Service utilization among the mentally ill homeless

Amanda Nicole Card
Heather Nicole Sylvester

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SERVICE UTILIZATION AMONG THE MENTALLY ILL HOMELESS

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
Amanda Nicole Card
Heather Nicole Sylvester
June 2007
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Approved by:

Dr. Teresa Morris, Faculty Supervisor
Social Work

Reverend David J. Kalke, Executive
Director Central City Lutheran Mission

Dr. Rosemary McCaslin,
M.S.W. Research Coordinator
ABSTRACT

Homelessness is a significant problem in San Bernardino County. There are many programs that serve the needs of this population, however little is known about the factors that contribute to service utilization among the homeless. This study conducted in-depth interviews with 11 homeless or formerly homeless individuals at the Central City Lutheran Mission. Utilizing a post-positivist design, the data was analyzed through open, axial and selective coding to determine a conditional matrix of service utilization. The data suggested that utilization is affected by the welcoming or unwelcoming nature of the agency. Welcoming agencies were less restrictive, provided diverse services, and treated consumers with respect. Unwelcoming agencies provided little outreach, had negative attitudes, and services did not address the full needs of the population. Society's view of the homeless is reflected in unwelcoming agencies, however there remain individual protective factors that can shield the homeless individual from negative consequences of homelessness.
ACKNOWLEDGMENTS

The authors would like to acknowledge their family and loved ones who have given their endless support, without which neither of us would have completed this journey. We would also like to acknowledge the peers, mentors, and faculty who have guided us along the way.
DEDICATION

To the homeless people of San Bernardino County.
Thank you for sharing your stories and allowing us to tell them to others.
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CHAPTER ONE

ASSESSMENT

Introduction

This chapter introduces the research focus and discusses post-positivist research design and why it is the most appropriate for this particular topic. The literature on the utilization of service among the mentally ill homeless is also discussed. Finally this study's contribution to social work on a macro practice level will be explored.

Research Focus and/or Question

The focus of this research project is mental health service utilization among the homeless in San Bernardino. A wide array of services are available to the mentally ill homeless in this area, however services offered often do not meet the needs of this population. These needs include coordinated care, which include services such as, mental health, medical, employment, benefits, and transportation services among others. Most service agencies offer only one component of the above model. This study sought to illuminate the factors that
contribute to and inhibit service utilization among this population.

Paradigm and Rationale for Chosen Paradigm

This study utilized the post-positivist paradigm. Researchers chose this paradigm because it allows for individuals to share their own experiences and views, which is often not the case for the homeless. Little of the available research explores the individual experiences of homelessness and rather focuses on numerical data and the experiences of professional staff. The post-positivist paradigm offers an approach that builds theory out of qualitative data with themes derived from that data, rather than using data to prove or disprove an existing theory.

Literature Review

Introduction

This review examines characteristics of the mentally ill homeless both at a local level and nation wide. Organizational characteristics and effective housing programs are also discussed. Finally individual perceptions regarding service utilization is explored.
Demographics of Homeless Population

While a large percentage of homeless individuals in San Bernardino County have a mental illness, many are not utilizing services. Approximately 30% of homeless individuals in San Bernardino have a mental illness. Only 20% of the homeless are receiving services for mental health. Sixty-seven percent of the homeless in San Bernardino County are eligible for some form of government assistance that they are not utilizing (Applied Survey Research, 2003).

The literature suggests that age, gender, and race are all risk factors for homelessness (Rossi, 1990 as cited in Acosta & Toro, 2000). Statistical data regarding the homeless population in San Bernardino is consistent with this finding. Individuals under the age of 25 comprise more than 14% of the homeless in San Bernardino County. The majority of the homeless are men, although women and children account 32% of the homeless population. Finally, while the majority of homeless are Caucasian, African Americans are overrepresented in the homeless population (Applied Survey Research, 2003).
Organizational Characteristics

Service utilization appears to be related to the types of services offered. "Homeless persons with severe mental illness will partake in services, if the service system can break out of the mold of traditional service provision and become responsive to their needs" (The Federal Task Force, as cited in Levy, 2000, p. 360).

Behavioral Health programs tend to focus solely on mental health issues while ignoring other basic needs that are viewed as priorities by the homeless population. The homeless population prioritizes their five basic needs as good health, steady income, permanent job, a permanent home, and regular meals (Acosta & Toro, 2000).

Comprehensive services that address all of these priorities are essential in engaging this population.

There are additional factors that have been cited as effecting service use among the homeless population. Consumers have stated with reference to health services, that cost of service, lack of transportation, concerns about personal theft, and inaccessible hours are all barriers to utilization (Swigart & Kolb, 2004). Regarding mental health services programs that are more streamlined in funding and have educated staff have higher

**Perceived Needs**

Perceived needs and previous experiences also contribute to service utilization. Traditional program focus on the agency’s perception of needs, rather than the consumer’s perception, which affects service utilization (Acosta & Toro, 2000’ Fisher, Florsheim, & Sheetz, 2005, p. 42). A study of homeless youth found that issues identified as problematic by the researchers (i.e. substance abuse, victimization) were not deemed problematic by the youth. “There are strong indications that homeless people themselves rate their needs for formal mental health and substance abuse service as relatively unimportant” (Salize, Horst, Dillmann, Killman, Stern, Wolf, Henn, & Rossler, 2001 p. 207). This indicates that client directed programs might improve service utilization. This may be accomplished by focusing services on the areas that the homeless find important, rather than what service providers deem important.

Primary service utilization by the homeless occurs in emergency settings. Youth tend to utilize services only when identified problems reach a crisis level.
Swigart and Kolb conducted a study exploring the utilization of health screening services found that homeless individuals may be habituated to chronic health problems, resulting in emergency-only service utilization. The extensive treatment process is often perceived as too cumbersome for individuals who have a variety of urgent basic needs (2004). This may explain lower rates of service utilization for long-term, comprehensive treatment programs.

Previous experience with services may affect utilization. For youth, previous experiences with mental health services may decrease utilization (DeRosa et al., 1999; Embry, Vander Steop, Evens, Ryan, & Pollock, 2000 as cited in Fisher et al., 2005). Individuals who have had negative outcomes in previous service encounters may also avoid treatment programs (Levy, 2004, p. 372). For example, if an individual went to a housing program and due to their mental health issues were hospitalized rather than housed, this would decrease their motivation to seek services again. However, Sosin and Bruni found that individuals with previous substance treatment history were more likely to utilize these services again.
than those who had never used services (2005, p. 25). This may indicate that substance abuse services are easier to access than mental health services.

Concerns Identified with Services

Human service utilization has been found to be negatively impacted by fears of negative outcomes among a variety of populations. An early study of a program in Philadelphia found that women did not utilize services because they were fearful of being hospitalized, fears of victimization, or other unidentified concerns (Culhans, 1992, p. 63-65). Homeless youth also cited concerns that workers would contact police or their families, which limited service utilization (Fisher et al.; 2005). Health service utilization can be limited by fear of confidentiality breaches and negative social service contacts (Swigart & Kolb, 2004). Therefore, the potential for negative outcomes may limit service utilization. Providing information about potential positive and negative outcomes before services are provided may be beneficial in increasing service utilization.

Housing and Homelessness

Having ample stock of affordable housing and making that housing accessible "without strings" is essential in
addressing the problem of homelessness. Yanos, Barrow, and Tsemberis (2004) found that housing is a central component in community reintegration for the mentally ill homeless population. The federal government found that throughout the nation, there is a significant shortage of affordable housing options for individuals with low-income (New Freedom Commission, 2003, p. 1). Without available housing resources, it is unlikely that homeless individuals will be able to find permanent housing.

[ ]Making housing readily available has been found to increase service utilization. Agencies that offer housing up-front and without imposing restrictive criteria, such as immediate employment or intensive therapy, have a higher rate of service utilization and higher quality of life indicators (Tsemberis, Moran, Shinn, Asmussen, & Shern, 2003, p. 307-310; Culhans, 1992, p. 63-65; New Freedom Commission, 2003). Programs which allow consumers to have more say in the types of housing services offered, and those that have few restrictive criterion for receiving those services have better outcomes. This service model allows for the development of a trusting relationship with the consumer, which is an essential part of engagement (Levy, 2000, p. 372).
Limitations of Literature

The literature is limited regarding specific factors related to service utilization for mental health services for homeless individuals (Lemming & Calsyn, 2004). The literature regarding homelessness tends to focus on individual factors of homeless, although some literature regarding program characteristics was found (North et al., 2005). In the article written by Speer (2000) it was identified that empowerment theory literature was limited and at times conflicting regarding the efficacy of the approach. Finally, research regarding comprehensive case management services was not located.

Summarization of Literature

The literature provides the theoretical concepts on which this project is founded. This discussion examined characteristics of the homeless both at a local level and nation wide. Organizational characteristics and effective housing programs are also incorporated. Finally individual perceptions regarding service utilization is explored.
Theoretical Orientation

The mentally ill have traditionally been an oppressed group, particularly the homeless mentally ill. Empowerment theory seeks to involve the oppressed individual in developing decisions and activities that give them more access to the community and power over their lives (Lindhorst, 2006). Power and self-efficacy are two key areas of empowerment theory. Having the power to make decisions regarding one’s own life increases self-efficacy, or the belief that one can make positive changes. Often for the consumer of services, power is not shared and tangible results of empowerment are not achieved, which has been found to be important for consumers (Boeh & Staples, 2002, p. 457-458). Therefore, individuals who have a sense of empowerment and the knowledge to act on that empowerment are more likely to participate in the community (Speer, 2000).

The goal of this research project is to obtain information from the homeless individuals themselves to better understand how providers may facilitate empowerment and increase community participation among this population. The researchers believe that empowered individuals will be more likely to actively participate
in services to better their lives, such as mental health services.

Potential Contribution of Study to Micro and/or Macro Social Work Practice

The study can contribute to social work practice at a macro level by providing information about mental health service utilization among the homeless. Most counties in California have programs geared towards providing services to the mentally ill homeless population. Providing information on factors impacting service utilization may be used to improve services throughout the state. Additionally, this study can contributed to micro social work practice by increasing service providers' knowledge regarding particular service needs of mentally-ill homeless consumers.

Summary

This chapter introduced the research focus and discussed post positivism and why it is the most appropriate for this particular topic. The literature on the utilization of service among the mentally ill homeless was also examined. Finally this study's contribution to social work was explored.
CHAPTER TWO

ENGAGEMENT

Introduction

This chapter focuses on the engagement of the research site and participants. Issues related to researcher’s self-preparation and challenges faced in the engagement process are also discussed. Finally, issues of diversity, ethics, and politics are explored.

Research Site and Study Participants

The study was conducted at a local mission in downtown San Bernardino where food is distributed. This site offers meals to the local poor and homeless daily. The site also has after school programs, housing for HIV+ homeless, and provides a cold-weather shelter. Study participants were homeless and formerly homeless adults accessing the food distribution program.

The majority of homeless in San Bernardino are Caucasian males between the ages of 26-55. Fourteen percent of the homeless are under the age of 25 and one-third of the homeless are women. Latinos and African Americans are over-represented in the homeless population. This was confirmed at the research site,
where the majority of individuals utilizing services were African American and Latino. Ninety percent of the homeless were born in the United States and have lived in San Bernardino for more than ten years (Applied Survey Research, 2003). This counters the misconception that individuals utilizing homeless services are either immigrants to the United States or are from other areas of the county.

Engagement Strategies for Each Stage of Study

The post positivist paradigm combines engagement and assessment. Initial engagement required communicating with gatekeepers. The research site has a working relationship with the University and staff contacted a social worker at the mission to discuss this project. Researchers then contacted the social worker and the executive director of the agency, who agreed to allow researchers to conduct the study. Researchers then met with individuals that work directly with the food distribution program. Researchers met with the supervisor of the food distribution program before beginning data collection to discuss food program and explain role of the researchers and the scope of the research project.
Upon gaining entrée to the site researchers spoke with agency staff at the food distribution site to gain information about individuals whom use the food program. This was done to determine logistical issues of conducting research, such as the best way to engage participants and to determine interview locations.

Initially researchers displayed flyers encouraging people to participate in research study. Researchers then spent the first two weeks going to the research site and making presence known to participants in the program and gatekeepers through informal conversations and by attending morning church services. Researchers decided to set up a station outside of food distribution site with research flyer posted and free refreshments. Finally, incentives were given to participants as a means of engagement which consisted of $10 gift cards to a local store.

When researchers were asked why they were present, they explained the purpose of study and parameters of interviews. Inquiring individuals were encouraged to share their experiences and beliefs related to mental health service and their experiences with homelessness. During the informal conversations with community members,
staff, and participants several themes and concepts emerged: including lack of available services, services that are difficult to access due to lack of information or restrictive criteria, services that are not comprehensive, and other factors affecting utilization (i.e. transportation, unfriendly staff, etc). The researchers assumed that service utilization is negatively affected by programs' inability to meet the needs of the population, the restrictive nature of the programs, and disjointed public transportation system.

Individuals that agreed to participate in the study were engaged using micro-level interviewing skills such as empathic listening, non-verbal prompts, creating an atmosphere free from judgment, and clarification of participant statements. These skills were needed to create a trusting environment in which participants felt comfortable speaking with researchers. For example, researchers utilized empathic listening, created an environment free of judgment, and clarified statements made by the participants to ensure their meaning and purpose (Morris, 2006). Researchers were mindful of body language and word choice in order to help participants feel at ease.
Self Preparation

The main areas of self-preparation were attention to diversity, communication, and utilizing professional experience. Issues of diversity will be addressed in the following section. Self preparation consisted of researchers evaluating their own style of communication, which tends to be more assertive and how that might impact the participants. Researchers discussed with each other that participants may communicate utilizing other styles, such as passive communication. Researchers needed to adjust their own communication in light of this.

Additionally researchers were mindful that their role was that of an active listener and not to impose judgment or attempt to change the participant’s perception.

Both researchers have six years of human services and counseling experience. This prepared researchers in understanding some of the issues faced by this population. One of the researchers used her experiences as an advocate for women in crisis situations to develop rapport with female participants. The other researcher had completed a year long internship with a mental health homeless program. This allowed her to better understand
the concerns of this population and how the community responds to homeless individuals.

Diversity Issues

The homeless population is far from homogeneous. The homeless population varies in ethnicity, homeless identity, gender, and personal history. This county has a migrant farm worker population, as well as African-American, Caucasian, Native-American, Asian, and Latino individuals. Some have been living in the area for generations, whereas others have recently arrived in the area. The different cultures have varying norms of interpersonal communication, for example the African Americans that researchers encountered tended to be open to sharing personal experiences. Researchers became familiar with these norms through personal experience, observation, and by speaking with agency staff and other professionals regarding cultural norms.

Researchers also had to be aware of the impact that their own culture may have on participants. The researchers were women, one Caucasian and the other African-American. The presence of a Caucasian individual among a racial minority group may have made participants
reluctant to approach researchers initially. Both researchers were women, which did not appear to impact participation, as genders were equally represented among participants. Both researchers were middle-class and educated, which may have impacted participation, as individuals made comments about college education and then declined to participate. Neither researcher was bi-lingual, which may explain why the Latino population did not engage in this study.

Homeless status is another area of diversity within the population. Individuals living in an encampment may have different self-identity than those who are either recently homeless or living in a shelter. Also, the many of participants were transitionally homeless and not chronically homeless. Transitionally homeless are more likely to engage in services than chronically homeless individuals. This distinction can help to determine the type of strategy used when encountering the individual. For example, a person who is chronically homeless has adapted to life on the streets and may be less likely to “jump through hoops” for services, thus requiring a longer engagement process than the transitionally homeless individual.
Personal experiences also played a role with regards to diversity. Many homeless have had negative encounters with government workers and authority figures. These experiences needed to be validated in order to engage the individuals. The researchers had to be aware that perceived socioeconomic class differences was a barrier in engaging this population. Researchers were sensitive to this class difference when preparing for this study and made efforts to minimize these differences through casual presentation and language. For example, researchers generally dressed in jeans and tee shirts and modified the language of materials to be more accessible to participants.

Ethical Issues

The post positivist paradigm has a decreased level of anonymity due to interview style of data collection. Post positivist researchers are highly involved with participants during data gathering process. However, involvement ends at the conclusion of the project, possibly resulting in negative emotional responses in the participants. Other ethical issues that arise are the vulnerability of the mentally ill homeless population;
therefore individuals may feel compelled to participate in the project believing it is part of services. This was addressed by having a comprehensive informed consent process where these issues were discussed with potential participants before they agreed to interview. A mini-mental health status exam was also administered to ensure the ability of the participant to provide informed consent.

Another issue that arose was the use of an interpreter. A significant number of individuals were mono-lingual Spanish speaking and while mission staff could have served as interpreters, it was determined that this would decrease anonymity and compromise confidentiality, therefore only English speakers participated.

Political Issues

Services for the mentally ill homeless population is a politically sensitive topic. The passage of the Mental Health Services Act and the AB34 legislation ushered in an era of provision of services to a population that has been underserved for many decades (Scheffler & Adams, 2005, p. 214). Additionally, The New Freedom Commission
(2003) states that the federal government is seeking to end chronic homelessness within the next ten years, resulting in potential funding and political pressure.

Non-profit organizations such as the mission are often in competition with other service providers for funding. The advent of increased government spending on this area has provided for more service provision opportunities. Any data that could depict the agency in a negative light may be construed as a threat to funding. Therefore, as part of engagement with gatekeepers, researchers discussed any concerns about the study, however gatekeepers were not concerned with negative outcomes. Finally, there has been a recent push for agencies to hire consumers for continued funding eligibility. The mission has addressed this by hiring former consumers as staff and therefore this was not an issue.

Summary

This chapter focused on the engagement of the research site and participants. Issues related to researcher's self-preparation and challenges faced in the
engagement process were discussed. Finally, issues of diversity, ethics, and politics were explored.
CHAPTER THREE
IMPLEMENTATION

Introduction

This chapter describes the selection of participants, phases of data collection, data gathering, and data recording. The demographics of the participants and the rationale for the selection of the participants are also given. Finally, the specific methods for gathering data is addressed.

Selection of Participants

Participants in this study consisted of 11 homeless and formerly homeless individuals who also had symptoms of mental illness. The participants were individuals who came to the Central City Lutheran Mission for meals during the week. The majority (73%) of the participants were African American. 18% of participants identified themselves as Caucasian and 9% were Latino. There were five males and six females who participated in the study. It must be noted that there was a large percentage of Latinos at the research site, however only one participated in the study. During informal conversation with these individuals, it was noted that Spanish was
their primary language and neither researcher was bi-lingual.

Participants were selected through purposive intensity sampling. Intensity sampling selects participants specifically because they represent the population being studied. This type of sampling allows for selection of participants who can provide vivid descriptions of the experience of being both mentally ill and homeless and factors that contributes to their usage or avoidance of services (Morris, 2006). The sampling in this study was conducted by placing flyers advertising the research project at the mission. The researchers then screened potential participants to identify those individuals who could provide a detailed description of experiences with both homelessness and mental health services.

Screening was completed through informal interviews while individuals were waiting to be called to get their food. Researchers spoke to individuals about their use of mission services. Researchers also provided a more in depth description of the research project. Researchers inquired briefly about the use of other community resources in addition to the food services at the
mission. Along with these informal inquiries researchers conducted the mini mental health status exams by asking information about dates, times, locations, and purposes of events.

Phases of Data Collection

Data gathering was conducted through interviews with homeless adults at a local mission. Researchers utilized all forms of interview questions including, descriptive, structural, and contrasting questions to clarify participant responses. Utilizing all forms of interview questions allowed the researchers to gain a more detailed picture of how participants view their resources and their current situations. For example, questions asking about the participants' experiences with mental health services assisted researchers in gaining a better understanding about reasons why services are not being used currently. After each interview, the data collected in that interview was coded and analyzed. The data from these interviews was used to formulate the questions and strategy for the next interview. For example during the first interview the participant brought up issues of employment therefore this subject was included in
subsequent interviews to determine if this was an issue for other participants.

The researchers were prepared and knowledgeable on anticipated topics of conversation and interview content before conducting any interview. Prior to obtaining informed consent, a mini mental health status exam was conducted through an informal conversation with potential participants during which time they were asked questions such as the date, present location, and other information to assess their ability to give informed consent. The researchers then obtained participant’s informed consent before proceeding with the interview process. This was done by giving the participant a copy of the informed consent to read while researchers read the information aloud. Participants were reminded that they could terminate the interview at any time, as the interview could explore emotional topics. Finally, to ease participants during interviewing, researchers provided participants a list of questions for them to view during the process. This allowed participants to better understand the interview process as well as anticipate what the process entailed.
Researchers were aware of diversity of participants when conducting interviews. Initially, the interviews were going to be divided into separate parts: engagements, development of focus, maintain focus, and termination. However, by having informal conversations with participants prior to the interview starting, initial engagement occurred prior to the formal interview starting. When conducting the interview researchers were conscious that not all participants required the same amount of time for each phase. For example, individuals who are more symptomatic required more time in the maintaining focus stage (Morris, 2006).

Once the interview was completed, the researchers summarized what has been discussed and ask the participant for any feedback and or clarification of responses. This information was used to formulate new questions in subsequent interviews and in developing areas for clarification and expansion.

Data Gathering

Data was gathered during interviews with study participants. The interviews took place in either the empty chapel of the church or at a quiet table set apart
from the counseling center outside the mission. The interviews lasted between fifteen and thirty minutes.

The first stage of the interview was engagement, followed by development and maintenance of focus, and concluded with termination of the interview. Researchers followed these stages and utilized a variety of questions to obtain and clarify information. Descriptive questions were used to gain general information, such as homeless status and mental health status. For example, participants were asked if they were currently homeless or were currently utilizing mental health services. Structured and contrast questions were used to clarify and define information such as how previous experiences with mental health services are similar or different from current utilization (Morris, 2006).

Researchers engaged in a bottom-up analysis of the interviews, which allowed the theory to develop out of the data. Researchers maintained journals throughout the research process where rationales for interview questions and interpretations and responses to interviews were developed. This allowed the researchers to track the development of the theory (Morris, 2006).
Data Recording

Qualitative data was recorded in accordance with the preference of the individual; either through digital recording, notes taken during the interview, or notes taken immediately after the interview is completed. All participants except one agreed to have the interview recorded. Researchers kept a journal for reflection on interviews and research findings. The researchers updated the journal after each interview and analyzed to ensure that the information was accurate and to decide the importance of the finished interviews. The journal allowed the researchers to consider what could be changed for future interviews and to reflect on their own reactions to and experiences of the interview.

Summary

This chapter focused on the selection of participants, phases of data collection, data gathering, and the methods for data recording.
CHAPTER FOUR
EVALUATION

Introduction

This chapter summarizes how data was analyzed and interpreted. The chapter discusses how open codes were derived from the interviews and then selectively coded to develop the theory.

Data Analysis

The qualitative data was analyzed using bottom up data analysis through the use of open coding, axial, selective coding, and the development of a conditional matrix. Atlas-TI software was used to analyze the data to develop codes and themes. An example of the coding process was several participants described situations where they went to get help from agencies and they were turned away. These various comments were all given the same open code of "criteria", as they were all related to the strict criteria of programs. This code was then linked with other similar codes through selective coding as characteristics of "unwelcoming agencies". This coding process was repeated to develop the theory or the
conditional matrix regarding service utilization (Morris, 2006).

Open and Axial Coding

As researchers reviewed the interview data, codes were developed for quotes and ideas that conveyed important ideas and specific aspects of the participant’s experiences. These open codes were developed further with the use of journals written by researchers after each interview. These axial codes were then clarified in subsequent interviews. Each code is defined and supported with a quote from a participant pertaining to that particular code along with references from journals indicating why the code was deemed important.

Cause of Homelessness

Cause of homelessness was defined as events that took place in a participant’s life that caused them to become homeless. “I think the main cause of being homeless is like what we went through, people like my wife and I, we had this home were barely surviving because she is on SSI and I am not working and I am not in great shape but we are surviving and then all of a sudden we are out on the streets for no reason of our own
and I think there are a lot of people like that”
(48-year-old Caucasian formerly homeless male). The
factors that led to a participant’s homelessness were
reflective of societal factors that keep people in
poverty.

**Community Resources**

Community resources were coded and defined when
individuals discussed not for profit services, churches,
and other private services. “A lot of churches give you
like $2 or something and give you a little food and that
is it” (42-year-old African-American male, currently
homeless). This code was used as many people were aware
of only a few if any community resources.

**Coordinated Care**

Coordinated care was coded in order to describe
participants describing services that addressed all areas
of life “because psychiatrist only look at a certain part
they are looking at the meds and the therapist who is
looking at one part and then luckily because of the viral
pneumonia I had a medical doctor because if I had not had
the viral pneumonia he would have been out of the loop
and there is no telling where I would be” (53-year-old
married African-American female, formerly homeless). This
was deemed to be an important aspect of services, as the homeless population often has multiple needs that need to be addressed. Treating the mental health problems without treating the medical needs sabotages the success of treatment.

Cost of Living

Many participants cited the cost of living as a cause of homelessness and a barrier to obtaining independent living. "And to this day, I can not pay my light, I can not pay my gas, I have to depend on help from the government, like the HEAP program" (66-year-old divorced African-American female, formerly homeless) and "We come here to get food because we have an income, we don't get food stamps with that income, we don’t qualify for food stamps so from our social security check we are paying for rent utilities and food and we just don’t make it all month" (53-year-old married African-American mother, formerly homeless). This was an idea shared by many participants as a factor in both their becoming homeless and the difficulty in maintaining independent living.
Restrictive entry criteria prevent many homeless individuals from accessing programs and services. Criteria code was defined as the programs or services criteria that had to be met in order for an individual to receive services. "So we actually had to be on the streets before we could receive any help. We couldn't find a place that would help us either keep our place or have something right after it" (53-year-old African-American married female mother, formerly homeless).

Most participants describe mental health services as inaccessible, however some participants did describe some experiences with Department of Behavioral Health that were positive and that led to continued service utilization. Department of Behavioral Health services was coded DBH Help when participants shared that they had been provided some form of assistance from this agency. "Well through the behavioral health, the mental health part, they have schools, they have basically everything you need. They have job club, help you get a job, they place you, they have everything. I don't see anything
they would need to add basically they have everything” (42-year-old African American married male, currently homeless). This shows that when services met the needs of the participants, they were utilized.

**Dehumanization**

Dehumanization was coded when participants conveyed experiences of being treated less than human or being taken advantage of due to homeless and or mental health. “yeah they are mean to the homeless, like they throw trash like nothing you know (participant referencing feeling like being thrown out)” (62-year-old Mexican-Indian widowed female, formerly homeless). “How do you feel that service providers view the homeless?” “One out of ten will treat you like a person, once you are homeless it is a stigma it is like leprosy” (66-year-old African American divorced woman, formerly homeless). Society views the homeless as trash and not worthy of respect. This impacts the way that services are provided to the homeless.

**Discrimination**

Participants spoke of discrimination based upon age, gender, or race of an individual. “...the doctors would scorn you, they would not touch you, they would look at
you and say "oh whatever" ...I think it was because I was black" (66-year-old African American divorced woman, formerly homeless) “we (participant and husband) could not get gainful employment...and we did not see an interest in putting us in a career at our age” (53-year-old married African-American female, formerly homeless). Like dehumanization, discrimination is a way in which societal views are reflected in the way participants were treated by agencies and the community.

**Emotions**

Emotions described the relationship between the feelings associated with being homeless and the feelings about services. “There was a lot of anger when I finally got with this (program name) they put us in a group and the first thing we had to tackle was the anger and the anger wasn’t about the situation because life has its ups and downs the anger was the system” (53-year-old married African American female, formerly homeless). There were strong emotions felt by participants regarding both their homeless status as well as the services that they received.
Employment

Employment was coded and defined based on the participants stating repeatedly an importance and desire for having a job. “I just need a job to tell you the truth, I wish there was a place where they give you jobs, but they don’t give you jobs” (42-year-old African American single male, currently homeless). Comprehensive employment programs could alleviate much of the homelessness that plagues local communities.

Faith

Personal beliefs can often serve as protective factors for the homeless. Faith was coded when participants identified their beliefs as helpful in keeping them strong during hardships “so I was by myself but I think the Lord was with me” (62-year-old Mexican Indian widowed female, formerly homeless).

Family Separation

Family separation was a reoccurring code within interviews with participants and a significant cause of limited service utilization. This code was defined as families being separated, primarily in shelter atmospheres. “we’ll take her but the kid can’t come and we have no room for him” so am I actually going to go
into a shelter and my son and my husband are going out on the streets? No I don’t think so we are in the care together” (53-year-old married African American female mother, formerly homeless). Family members chose to remain on the streets rather than be split apart, indicating the need for services that serve the whole family.

Fear

This code was selected when participants expressed concern about their personal safety or their future. “Yeah it is dangerous I just find somewhere to sleep and that is it, I wake up really early like when the sun is coming up and get dressed and leave” (42-year-old single African-American male, currently homeless). This code provided a description of the daily existence of the homeless population.

Homeless Status

Homeless status was identified as how long the participant had been homeless. This included if they were chronically homeless, transitional homeless, or had multiple episodes of homelessness. “I was homeless for close to five years” (62-year-old Mexican Indian widowed female, formerly homeless). This was determined to be
important as those individuals who have been homeless for longer than one year or have had several episodes of homelessness are more likely to stay homeless.

Housing

While some agencies do offer housing to homeless individuals, this is infrequent and often inadequate. Housing was coded and defined in reference to participants identifying the housing services that they were offered. "they didn’t give me no place to live, they gave me a place to stay for like a week and that was it (participant referring to county agency)” (42-year-old single African-American male, currently homeless).

Housing and Mental Health

Many agencies offer services to address the mental health needs of the homeless, however participants rightly stated that it is nearly impossible to have good mental health without permanent housing. Housing and mental health defined the relationship between permanency of a home and an individual's mental health. "Give us a place to live because that is necessary, to get over your sickness you can not be in distress” (66-year-old African American divorced female, formerly homeless).
Lack of Information

While there are many agencies that offer services to the homeless or those living in poverty, few of the homeless actually knew about the services. Lack of information was defined when participants stated that they were unaware of available services and where to access these services. "I don’t know, I really don’t know of anything really (referring to available services" (25-year-old African American female, formerly homeless). Without the agencies reaching out to the homeless, it was up to the homeless to seek out resources.

Law Enforcement

The criminalization of the homeless is one of the many factors that keeps the homeless from reengaging into society. The code for law enforcement gives the participants perception of the relationship between the homeless population and the law enforcement. "They don’t have to call the police and automatically put (sic) into jail, because that is what is going on, they having people get arrested and put into jail that are mental health" (34-year-old single Caucasian female, formerly homeless).
Limited Funding

While some agencies seek to provide quality services, there are rarely able to provide comprehensive services to the full range of individuals in need. This is frequently due to limited funding. “then when we lost everything which happened around October we found out that they were not accepting anymore new clients until the beginning of the next year” (53-year-old married African American female, formerly homeless).

Medical Needs

Medical needs referred to physical health problems the individual was contending with. “...I got out of the hospital on the 4th of July because I had a heart attack because of all of the stress” (43-year-old African American wheelchair-bound female, homeless two years). Medical problems present as an additional barrier for homeless trying to obtain permanent housing and community reintegration.

Negative Attitude

Agencies can prevent service utilization through agency characteristics and personal characteristics. Negative attitude was specific to service providers having negative attitudes toward participants. “It’s like
he got tired of being asked to help and I got tired of asking for help." For homeless people who have faced significant adversity, a negative attitude can ensure that homeless do not utilize services. (53-year-old African American married male, formerly homeless)

**Partnership**

Homeless people are more likely to utilize services if they are made partners in their treatment. This gives them power in their lives and in the services that they receive. Partnership was identified as the participant feeling like a partner in the provision of services. "I finally found someone who would work with me" (53-year-old married African American married female, formerly homeless).

**Physical Environment**

The code described physical characteristics of an agency that contributed to participants not finding services welcoming therefore decreasing utilization. "and at night time you all you smellin' (sic) is people feet and stuff and you don’t even want to stay there" (42-year-old African American male, currently homeless).

"It is very hard you know to have your own privacy" (43-year-old African American disabled female, currently
homeless). These factors contribute to the utilization of services as people do not want to stay in a place that is physically distasteful.

**Positive Attitude**

Positive attitudes are an essential component to creating an agency where consumers feel welcomed. An example is "they were pretty helpful. You know, it was, it seemed like they had concern for the problem, they tried to get me in as soon as possible and that is the only place I had ever been that was that good" (48-year-old married Caucasian male, formerly homeless).

**Preventative Assistance**

Preventive assistance highlights the lack of preventative assistance available to homeless before they are identified as such. "so the whole thing was before we can help you, you have to actually be homeless, you can’t be going through the eviction" (53-year-old married African American female, formerly homeless). Most of resources that are dedicated to serving the poor are available to those who have completely exhausted their resources. Providing services to prevent homelessness would keep people from having to face many of the trials that they endure, and also would be more cost effective.
Quality of Life

Quality of life was coded as subjective perspectives from participants on their personal quality of life. "You don’t really do nothing (sic) but walk around trying to find somewhere to live and eat and all that, you know" (42-year-old single African American male, currently homeless). This provides a deeper insight into the daily experiences of the homeless population and the poor quality of life that they have while they are on the streets.

Resilience

Despite the challenges that they face every day, many homeless find the strength to overcome adversity. Resilience was coded and defined as individual factors that helped an individual survive. "We are functioning folks, we are the functioning disabled" (66-year-old divorced African American divorced female, formerly homeless).

Self Medication

Self medication was coded and defined when an individual described an experience of using a substance to medicate themselves. "there is a lot of the drugs, a lot of the people that are mental health patients are
self medications because they don’t get the medication, so what they are doing is self medicating so everything is normal and the minute you pull away the alcohol and drugs and they don’t have the medication they flip” (34-year-old single Caucasian female, formerly homeless).

Due to the daily trauma faced by the homeless many use drugs and alcohol to numb themselves. However, this also serves to prolong their homelessness and further ostracize them from society.

Self Refer

Self refer was defined when participants sought out services on an individual basis. “It was just overwhelming everything all at one time. It was overwhelming and I finally just stumbled into the Department of Behavioral Health and begged for help, crying like someone has got to help me, I don’t know if I am going to kill somebody or myself I haven’t decided which way I was going to go yet” (53-year-old married African American female, formerly homeless). Since there was limited outreach by agencies, individuals who were able to access services needed to have the capacity or desperation to seek help from any place where it could be found.
Service Gap

Due to the limited amount of available services and the vast number of people requiring assistance, most participants had to wait for months or years before they could receive assistance. Service gap was defined when participants experienced a period of time when services were unavailable. "It is a 4 to 8 year waiting list...nobody is going to survive the streets for 4 to 8 years" (34-year-old single Caucasian female, formerly homeless).

Service Termination

Those that were able to access resources often ended the relationship because they were treated poorly or because services were inadequate. Termination referred to participants voluntarily or involuntarily ending services received. "I was going there and I went there I guess for about 2 to 3 years and I just got tired of it, the doctor that I had I would try to go there and talk to him but it seems like all he wanted to do was issue meds out and I got tired of it because he really did not look for what I had to say" (53-year-old married African American male, formerly homeless).
A common experience among the homeless is being sent from agency to agency or county to county to use their resources, rather than the ones provided in their community. Shuffle references when a participant was moved from one program to another with minimal to no support from the previous agency. "When I am in San Bernardino they refer me to the LA mission...and LA refers me to Riverside and Riverside refers me back to San Bernardino, they go back you know what I am saying, they pass the buck" (34-year-old single Caucasian female, formerly homeless).

Another protective factor for the homeless is having people in their lives that shield them from the negative impact of homelessness. Social supports reflected the level of perceived support felt by the participant. "And god was good to me and a friend let me park the car in their driveway and I was able to stay there" (66-year-old divorced African American female, formerly homeless).

Society's view of the homeless bleeds into almost every interaction that a homeless person has with someone
that is not homeless. Stigma refers to the perceptions of the mentally and homeless within society and the mentally ill and homeless community as well. "...and a lot of times you hear they are not going to do nothing but buy drugs and they are not going to do nothing but buy alcohol. 70% of the time they might be right because a lot of people are homeless because of that, but what about the 30%?" (42-year-old African American married male, formerly homeless)

Suggestions for Improvement

After the first interview, it became apparent that participants had much to say about how agencies operated. Therefore, it was deemed appropriate to give participants an opportunity to convey suggestions for change for service providers. “give us a job make, so we can make money and get our own place to live” (42-year-old single African American male, currently homeless) and “they have to work with the police the homeless and the police together” (48-year-old married Caucasian male, formerly homeless).

Transportation

Access to resources is often dictated by physical location and availability of public transportation.
Transportation defined the availability or lack of availability of transportation to access services. "you know a lot of times I can’t make it to my doctor’s appointments because these buses really. Like yesterday I was out waiting for the bus the one that goes down (street name) and I was out there for an hour, I didn’t have to go anywhere important so I said screw it and went back home” (48-year-old married Caucasian male, formerly homeless).

**Trauma**

Most homeless people have been victims and experienced trauma. This code was defined as participants having an experience which they described as traumatic, or where their story was such that victimization could be assumed. An example is “she (referring to his wife) had a miscarriage in front of Stater Brothers and that was totally traumatic...that just broke us apart” (48-year-old married Caucasian male, formerly homeless). Another example is “the lady took $550 from my check to pay for my rent they were supposed to supply food, um and a bed and stuff and there were 5 people in the same room and once in a blue moon they would fix dinner and the rest of the time you had to find something to eat”
(48-year-old married Caucasian male, formerly homeless). These experiences further serve to paralyze and degrade homeless people.

**Word of Mouth**

The homeless community is resourceful and they are often the key disseminators of information about which agencies offer what services. Word of mouth describes service utilization occurred due to finding out about services from peers. "I just know about the food because I my mother in law, my boyfriend’s mom" (25-year-old single African American mother, formerly homeless)

**Data Interpretation**

Selective coding consists of creating links between open and axial codes. Codes were linked under similar themes to begin developing the theory of the data. The interpretation of the data revealed that service utilization was determined by the welcoming and unwelcoming nature of the agency. The data also suggested that agency behavior was reflective of society’s attitude towards the homeless. Individual protective factors can mitigate the consequences of homelessness. Each of these themes will be explored in this section.
Characteristics of a Welcoming Agency

Those participants who were actively participating in services described characteristics of the agency that resulted in utilization. These characteristics were coded as coordinated care, partnership, DBH help, and positive attitudes. Each of these factors contributed to the participants' use of the service and belief that the agency was helpful to overcome homelessness.

Positive attitudes of workers within the Department of Behavioral Health and ways in which the Department helped the recipients of services was a significant factor in service utilization. Participants described that at one or two of the agencies used, that workers were friendly and helpful. One participant stated that he felt listened to by his worker. These attitudes kept participants engaged in services.

Coordinated care was coded in order to describe participants describing services that addressed all areas of life. Most participants stated that services addressed only one area of functioning, such as food, shelter, or medications. Two participants stated that the agencies that they worked with helped them to meet multiple needs.
Partnership was identified as the agency including the participant in the provision of services. Participants identified that they felt that partnering agencies valued their input and allowed them to make decisions about how services were administered. This was deemed to be an important factor in service utilization as those participants who were not included in service provision were less likely to follow through with service agencies.

Department of Behavioral Health services was coded when participants shared that they had been provided some form of assistance from this agency. Some participants sought out assistance from DBH and were either turned away or were not given assistance. Others did seek out and receive assistance. These participants received assistance in obtaining resources such as Social Security, Section 8 housing, emergency housing, and food resources. Those who received such assistance were more likely to stay engaged in services.
Characteristics of A Welcoming Environment

Figure 1. Characteristics of a Welcoming Agency

DBH Help is defined by coordinated care, partnership, and positive attitude. These characteristics define a welcoming environment.

Characteristics of An Unwelcoming Agency

Agencies were defined as unwelcoming when barriers existed within an agency that deterred individuals from utilizing services. Of the three, this was the most significant barrier. Barriers in this category included outreach, program criteria, coordinated care, lack of funding, discrimination, and poor attitudes. None of the participants received outreach services informing them of what programs were available in their community. Many at the time of the interview, did not even know what other
services were provided at the agency site, other than food and clothing assistance. Three participants had been referred to County programs specifically for homeless assistance after seeking out mental health treatment, however they had to initiate contact. Finally, when they did find agencies that would assist with one particular need, only three were referred to other services that offered more comprehensive care.

When participants did seek out services, they often found that they did not meet the criteria for the specific program. One individual stated that she was able to find a program to help prevent eviction, but they only served parolees. Another woman stated that she sought assistance when she knew her family was going to be evicted, however the program could not assist her until she was actually homeless. Yet another participant was kicked out of one program due to not finding employment, even though she had not yet been stabilized on her psychiatric medication. Those seeking out assistance from welfare were unable to receive funding because they did not have an address. Two men stated that because they did not have identification, they could not receive help with any services, even food assistance. None of the
participants reported that the agency assisted them in any way in overcoming the criteria barriers.

Researchers also found through the data that participants had identified family separation as a characteristic of an unwelcoming agency. Individuals stated that often shelters would not allow the entire family to stay together. One woman stated that when she went to a shelter with her family, that the shelter would allow her to stay, but not her husband or teenage son. She chose to stay with her family in their car parked in the parking lot rather than leave her husband or son. Another man also stated that when he was able to locate a program that would assist him with housing, he and his wife could not stay together and he stated that the only reason why he ended up going into the program was because they would also house his wife, although it would be in a separate facility.

Lack of information was associated with lack of service utilization. One woman stated that she did not utilize mental health services because “they just give you a bunch of pills”. Eight of the eleven participants were unaware that there were programs that assisted homeless people with mental illness.
Coordinated care was another aspect of agencies that was identified as a barrier to utilization. Each agency specializes in one aspect of service. One agency provided assistance with food, another shelter, another medical care, etc. Only one participant stated that she received comprehensive services that encompassed all of these areas. While one woman was told she needed to obtain employment, she was not given any assistance in doing so. Another man stated that his case manager would drive him around to look for places to live, but the agency would not provide any financial assistance to cover move in costs or utilities. Several participants stated that they discontinued or were unsatisfied with mental health services because when they went, they were only given medication, and not assistance in any other area of functioning.

None of the participants stated that physical atmosphere of the agency was welcoming. In fact, many stated that this was a reason why they did not go to shelters or utilize services. One man stated that he would rather stay on the streets than spend a night in a shelter where he would have to smell men’s feet all night long and be kicked out before the sun came up. Another
woman stated that when she was able to get a quarter to call her case manager regarding an appointment, that she was told she had to call back to speak to another person regarding that and that the case manager could not simply transfer her.

Another aspect of unwelcoming was the attitude of the workers themselves. One man stated that he stopped attending services because his case manager always seemed like he was “tired of being asked for help, and I got tired of asking”. One man was yelled at when he went to get food that a worker had set aside for someone else. One man stated that when he would go to meet with his psychiatrist, that “he would already be writing the stuff out” before he even entered the room and that the psychiatrist would not spend any time talking with the man, but rather handed him a prescription and told him to come back at his next visit. Finally, one woman recalled that whenever she would complain about an aspect of service provision she was told that she did not have to use services at that location and was encouraged to leave.

Some participants experienced discrimination when receiving services. One woman was told that she could
only come to get food once per month, when others were allowed to come weekly. She stated that this was due to her skin color and accent, as other service recipients who were of different ethnic backgrounds did not have this restriction imposed. While this woman experienced racism at the agency level, most cited discrimination and racism at the system or society level and therefore, this will be discussed further in that section.

Participants reported dissatisfaction with the lack of partnership and inclusion in services. An example of this was one participant who stated that he was made to attend group therapy when he wanted individual therapy. He stated that he did not want to listen to other people’s problems, he just wanted help for his own. They reported that their doctors did not provide them with information about their condition or medical treatment.

The final aspect of unwelcoming agencies identified was lack of funding. A participant who was told she could not receive services until she was homeless returned to the same program one month later and was told that the years funding had been exhausted and that she would need to wait for five months until more funding was received. Others stated that they could not receive services
because agencies were full and did not have funding to help more individuals. One participant was sent to another county for services when her own county did not have the funds to assist her. This extended the amount of time that she spent homeless and living on the streets.

Unwelcoming Environment

Figure 2. Characteristics of an Unwelcoming Agency
An Unwelcoming environment is defined by all of these characteristics and leads to service termination.

**Societal View of Homelessness**

Aspects of unwelcoming agencies are also reflected in society’s view of the homeless. Stigma, transportation, discrimination, and law enforcement were all identified as problems existing within societal systems that limited service utilization.

Two participants reported symptoms of mental illness, but denied having a mental illness. One woman, who identified as having depression and anxiety stated that she did not utilize mental health services because she did not want to associate with “those people”. Another person identified that she had a mental illness but that she was not “nutty”, like others with mental illness. Each of these individuals used phrases indicating that they did not want the negative label given to people who have mental illness and that this label prevented them from using services. One woman identified herself by her mental illness rather than any other aspect of her life. Other participants also labeled themselves as “crazy” or indicated that they were inferior due to having a mental illness, indicating that
they had been labeled by others in such a way. Each of these exemplifies the way in which society stigmatizes individuals who have mental illness.

Discrimination and dehumanization were also sited as system and societal barriers to services. One man stated that he knew others looked at him differently because he was homeless. He reported witnessing passer-bys throwing trash at homeless people. Many participants identified with being called derogatory names and being harassed due to either their ethnicity or homeless status. One woman stated, “people are just mean to homeless. Like they throw trash like nothing, you know?”

Transportation was a barrier for several participants. They were often dependent upon public transportation, which they reported did not run on time and at convenient hours. Others stated that they had to walk everywhere because there was no system in place to get them funds for the bus. Participants had to go to several different service locations to get help and some could not access services due to lack of transportation and difficulty in getting to several different agencies.

The relationship between the homeless and law enforcement was described as tenuous and often
conflictual. Participants stated that they felt targeted by the police force and punished for their poverty or mental illness. Other participants reported that they did not have negative experiences with law enforcement themselves, but had witnessed the harassment of others. One woman attributed her lack of police interaction with the fact that she had access to hygiene supplies and therefore she never appeared to be homeless.

Societal View of Homelessness

Figure 3. Societal View of Homelessness

Society’s view of homelessness is characterized by stigma, which result in dehumanization, discrimination,
negative interactions with law enforcement and limited access to resources such as transportation.

Protective Factors

Personal characteristics that supported service utilization were resilience, social supports, faith, and word of mouth sharing of information. Participants who were able to overcome barriers and advocate for themselves were able to get assistance with housing and basic needs that others were not. For example, one woman stated that she was able to continue working with a particular program for long enough to obtain assistance with training for employment. She believed that with this assistance, she would be able to become independent and have stable housing.

The homeless community shares information about resources and services in local neighborhoods. This sharing of information can compensate for the lack of outreach from a given agency. Several participants stated that they only found out about services by talking with others, at their children’s schools and with other homeless individuals to locate the resources that they needed.
Faith is a belief system that participants stated gave them hope that their lives and their situations would improve. This belief, coupled with social supports allowed participants to overcome daunting challenges and continue fighting for survival and independence. Social support provided a natural defense for participants against external negative forces.

Figure 4. Protective Factors

Each of the above codes describes individual protective factors. Each demonstrates a different factor that serves to protect the individual from the negative effects of homelessness.
Conditional Matrix

The final step in data analysis was the combining of selective codes into one unified statement of theory, called the conditional matrix. The data suggested that service utilization is affected by the welcoming or unwelcoming nature of the agency. Society’s view of the homeless is reflected in unwelcoming agencies, however their remain individual protective factors that can shield the homeless individual from negative consequences of homelessness.

![Diagram of Conditional Matrix of Service Utilization]

Figure 5. Conditional Matrix of Service Utilization
Service utilization is affected by both the nature of the agency and individual protective factors. Societal views of homelessness are reflected in unwelcoming agencies.

Implications of Findings for Micro and/or Macro Practice

This study provides implications for both micro and macro social work practices. The data shows that micro practitioners need to be mindful of how their interpersonal interactions affect service utilization. Micro practitioners need to partner with consumers and provide services that meet all of the individual's needs. They need to maintain an attitude that is accepting and helpful, rather than judgmental. They need to work to ensure that they refer consumers to appropriate services. Finally, micro practitioners can work to enhance protective factors by empowering individuals.

Macro service practitioners can learn from the data that agencies need to provide services to a diverse population. Agencies need to have flexible criteria and create welcoming environments. Macro practitioners need to advocate for more funding so that agencies can provide comprehensive services. Finally, macro practitioners can
educate the community to eradicate discrimination and increase awareness regarding the needs of the homeless.

Limitations of Study

The limitations of this study include size, location, and limited population. Due to the in-depth nature of the interviews, the sample size was small and represented only the San Bernardino County area, which may not be representative of other counties. The location of the study is also limiting, as all participants were engaged in some aspect of services and therefore may not be fully reflective of the population. Additionally, due to the fact that neither researcher spoke Spanish, the needs of the Latino community were not explored, although they represent a significant portion of the community. The final limitation is that approximately half of the population were transitionally homeless and this population does not experience the full range of homeless experience.

Summary

This chapter summarized how data was analyzed and interpreted. The data interpretation was presented. The
implications for social work practice and the limitations of the study were also discussed.
CHAPTER FIVE
TERMINATION AND FOLLOW UP

Introduction

This chapter covers the termination process with individual participants and the study site. The methods of termination and means for communicating outcomes to the study site are also discussed.

Communicating Findings to Study Site and Study Participants

Findings will be provided to the agency through a final written report. Individuals who are no longer participating in services at the mission at the conclusion of the study will be able to access the report in the California State University library. Findings will be provided to California State University in the form of poster day and a written report.

Termination of Study

All participants were provided a debriefing statement. This was reviewed with each participant at the conclusion of their interview. Researchers were also available at the site for two weeks after the conclusion of the study to be available for further consultation,
however no participants utilized this. Finally, information was provided in the form a resource packet to several participants regarding available services in the area for continued support. Some individuals requested information on services to assist with employment, housing, and mental health. Researchers provided them with local community resources to meet these needs.

Ongoing Relationship with Study Participants

Due to the nature of the site and study parameters, no ongoing relationship will exist between the researchers and study participants. Information about available outside resources was given to the participants to address ongoing needs in the form of the resource packet and referral to agency representative.

Summary

This chapter discussed termination with individual participants and the study site. It identified where participants would have access to the research findings and how those findings were communicated with participants.
APPENDIX A

DATA COLLECTION INSTRUMENT(S)
DATA COLLECTION INSTRUMENT(S)

1. Do you have any questions before we begin?
2. What is your age? What ethnicity do you identify? What is your marital status?
3. How long have you been coming to the mission?
4. Are you currently homeless?
5. Is this the first time that you have been homeless?
6. When was the last time you had a permanent place to live?
7. What factors contributed to the loss of permanent housing?
8. Does the mission program offer any supportive services?
9. Have you used any of these services?
10. Are there other local services that you have used in the past?
11. If so, what services?
12. What was your experience regarding these services?
13. If you have not used services, why not?
14. Do you feel that you have experienced depression either currently or in the past?
15. Has depression impacted your daily life in any way?
16. Do you have anxiety that you feel is excessive?
17. Has anxiety impacted your daily life in any way?
18. Have you experienced something that you feel is traumatic?
19. Has this trauma had a lasting impact on your daily life?
20. Have you had any experiences which other people have told you are odd or unusual, such as hearing voices that no one else could hear?
21. Do you believe that mental health issues are problematic for you?
22. Have you ever been referred to mental health services?
23. Have you ever used mental health services?
24. If so, what were your experiences with mental health services?
25. What would you change about services?
26. Are there parts of the services that you felt were helpful?
27. If you have not used services, why not?
28. What types of services, if any would you be interested in receiving?
29. If current services were changed in some way, what changes would you like to see?
30. Would these changes be enough to prompt you to use services?
31. If you could tell service providers something that would help other homeless people, what would it be?
32. Is there anything else you would like us to know?
33. Are there any questions that you have for us?
APPENDIX B

INFORMED CONSENT
INFORMED CONSENT

This study is designed to better understand the reasons why homeless adults do or do not use mental health services. This study is being done by Amanda Card and Heather Sylvester under the supervision of Dr. Tom Davis, Professor of Social Work. This study has been approved by the Institutional Review Board, California State University, San Bernardino.

In this study, you will be asked to talk to us about mental health, using mental health and homeless services, and homelessness. The interview should take about 30 to 45 minutes to complete. The information from your interview will be kept private and will not be shown to anyone at the Central City Lutheran Mission. Your will not be asked to say your name during the interview and we will not attach your name to the information that you give. You may review a copy of the study report when it is done in September 2007 at Central City Lutheran Mission.

You do not have to participate in this study if you do not want to. Your decision to be or not to be involved in this study will not change any services that you are receiving from Central City Lutheran Mission. Even though we are not trying to bring up bad memories for you in the interview, it is possible that talking to us may be uncomfortable.

You can refuse to answer any questions that are upsetting to you or choose to leave the interview altogether. Also, you may speak with Michael Chavez, MSW for additional support. When you are done with the interview, you will receive more information about the study and a list of agencies in your area that can help you if you want. Please do not talk about your interview with others who may also be talking to us. You will also receive a $10 gift card for your participation. We hope that the information that you give us will be used by agencies to improve services to the homeless.

By checking the box below, I understand that the nature and purpose of this study has been explained to me and that I agree to participate. When I check the box, I am also agreeing that I am at least 18 years old.

Place a check mark here □  Today’s date: ____________________

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APPENDIX C

DEBRIEFING STATEMENT
Study of Mental Health Service Utilization by Homeless Adults

This study you have just completed was designed to study reasons why homeless or formerly homeless adults do or do not use mental health services. We asked you about your experiences with mental health services and reasons why you may not be using services now. This information will be used to better understand how mental health and homeless services can be improved.

Thank you for talking with us. The information that you gave will be very useful. If you have any questions about the study, please feel free to contact Dr. Tom Davis at the Department of Social Work at California State University San Bernardino at 909-537-5001. If you would like see the finished study, please contact Reverend Kalke at Central City Lutheran Mission in June, 2007. If you need additional support or services, please contact Mike Chavez MSW at the Central City Lutheran Mission at 909-381-6921. Mental health services may be obtained through Inland Behavioral and Health Services at 909-881-6146.
APPENDIX D

INFORMED AUDIO USE CONSENT FORM
PHOTOGRAPH/VIDEO/AUDIO USE
INFORMED CONSENT FORM
FOR NON-MEDICAL HUMAN SUBJECTS

As part of this research project, we will be making a audiotape recording of you during your participation in the interview. Please indicate what uses of this audiotape you are willing to consent to by initialing below. You are free to initial any number of spaces from zero to all of the spaces, and your response will in no way affect your participation. We will only use the audiotape in ways that you agree to. In any use of this audiotape, your name would not be identified. If you do not initial any of the spaces below, the audiotape will be destroyed.

Please indicate the type of informed consent

☐ Photograph  ☐ Videotape  XAudiotape

(AS APPLICABLE)

• The audiotape can be studied by the research team for use in the research project.
  
  Please initial: ______

• The audiotape can be played to subjects in other experiments.
  
  Please initial: ______

• The audiotape can be used for scientific publications.
  
  Please initial: ______

• The audiotape can be played at meetings of scientists.
  
  Please initial: ______

• The audiotape can be played in classrooms to students.
  
  Please initial: ______

• The audiotape can be played in public presentations to nonscientific groups.
  
  Please initial: ______

• The audiotape can be used on television and radio.
  
  Please initial: ______

I have read the above description and give my consent for the use of the photograph/videotape/audiotape as indicated above.

The extra copy of this consent form is for your records.

SIGNATURE ___________________________  DATE ___________________
REFERENCES


This was a two-person project where authors collaborated throughout. However, for each phase of the project, certain authors took primary responsibility. These responsibilities were assigned in the manner listed below.

1. Data Collection:
   Assigned Leader: Amanda Card
   Assisted By: Heather Sylvester

2. Data Entry and Analysis:
   Assigned Leader: Heather Sylvester
   Assisted By: Amanda Card

3. Writing Report and Presentation of Findings:
   a. Introduction and Literature
      Assigned Leader: Amanda Card
      Assisted By: Heather Sylvester
   b. Methods
      Assigned Leader: Amanda Card
      Assisted By: Heather Sylvester
   c. Results
      Assigned Leader: Amanda Card
      Assisted By: Heather Sylvester
   d. Discussion
      Assigned Leader: Heather Sylvester
      Assisted By: Amanda Card