METHOD

In this present study, data were collected in two ways. The first set of data collection consisted of obtaining archived data documenting characteristics of the 257 mentally ill homeless individuals served in 1999. The second set of data collection consisted of interviewing 18 individuals who were currently receiving services or had previously received services from the County's Mentally Ill Homeless program.

Sampling

The archived data/report from 1999 were studied. The report documented the number of mentally ill homeless by noting the diagnosis, ethnicity, age, and gender. This sample was chosen because it is the most recent report submitted.

Participants

The participants consisted of 18 adults who had received services from the Mentally Ill Homeless program. The case managers in the Homeless program provided the names and ethnicity of the stable clients. From the list

of individuals selected, the participants consisted of six African American, two males and four females. Attempts were made to obtain an equal amount of African American males and females. Unfortunately, there were not three African American Males available at the time of the interviews. Another six were Hispanic, three male and three female. The remaining six were White, three male and three female. Approval to interview participants was received from San Bernardino County, Department of Behavioral Health Research Review Committee and California State University, Internal Review Board.

The criteria was that they must have been in the homeless program and not be on the interviewees caseload. They must have been stable at the time of the interview. The interview was completely voluntary and in no way affected their standing in the homeless program. All participants signed two informed consents (Appendices A and B), one for San Bernardino County, Research Review Committee and the other for California State University, Internal Review Board, and were debriefed after participation (Appendix C).

Data Collection and Instruments

The data collected from the report were age, gender, diagnosis, and ethnicity. Ethnicity was the primary variable of interest and the subcategories studied were gender, diagnosis, and age.

The goal of the qualitative study was to explore how each group perceives their homeless experience. The data collection for the interviews was an interview guide that was developed by the researcher. The interview guide (Appendix D) attempted to explore cultural differences, values and attitudes in order to understanding some of the dynamics surrounding homelessness.

Procedure

The case managers provided the names, ethnicity and shelter location of stable clients. The individuals were contacted and asked if they would like to participate. After the interviewees agreed to the interview, the researcher conducted the interviews in a discrete place either at the shelter or in the office. All participants gave informed consent (Appendices A and B) to be interviewed and were debriefed afterward (Appendix C). The researcher was the only one interviewing and it took

approximately eighteen hours to interview eighteen individuals.

Data Analysis

For the quantitative part of the study, the procedures that were utilized to test the hypotheses were comparative. The ethnic make up of mentally ill homeless population was converted into percentages. These percentages were then compared to San Bernardino County's population to see if minorities are underrepresented or overrepresented (Table 1).

The qualitative part of the study was exploratory. Each group's responses were categorized and evaluated to discern if there were possible reasons for the differences in representation. Information about each ethnic groups attitudes, beliefs and service use regarding homelessness and mental illness were also explored.

Table 1

Ethnic Distribution

Ethnicity	San Bernardino County's Population (over 18 years)	San Bernardino County's Mentally ill homeless program	Percentages
Caucasian	568,710	156	49.1 versus 60.0
African American	95,401	61	8.2 versus 23.8
Hispanic	399,925	32	34.6 versus 12.5
American Indian and Alaska Native	7,054	0	0.6 versus 0
Asian	58,020	4	5.0 versus 1.5
Native Hawaiian and Other Pacific Islander	2,763	2	0.2 versus 0.7
Other	1,855	1	0.2 versus 0.3
Two or more	23,659	0	2.0 versus 0
Total Minority Population	588,667	100	48.8 versus 38.8
Total Population	1,157,387	256	48.8 versus 38.8

CHAPTER FOUR

RESULTS

Results from the quantitative part of the study showed that Caucasians were overrepresented by 10.9 percent in San Bernardino County's Mentally Ill Homeless program when compared to the population of San Bernardino County (Table 1). Minorities, as a whole were underrepresented by 10 percent. However, when ethnicities were broken down further, African Americans were overrepresented by 15.6 percent. Hispanics were underrepresented by 22.1 percent.

The ages of individuals served ranged from 18 to 69 with the largest age grouping in the 30s. Forty-five percent of the homeless served were women and 55 percent were men. Twenty-five percent of individuals served had a documented drug and/or alcohol problem. Mood disorders were the most common diagnosis (48.8 percent) of individuals served following schizophrenia and other psychotic disorders (40 percent).

For the qualitative part of the study, the ages of the eighteen individuals interviewed ranged from 18 to 53 with the largest age grouping, again, in the 30s (Appendix G). Seventy-seven percent of all participants lived in San

Bernardino County more than 6 months (Appendix I). Fifty-five percent of the participants reported family problems, domestic violence, and/or no living family members contributed to their homelessness. Eighty-three percent of the participants did not consider their mental illness a contributing factor to their homelessness. Fifty percent of the participants reported that they had a drug or alcohol problem. However, only 27 percent reported that drugs and/or alcohol contributed to their homelessness (Appendix I). A higher level of education was reported in this group than in the national studies. Forty-four percent of this group as a whole had graduated from high school and 33 percent had some college (Appendix J). Only 11 percent had ever been in the military (Appendix k). Fifty percent of the participants were referred to the program by hospitals. Family and friend referrals accounted for 11 percent, whereas 16 percent found out about the program through a walk by (Appendix L). Sixty-six percent of the participants were homeless alone (Appendix M).

Due to the low number of participants interviewed, statistical significance was not expected. However, when examining the data, one major difference was noted

(Appendix N). Seventy-two percent of the participants grew up with one or both parents. Whereas, 11 percent were raised by other family members, 11 percent were raised in foster care, group homes, or institutions and 5 percent were runaways. Of the percentage of participants who were raised in a place other than one or both parents, a significant number were Hispanic. One or both parents raised one Hispanic participant. Family members other than parents raised another Hispanic. Two Hispanic participants were raised in foster care, group homes or institutions, and one was a child runaway. All of the Caucasians participants were raised by one or both parents. All of the African Americans, except one (who was raised by a family member other than parents), were raised by one or both parents.

Many of the participants had few immediate surviving family members (mother, father, brother and sisters). Two of the Caucasian participants did not have any immediate surviving family. The rest of the Caucasian participants had surviving family members living in close proximity (in California).

The surviving members of the Hispanic family were more varied. All of the fathers of the Hispanic participants

were either dead, in jail, or had no contact at all with the participants. And three of six participants mother's were dead. Of the three mothers that were living, one was frail and elderly, the second one suffered from drug problems and the third suffered from psychiatric problems.

The African American participants also had few surviving immediate family members. Five of the six participant's fathers were either dead or had no contact at all with them. Two of the participants mothers were no long living. Three of the participants surviving family members lived in other states. Two of the participants had a family member (one brother and one mother) who was also homeless. In both these cases they experienced homelessness at the same time as their other family member and chose to experience it alone.

Of the participants who had surviving family members, all but three participants had families that knew they were homeless. The three participants that did not disclose to family members that they were homeless were African American.

The participants perceived relationships with surviving family members varied. Two of the Caucasian participants reported that the relationship with family

members was "strained" and the other two reported that the relationship was "good". All six of the Hispanic participants reported that their relationship with family members was strained because they were uncaring. Three of the participants reported, "If they cared, they wouldn't have let it happen". Two of the African American participants reported the their relationship with family members was close, two reported that it was strained and the other two reported that they did not know.

The participants' responses varied when asked if it was culturally appropriate to receive services (such as shelter) from a mental health agency. One of the Caucasian participants and one of the African American participants reported that it was inappropriate to receive services. However, four of the Hispanic participants reported that it was inappropriate to receive services. The four Hispanic participants consistently reported that they were "embarrassed", "feel guilty", and that "family is disappointed".

All participants received some kind of support (money, food, shelter and emotional support), regardless of ethnicity, from family and friends, except those who had no

family. There did not appear to be any differences in the type or kind of support received from family members.

Sixteen of the eighteen participants reported that the ethnicity of the case manager was irrelevant. There was no uniformity in the two participants who reported that it was important to have a case manager with the same ethnicity. One participant was a Caucasian female and the other was an African American male. However, two Hispanic females reported that it would be beneficial to have a female case manager. Even though the ethnicity of the case manager was irrelevant, the participants reported that there were certain qualities that make a case manager effective. Listed in order of importance, a good case manager is one that is "caring, listens, helpful, visits and calls, responsive, open, honest, and diligent". The participants' responses did not vary in groups. They all consistently reported the same theme.

CHAPTER FIVE

DISCUSSION

Again, the sample population of this study was very small and does not represent a true reflection of the homeless population. However, these results strongly suggest that differences in the homeless representations are partly due to cultural attitudes, beliefs, and values.

This research supports studies that indicate the mean age of homeless individuals is in the thirties. The current homeless population is no longer the stereotypical elderly, Caucasian, male.

Sixty-six percent of the participants experienced homelessness alone. This concurs with the literature that homelessness is an isolating and lonely experience (Johnson & Cnaan, 1995). A large percentage of these individuals had no living relatives.

The number of homeless individuals who were raised in foster care, group homes, institutions or became runaways was concerning. It appears that these components may be important factors to consider. The Hispanic group had a significant number of individuals who were raised under those conditions. The Hispanics in general are

underrepresented in the homeless population. The literature suggested that underrepresentation was probably attributed to their kinship ties. This group probable has the same number of homeless, but they do not seek services because of pooling of resources along with the guilt and shame associated with the homeless family member. When they do seek services, it may due to a break down in the family structure either through death, neglect or mistreatment.

All of the Caucasian and four of the six African American participants were raised by one or both parents. Whether this variable is a contributing factor for homelessness in these two groups is unknown. But, the stigma attached to the family name does not appear as strong in these two groups. The common theme of self-reliance was eminent in both these groups and may account for them not going to family members in time of need.

Based on the participant responses it appeared that Hispanics were more often homeless when family members were deceased or absent. The African Americans were more often homeless after they lost contact with family members. The Caucasian were more often homeless when the relationship

with family members became so strained that they could no longer reside with them.

Only 17 percent of the participants reported that their mental illness contributed to their homelessness. That is interesting when one considers that all of them had a documented diagnosis. It would appear that this group does not perceive their mental illness as severe.

The low number of reported drug and alcohol problems were probably invalid. This may have been attributed to the researcher being a case manager in the Mentally Ill Homeless Program. Participants may be asked to leave the shelter if they are currently using. Even though the researcher stressed confidentiality, the fear of not having a place to sleep most likely superseded their decision to fully disclose.

Fifty percent of the participants were referred to the County's Homeless program from hospitals. This could suggest that the community is not familiar with this agency. Homeless individuals that live on the streets are generally worse off than those who are referred by the hospital or other mental health agency. This may suggest that the Mentally Ill Homeless Program is not serving the most chronically severe homeless.

Sixteen of the eighteen participants reported that the ethnicity of their case manager did not make a difference in helping form a relationship. The participants reported that the qualities a case manager possesses were the most important aspects in establishing a rapport. A great deal of emphasis should be placed on the engagement process. Levy's (1998) developmental perspective may be effective to use because the engagement process begins with the issue of trust. Offering homeless people basic needs such as shelter, food and clothing may be one useful approach to initiate engagement. It may facilitate trust by demonstrating to the client that the case manager is a receptive caregiver and the client may perceive the case manager as caring. A successful engagement is one that addresses the clients perceived needs in a case manager. Frequent visits and phone calls are also perceived as caring.

Once the engagement process has been established, a treatment plan that focuses on goals should be initiated. The homeless person needs support, positive regard and openness. The case manager forms a sense of partnership and does not take control. The client should define his or her own goals and develop a strategy for exiting

homelessness. These goals should take into consideration the ethnicity of the client and help to empower and promote self-determination. For example, a Hispanic client chooses the goal of obtaining employment. Based on literature (Julia & Hartnett, 1999), that suggests many homeless Hispanics have limited support systems, it may be more beneficial if the client searches for employment in a group setting. The group may help to improve his/her skills and strengthen the support systems. The case manager may then be perceived as helpful and responsive.

After the goals have been met, the termination phase should be initiated. In this phase, support systems are reinforced and redirected if necessary, feelings of loss are explored, and the client-worker relationship is reviewed and redefined (Levy, 1998).

Limitations of the Study

The limitation of this study was that the data only accounted for people in the years 1999 and 2001. There was historical information that was not obtained. The study was not able to discern if various ethnic groups sought services at different times within the last seventeen years from San Bernardino County's, Mentally Ill Homeless

program. Limiting the study made it impossible to show if the homeless population has changed over the years. However, going back any further was beyond the scope of this research project.

Another limitation was that the researcher developed the interview guide. The instrument had not been used and tested previously. The use of a new instrument questions the reliability and validity and findings are only suggestive.

Recommendations

The mentally ill homeless are a diverse group of individuals with special needs. This research project just touched on a few aspects involved in the homeless experience. Further analysis is necessary to determine to what extent cultural difference play in the homeless experience. Also, longitudinal studies would help identify changes in patterns of homelessness and evaluate the effects of services.

The researcher strongly recommends that when working with homeless people, respect and be responsive to people who remain attached to an ethnic identity. Implications for social work need to be directed at understanding the

diversity of the mentally ill homeless. Social workers need to be knowledgeable of current research in order to be culturally sensitive and aware of each group's unique differences. Effective case management services need to go beyond meeting the basic needs of food, clothing and shelter and also focus on their unique characteristics, values, attitudes and help seeking behaviors.

APPENDIX A
INFORMED CONSENT

INFORMED CONSENT

This study in which you are about to participate is designed to gather some personal background information and opinions about service needs from individuals who are currently seeking services from San Bernardino County's Mentally Ill Homeless program. This study is being conducted by Cynthia Roth under the supervision of Jetta Warka, a graduate student at Loma Linda University, and under the guidance of Dr. Rosemary McCaslin, Professor of Social Work. This study has been approved by the Institutional Review Board, California State University, San Bernardino and the Research Review Committee, San Bernardino County, Department of Behavioral Health.

If you decide to participate, you will be interviewed by Cynthia Roth. The interview will take approximately one hour and you will be asked to answer some questions related to you, your family, and your service needs. Please understand that your participation in this interview is completely voluntary. Your receiving of services from the Homeless Program will in no way be influenced by whether or not you participate in this study. Please also understand that you are free to withdraw at any time during the interview without penalty, and you may choose to not answer

any questions during the interview. All of your responses will be held in the strictest of confidence by the researcher. Your name will not be reported with your responses. All results will be reported in group form only.

If you have any questions about the study, please contact Cynthia Roth at (909) 388-4120. If you have any concerns about the study, please contact Dr. McCaslin at (909) 880-5507. Group results of the study will be available at the California State University, San Bernardino, Pfau Library after June 15, 2001, or you may contact Cynthia Roth and she will arrange a time to explain the results to you. If you agree to be interviewed, please sign your name below.

By signing my name below, I acknowledge that I have been informed of, and that I understand, the nature and purpose of this study, and I freely consent to participate. I also acknowledge that I am at least 18 years of age.

Signature _____

Date _____

APPENDIX B
INFORMED CONSENT FORM

INFORMED CONSENT FORM

It has been explained to me that participation in this study is not required as part of my treatment. I understand the above and am taking part in this study of my own free will. I also understand that I can refuse to participate at any point in the study. I further understand that all information obtained is confidential, and that my rights as a client will be fully protected as specified by the Welfare and Institutions Code.

Client's Signature

Date

Client's Printed Full Name

(Parent's Signature if Client is a Minor)

Date

Researcher's Signature

Date

The original of this form must be submitted to the Chair of the Research Review Committee for inclusion in that investigator's file.

APPENDIX C
DEBRIEFING STATEMENT

DEBRIEFING STATEMENT

Thank you for your participation. The information you provided will be used to gain insight into the service use of mentally ill homeless people in regards to their ethnicity. Confidentiality will be protected by not releasing or reporting names. The person who conducted the interview was Cynthia Roth and she is an MSW student at California State University, San Bernardino. If you have any questions, you may contact her at San Bernardino County, Department of Behavioral Health, Mentally Ill Homeless program at (909) 388-4120. If you have any concerns about the study, please contact Dr. McCaslin at (909) 880-5507. Results will be available in the California State University, San Bernardino, Pfau Library or let Cynthia Roth know and she will arrange a time to explain the result to you after June 15, 2001.

After the interview, if you need assistance in discussing any feelings that may be upsetting or distressing, please contact your case manager in the Homeless Program.

APPENDIX D

INTERVIEW GUIDE

INTERVIEW GUIDE

1. What is your identified ethnicity?
 - a. Black
 - b. White
 - c. Hispanic (obtain information on level of assimilation such as 1st generation and how long have you been in this country?)
 - d. Other
2. Age?
3. Have you lived in San Bernardino County all your life?
4. Raised by one or both parents, Foster Care, group homes, institutional care, run away, raised by family other than parents?
5. Why are you homeless? (note all that apply)
 - a. Economic problems (unemployment, difficulty handling funds)
 - b. Family problems (domestic violence, no living family members, or alienated from family)
 - c. Mentally illness
 - d. Drugs and/or alcohol problems
 - e. Other
6. Do you have any surviving family?
 - a. How many existing family members do you have and what is your relationship them
 - b. Are they demographically close?
 - c. How often do you see them?
 - d. Are they supportive? (tangible resources such as money, food, clothing, a place to stay, a place to wash up, or expressive in nature such as moral or emotional support, companionship, recreational socializing or just sharing conversation?)
 - e. What does your family think about you going to a shelter?
 - f. Within your culture, is it appropriate to receive services from a shelter?

7. How many different people do you sometimes turn to for help?
 - a. Description of relationships closeness, how often do you see them?
 - b. Mode and frequent of contact - face to face, phone, mail, through the intervention of another person or combination
 - c. Emotional connections to the people
 - d. Types of support or resources acquired from relationship?
 - d. Reciprocity - mutually support each other and how (emotionally or materially)?
8. Where were you living before you came to this program? (Streets, apartment, home, etc.)
 - a. (If in the streets) How long have you been living on the streets?
 - b. (If not in the streets) How did you support yourself? (Employment, SSI, GR)
9. Do you have an income? If yes, from where, and how much?
 - a. How many times have you been homeless?
 - b. Are you homeless in the company of someone else or are you alone?
 - c. Do you have many homeless friends and if so, are they supportive?
 - d. What kind of support do they provide?
10. What is your education level?
11. Are you a veteran?
12. Religious affiliation? Relevance and Importance to you. Importance to family?
13. Have you ever been hospitalized? If yes, for what, when and how many times?
14. How did you find out about this program? (Hospital, friends, mental health agency)
15. Has this program been beneficial in meeting your needs?
16. Are there any other services this program may be able to provide that you could benefit from?
17. What services are most important to you?
18. What is the most important thing to you?
19. What can case managers do to help you?
20. Do you think it would be helpful to have a case manager that is of the same ethnicity as you are?
21. If yes, why? If no, why?

APPENDIX E


LETTER OF APPROVAL FROM SAN BERNARDINO COUNTY, RESEARCH
REVIEW COMMITTEE

INTEROFFICE MEMO



DATE: MARCH 27, 2001

PHONE: 387-7242

FROM:  ROSARIA A. BULGARELLA, Ph.D.
Chair, Research Review Committee

TO: CYNTHIA ROTH-FELTER

SUBJECT: APPLICATION FOR RESEARCH APPROVAL

Your application for project approval entitled **THE ETHNIC MAKEUP OF INDIVIDUALS WHO SEEK SHELTER FROM SAN BERNARDINO COUNTY'S MENTALLY ILL HOMELESS PROGRAM** has been approved by Rudy Lopez, upon recommendation of the Research Review Committee.

The following changes have been recommended for your project;

1. The researcher will compare the San Bernardino County population with the San Bernardino County Mentally Ill Homeless population, **the San Bernardino County Mentally Ill population and San Bernardino County Homeless Program.**
2. Sample selection **shall not be called a random sample.**

Phyllis Rattely will be your monitor for this project.

IN ACCORDANCE WITH SECTION VII OF THE RESEARCH REVIEW COMMITTEE'S GUIDELINES, VERBAL PROGRESS REPORTS WITH YOUR MONITOR ARE DUE WEEKLY, AND WRITTEN PROGRESS REPORTS ARE DUE MONTHLY.

I wish you well on the completion of your project.

RAB:ns

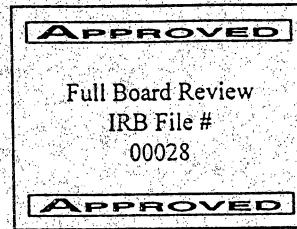
cc: R. Lopez
B. Morris
J. Babiera
C. Ebbe
P. Rattely

APPENDIX F

HUMAN SUBJECTS APPROVAL



CALIFORNIA STATE UNIVERSITY
SAN BERNARDINO



The California
State University

April 17, 2001

Ms. Cynthia Roth-Felter
c/o Professor Jette Warka
Department of Social Work
California State University
5500 University Parkway
San Bernardino, California 92407

Dear Ms. Cynthia Roth-Felter:

Your application to use human subjects, titled, "Ethnic Makeup of Individuals Who Seek Shelter from the San Bernardino County Mentally Ill Homeless Program" has been reviewed by the Institutional Review Board (IRB). Your informed consent statement should contain a statement that reads, "This research has been reviewed and approved by the Institutional Review Board of California State University, San Bernardino."

Please notify the IRB if any substantive changes are made in your research prospectus and/or any unanticipated risks to subjects arise. If your project lasts longer than one year, you must reapply for approval at the end of each year. You are required to keep copies of the informed consent forms and data for at least three years.

If you have any questions regarding the IRB decision, please contact Michael Gillespie, IRB Secretary. Mr. Gillespie can be reached by phone at (909) 880-5027, by fax at (909) 880-7028, or by email at mgillesp@csusb.edu. Please include your application identification number (above) in all correspondence.

Best of luck with your research.

Sincerely,

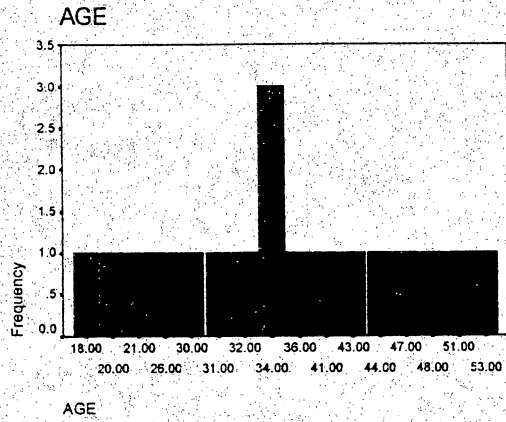
Joseph Lovett, Chair
Institutional Review Board

JL/mg

cc: Prof. Jette Warka

APPENDIX G
AGE DISTRIBUTION

AGE DISTRIBUTION



AGE

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	18.00	1	5.6	5.6	5.6
	20.00	1	5.6	5.6	11.1
	21.00	1	5.6	5.6	16.7
	26.00	1	5.6	5.6	22.2
	30.00	1	5.6	5.6	27.8
	31.00	1	5.6	5.6	33.3
	32.00	1	5.6	5.6	38.9
	34.00	3	16.7	16.7	55.6
	36.00	1	5.6	5.6	61.1
	41.00	1	5.6	5.6	66.7
	43.00	1	5.6	5.6	72.2
	44.00	1	5.6	5.6	77.8
	47.00	1	5.6	5.6	83.3
	48.00	1	5.6	5.6	88.9
	51.00	1	5.6	5.6	94.4
	53.00	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

APPENDIX H

RESIDENCY

RESIDENCY

RESIDENT

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	less than 6 months	4	22.2	22.2	22.2
	more than 6 months	14	77.8	77.8	100.0
	Total	18	100.0	100.0	

APPENDIX I

REASON FOR HOMELESSNESS

REASON FOR HOMELESSNESS

Family problems, domestic violence, no living family members

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid yes	10	55.6	55.6	55.6
no	8	44.4	44.4	100.0
Total	18	100.0	100.0	

mental illness

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid yes	3	16.7	16.7	16.7
no	15	83.3	83.3	100.0
Total	18	100.0	100.0	

drugs and/or alcohol problems

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid yes	5	27.8	27.8	27.8
no	13	72.2	72.2	100.0
Total	18	100.0	100.0	

other reason

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid yes	6	33.3	33.3	33.3
no	12	66.7	66.7	100.0
Total	18	100.0	100.0	

APPENDIX J

EDUCATION

EDUCATION

education

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	not graduated	4	22.2	22.2	22.2
	graduated from high school	8	44.4	44.4	66.7
	some college	6	33.3	33.3	100.0
	Total	18	100.0	100.0	

APPENDIX K

MILITARY SERVICE

MILITARY SERVICE

military service

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid yes	2	11.1	11.1	11.1
no	16	88.9	88.9	100.0
Total	18	100.0	100.0	

APPENDIX L
HOW REFERRED

HOW REFERRED

how one found out about this program

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid hospital	9	50.0	50.0	50.0
friends	2	11.1	11.1	61.1
mental health agency	4	22.2	22.2	83.3
walked by	3	16.7	16.7	100.0
Total	18	100.0	100.0	

APPENDIX M

HOMELESS ALONE OR IN THE COMPANY OF OTHERS

HOMELESS ALONE OR IN THE COMPANY OF OTHERS

homeless alone or with somebody

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid in the company of someone else	6	33.3	33.3	33.3
alone	12	66.7	66.7	100.0
Total	18	100.0	100.0	

APPENDIX N

RAISED BY FAMILY OR FOSTER CARE

RAISED BY FAMILY OR FOSTER CARE

foster care, ward of the court

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid raised by parents	13	72.2	72.2	72.2
raised by family, other than parents	2	11.1	11.1	83.3
foster care, group homes, institutions	2	11.1	11.1	94.4
child runaway	1	5.6	5.6	100.0
Total	18	100.0	100.0	

ANOVA

foster care, ward of the court

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	6.333	2	3.167	5.816	.013
Within Groups	8.167	15	.544		
Total	14.500	17			

Multiple Comparisons

Dependent Variable: foster care, ward of the court

Tukey HSD

(I) ETHNIC	(J) ETHNIC	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
African American	Caucasian	.1667	.4260	.920	-.9399	1.2732
	Hispanic	-1.1667*	.4260	.038	-2.2732	-6.0123E-02
Caucasian	African American	-.1667	.4260	.920	-1.2732	.9399
	Hispanic	-1.3333*	.4260	.018	-2.4399	-.2268
Hispanic	African American	1.1667*	.4260	.038	6.012E-02	2.2732
	Caucasian	1.3333*	.4260	.018	.2268	2.4399

*. The mean difference is significant at the .05 level.

RAISED BY FAMILY OR FOSTER CARE

foster care, ward of the court

Tukey HSD^a

ETHNIC	N	Subset for alpha = .05	
		1	2
Caucasian	6	1.0000	
African American	6	1.1667	
Hispanic	6		2.3333
Sig.		.920	1.000

Means for groups in homogeneous subsets are displayed.

a. Uses Harmonic Mean Sample Size = 6.000.

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