Journal of Rural and Community Development

Unmet Needs of Homeless at a Shelter in an Area Undergoing Urbanization

Authors: Maranda Herner, Christopher Parker, Nicholas McClellan, Louise Muscato, & Elisabeth Guenther

Citation:
Herner, M., Parker, C., McClellan, N., Muscato, L., & Guenther, E. (2018). Unmet needs of homeless at a shelter in an area undergoing urbanization. *The Journal of Rural and Community Development*, *13*(2), 100-109.

Publisher:
Rural Development Institute, Brandon University.

Editor:
Dr. Doug Ramsey

ISSN: 1712-8277 © Journal of Rural and Community Development
www.jrcd.ca

Unmet Needs of Homeless at a Shelter in an Area Undergoing Urbanization

Maranda Herner
Western University of Health Sciences, College of Osteopathic Medicine of the Pacific Northwest
Lebanon, Oregon, USA
mherner@westernu.edu

Christopher Parker
Western University of Health Sciences, College of Osteopathic Medicine of the Pacific Northwest
Lebanon, Oregon, USA
cwparker@westernu.edu

Nicholas McClellan
Western University of Health Sciences, College of Osteopathic Medicine of the Pacific Northwest
Lebanon, Oregon, USA
nmcclellan@westernu.edu

Louise Muscato
Western University of Health Sciences, College of Osteopathic Medicine of the Pacific Northwest
Lebanon, Oregon, USA
lmuscato@westernu.edu

Elisabeth Guenther
Western University of Health Sciences, College of Osteopathic Medicine of the Pacific Northwest
Lebanon, Oregon, USA
eguenther@westernu.edu

Abstract

Background

Homelessness persists as a reality for many. Homeless individuals in smaller cities may face unique challenges.

Objective

This study aims to describe the current situation of the homeless at a shelter in a small city with rural surroundings to inform program development and resource allocation.

ISSN: 1712-8277
www.jrcd.ca

Methods

A cross-sectional, orally-conducted survey assessed demographics, service utilization and health status of a convenience sample of individuals using the services of a homeless shelter in Albany, Oregon. IRB approval was obtained (exempt status).

Results

A total of 37 individuals participated in this survey. Of those surveyed, 43% reported being homeless a year or longer, only 9% reported current employment, and 46% reported a past felony conviction. Despite 65% reporting a mental health diagnosis, only 33% of those diagnosed reported medication use. Considering general health, 59% report chronic pain and 19% report history of seizures.

Many of those surveyed reported having health insurance (75%) and visiting a healthcare provider within the last year (78%) and within the last month (43%).

Conclusions

Despite having some access to healthcare, attention to both physical and mental health problems is lacking. Furthermore, unemployment and long-term homelessness remain problems.

Keywords: homeless; rural; urbanization; health; unemployment

1.0 Introduction

Homelessness remains a reality for many despite the expansion of social programs, new focuses such as "housing first" (Waegemakers Schiff & Schiff, 2014), and a government plan to end chronic homelessness by 2017, recently extended from 2015 (Henry, Shivji, de Sousa, & Cohen, 2015). Although these programs have found some success, with the estimated number of homeless declining 11% since 2010, approximately 565,000 people remain homeless in the United States (Henry et al., 2015).

Although only 48% of homeless reside in major cities (Henry et al., 2015), most studies on homelessness are conducted in large urban settings. Populations outside of urban centers face unique challenges: less access to services, fewer housing options, and fewer employment opportunities. The situation may be compounded in former rural areas undergoing growth where new strains are placed on a community without established systems for social support.

Little research has been performed on the situation of the homeless in smaller cities. Providing assistance to this homeless population requires better knowledge of their current situation to identify needs and where available services have fallen short.

2.0 Objective

The objective of our study was to describe the current situation of the homeless at a shelter in a small city with rural surroundings. We hypothesized that a more in-depth understanding of this population may help inform program and policy development and identify resource needs.

3.0 Methods

Our study method was a cross-sectional survey that was administered orally to individuals using the services of the shelter to assess demographics, service utilization, and health status.

3.1 Study Population

This survey was administered to individuals at Albany Helping Hands Homeless Shelter (AHH) in Albany, Oregon. This facility provides shelter for the homeless in the city of 51,980 (U.S. Census Bureau, 2015) and the surrounding rural area. The Oregon Office of Rural Health defines "rural" as being greater than 10 miles from the nearest population center of 40,000 or more (Rural Definitions, 2015), by this definition, Albany was considered rural until 2000, when it first reached a population of 40,000 (U.S. Census Bureau, 2015).

The shelter includes both a dorm with 110 dorm room beds and one warming center unit with tables and chairs but no beds. On average, 85 individuals occupy dorm beds per night, and about 12 individuals spend the night in the warming center. The warming center remains open only during the winter months from 10 p.m. until 6 a.m.

When compared to the 2015 Point-in-Time survey's finding of 222 homeless individuals in Linn County (Oregon Housing and Community Services, 2015), this location would account for approximately 97 of the county's 222 homeless individuals (44%). Considering sheltered homeless individuals, this location includes approximately 85 of 154 sheltered individuals (55%).

3.2 Study Protocol

Research assistants administered surveys to a convenience sample based on their availability over a six-week period from February to March 2014.

Inclusion criteria consisted of all adults from both the warming center and the dorm present at the shelter between 9 p.m.-12 a.m. without regard to the day of the week. Exclusion criteria consisted of psychosis, incoherency, or incommunicability.

Before beginning each interview, research assistants explained the study purpose, protocol, confidentiality agreement, and the ability to decline any or all questions. Participants provided oral informed consent. No monetary gift or other incentive was provided.

3.3 Instrument

The survey instrument contained 38 questions covering the demographics, social service utilization, employment, and health, along with additional questions specific to AHH. This survey was developed by researchers from Western University of Health Sciences in collaboration with the shelter director and staff.

Definitions of Homelessness We define a homeless individual as either lacking adequate nighttime residence, having a nighttime residence in a public place not intended for sleeping, or having a residence in a shelter intended to provide temporary assistance. This definition is based on the one used in the McKinney-Vento Homeless Assistance Act (McKinney-Vento Homeless Assistance Act, 1986).

3.4 Data AnalysisWe compiled individual survey responses into a spreadsheet using Microsoft Excel. In this analysis, we excluded questions specific to AHH (e.g., how did you hear about AHH), questions with too few useable responses (e.g., what was your last blood pressure reading), and free response questions (e.g., how did you become homeless).

3.5 IRB Approval

Western University of Health Sciences provided institutional review board approval for this survey (exempt status).

4.0 Results

Over a six-week period, a total of 37 individuals completed the survey.

4.1 Demographics

Individuals responded to questions pertaining to demographic information, summarized in Table 1. The age of respondents ranged from 19 to 57 years with a median of 36. Of the sample, 70% were male, 73% possessed a high school diploma or GED, 11% were veterans, and 46% had past felony convictions. Nearly half (43%) of respondents reported being homeless one year or longer, half (54%) less than one year, and one individual (3%) reported not being homeless.

Most respondents reported being unemployed (91%). Of those unemployed, 19% have never been employed, 53% worked within the last five years, and 28% have not worked in the last five years.

4.2 Social Service Utilization

Questions assessed the utilization of some social services (see Table 1). Of the respondents, 84% reported receiving food stamps and 41% social security disability income (SSDI) or supplemental security income (SSI). 35% reported having children under 18 years old of which 31% reported a need for help with custody or child support when asked.

4.3 General Health Status

Respondents answered questions pertaining to their health insurance status and utilization of services (see Table 2). Generally, most respondents reported having insurance and using healthcare services. Specifically, when asked about health insurance coverage, 75% reported having health insurance, and of those who did not have insurance, 33% (three individuals of nine) specified a need for help applying. Considering utilization of healthcare services, 43% of all respondents had seen a healthcare provider within the last month and 78% within the last year. Respondents also stated being up-to-date on vaccines (82%), receiving an influenza vaccine in the past year (38%), and tetanus vaccine in the last ten years (86%).

Questions also assessed the prevalence of several health conditions. Respondents reported chronic pain most frequently (59%), followed by foot problems (46%), dental problems (35%), history of a seizure (19%), and diabetes (8%).

Table 1: *Demographic Information of Survey Respondents*

Characteristics	**N (%)**	**Respondents**
General		
Age in years - median [range]	36 [19-57]	37
Male	26 (70%)	37
Veteran	4 (11%)	37
Past felony conviction	17 (46%)	37
High School Diploma or GED	27 (73%)	37
Duration of Homelessness		
Not homeless	1 (3%)	35
>1 year	15 (43%)	35
<= 1 year	19 (54%)	35
Social Services		
SSDI/SSI	15 (41%)	37
Food Stamps	31 (84%)	37
Children under 18?	13 (35%)	37
If yes, need help with custody/child support?	4 (31%)	13
Employment		
Currently employed	3 (9%)	35
If no, time since last employment?		
Greater than 5 years	9 (28%)	32
Never	6 (19%)	32
Less than 5 years since last job	17 (53%)	32

Table 2: *General health information including insurance, utilization, and prevalence of common disorders among respondents*

	N (%)	Respondents
Insurance		
Health insurance	27 (75%)	36
If no, need help applying?	3 (33%)	9
Last Seen Healthcare Provider		
Within last month	16 (43%)	37
Within last year	29 (78%)	37
More than a year	8 (22%)	37
Vaccines		
Up-to-date on immunizations	27 (82%)	33
Influenza vaccine, past year	14 (38%)	37
Tetanus vaccine, past 10 years	31 (86%)	36
General Health		
Diabetes	3 (8%)	37
Hypertension	11 (30%)	37
Foot problems, currently	17 (46%)	37
Dental problems, currently	13 (35%)	37
Seizure, ever	7 (19%)	37
Interest in STD prevention info	6 (16%)	37
Chronic Pain		
Chronic pain	22 (59%)	37
Back	12 (55%)	22
Neck	5 (23%)	22
Shoulder	3 (14%)	22
Knee	7 (32%)	22

4.4 Mental Health Status

Mental health disorders, as shown in Table 3, were common among respondents. With 65% reporting a past diagnosis, though only 33% reported currently using a medication. Of disorders included in questioning, depression was present in 50% of those reporting at least one disorder, and bipolar disorder was also found in 50%. Following these were ADHD (42%) and schizophrenia (33%), with other disorders being specified by 38% of those with any disorder.

Assessment of substance use among respondents, also shown in Table 3, revealed use of alcohol by 32% and illicit drugs by 17%. When asked about whether a drug or alcohol treatment program would help them, 30% reported a program would be helpful.

Table 3: *Mental Health and Substance Use among Respondents*

	N (%) Responding Yes	**Total Number of Respondents**
Mental Health		
Do you consider yourself happy?	30 (81%)	37
Past Mental Diagnosis	24 (65%)	37
If yes, what diagnosis?		
Depression	12 (50%)	24
Schizophrenia	8 (33%)	24
Bipolar	12 (50%)	24
ADHD	10 (42%)	24
Other	9 (38%)	24
Using mental health medications currently?	7 (33%)	21
Substance use		
Alcohol use	12 (32%)	37
Illicit drugs	6 (17%)	36
Would drug/alcohol treatment help you?	11 (30%)	37

5.0 Discussion

Our study sought to describe a homeless population in order to better direct resource allocation while the surrounding area continues to urbanize. From this assessment, several findings have implications for resource allocation and service planning. For one, several factors limit employability including skills, the burden of service requirements, and a history of felony convictions. For another, despite having health insurance and contact with healthcare professionals, gaps in mental health care persist. Also, chronic general health problems are prevalent.

Finding employment was difficult for those surveyed, reflecting the fact that unemployment is a common problem among the homeless. In a review of surveys of older adults, financial and employment problems were ranked among the top causes of homelessness (Ng, Rizvi, & Kunik, 2013). In our survey, the high percentage of homeless who have not held a stable job in the past five years, or ever, suggests that job maintenance may be a common challenge.

Several factors may be responsible for low levels of employment. For one, homeless individuals often struggle with unfavorable job histories, inadequate clothing, lack of transportation access and poor job skills (Lee, Tyler, & Wright,

2010). Although 73% of individuals we surveyed reported having a high school diploma or GED, programs helping to impart highly valued job skills such as timeliness, reliability, and productivity could enhance job readiness and maintenance. Currently, the AHH shelter aims to develop these skills by requiring service from guests at the shelter's resale shop, farm, and woodlot. However, even with job skills, criminal history may restrict employment opportunities, as nearly half of those surveyed (46%) reported a past felony conviction. A program which provides assistance with job placement, applying for employment fidelity bonds or other legal assistance may help with obtaining employment after a conviction. A comprehensive employment program likely needs to address these two facets to produce tangible improvements.

Additionally, more subjective factors may also influence the employment situation in our study. Dorm residents work approximately 20-30 hours per week for AHH in exchange for room and board. They work at the AHH woodlot, garden, and resale shop in addition to cleaning, cooking, and staffing at the shelter. Many dorm residents have expressed the challenge of working at AHH while also applying for jobs, and, therefore, they quickly end their job searches. The shelter makes accommodations for individuals with jobs so as not to deter employment opportunities, but with the extreme difficulty in finding a job in Albany and the surrounding rural area, extensive job searches are often forfeited for the ease of exchanging 20-30 hours for food, a bed, and a dorm room. Furthermore, considering homeless individuals often prefer the company of other homeless people and benefit from the social support, a close-knit dorm community develops connections which can be hard to leave (Lee et al., 2010). Considering these factors of dorm reality that are often overlooked by simple percentages, the perseverance of long-term homelessness among the dorm residents seems more understandable. Addressing these factors is difficult and may require careful consideration towards restructuring programs to facilitate job searches while simultaneously addressing the immediate need for shelter.

Also of interest in our study, was the access to and utilization of health care. We found that 75% of those surveyed reported having health insurance and 78% have seen a healthcare provider within the last year, and 43% within the last month. Mental health disorders were prevalent, with 65% reporting having a diagnosed disorder. Only 33% (seven individuals) of all surveyed reported are currently using medication for managing their mental health despite eighth individuals reporting a past diagnosis of schizophrenia and 12 individuals reporting a past diagnosis of bipolar disorder. This mismatch between diagnosis and treatment suggests that care for mental health continues to lag and is possibly not attributable to a lack of access. This agrees with findings from studies in Massachusetts and Canada, where universal healthcare is available, which argue that increasing access alone is not enough to create substantial improvements in the health of the homeless (Bharel et al., 2013; Hwang et al., 2010).

Physical health problems, particularly seizures and chronic pain, also affected individuals surveyed. In our sample, a history of seizures was common, appearing in 19% of those surveyed. This number is similar to the 14.5% history of seizures in a homeless population reported by Laporte et al. (2006). In their study, 60% of seizures were attributed to epilepsy and 40% to alcohol-related seizures. The resulting prevalence of epilepsy was 8.1%, exceeding the estimated prevalence in the general population of less than 1%. We did not attempt to distinguish between

possible causes of seizures, but the high overall prevalence highlights the need for further investigating the need for epilepsy management in this population, especially considering the implications of an uncontrolled debilitating chronic disease. Chronic pain also affected 59% those surveyed in our study, compared to an estimated prevalence of 11% (Hardt, Jacobsen, Goldberg, Nickel, & Buchwald, 2008). A study of chronic pain treatment in the homeless found many physicians were reluctant to treat pain in the homeless. Physicians surveyed expressed concern for substance abuse, resulting in withholding treatment or using difficult prescribing methods such as single day or week supplies (Hwang et al., 2011). These findings highlight the fact that traditional healthcare delivery has difficulty assisting the homeless population, which necessitates population-specific intervention.

Considering the findings of this small exploratory survey, we see several implications for policy and resource allocation. Looking at difficulties with employment, it appears that a single approach, such as a jobs skills program, may not address the underlying difficulties with having a criminal history and transition from shelter life to the workforce. Additional research at other locations with a large sample size may clarify whether the difficulties seen here are present elsewhere, and inform the design of a more comprehensive program. For health conditions, both physical and mental, it appears access to healthcare alone does not translate into improved health status. More research into this disparity could suggest approaches to this problem. Possibly, a trial of different approaches such as a shelter-based program for coordinating care and monitoring treatment could improve care. Another possibility is a health skills program that could be incorporated alongside existing job skills programs. It is clear additional research is required to further our findings and solidify a course of action.

Several factors limited this study. Concerning overall study design, our small sample size from a single homeless shelter reduces the ability of this study's results to be considered reflective of the homeless elsewhere, even under similar circumstances. Additionally, we collected a convenience sample rather than using a systemic or randomized methodology, which introduces the potential for additional bias as respondents available at the times we conducted interviews may not be representative of the typical users of the shelter. Concerning the data collected, we performed no validation of answers, presenting the possibility of unchecked recall bias or inaccuracy due to reluctance disclosing information pertaining to topics such as substance use. We also did not collect data on race or ethnicity as part of the demographic information, and this information is potentially important for highlighting additional barriers that may be present. Despite these limitations, we feel this information provides new insight into challenges facing homeless individuals in a relatively understudied rural area undergoing urbanization.

6.0 Conclusion

In summary, we see several salient challenges facing a homeless shelter in a traditionally rural area undergoing urbanization. Unemployment and long-term homelessness remain problems. Despite having some access to healthcare, treatment for both mental and physical health problems remains inadequate. Further study of the challenges facing this population is needed.

References

Bharel, M., Lin, W.-C., Zhang, J., O'Connell, E., Taube, R., & Clark, R. E. (2013). Health care utilization patterns of homeless individuals in Boston: Preparing for Medicaid expansion under the Affordable Care Act. *American Journal of Public Health, 103*(S2), S311–S317. Retrieved from http://doi.org/10.2105/AJPH.2013.301421

Hardt, J., Jacobsen, C., Goldberg, J., Nickel, R., & Buchwald, D. (2008). Prevalence of chronic pain in a representative sample in the United States. *Pain Medicine, 9*(7), 803–812. Retrieved from http://doi.org/10.1111/j.1526-4637.2008.00425.x

Henry, M., Shivji, A., de Sousa, T., & Cohen, R. (2015). The 2015 Annual Homelessness Assessment Report (AHAR) to Congress.

Hwang, S. W., Ueng, J. J. M., Chiu, S., Kiss, A., Tolomiczenko, G., Cowan, L., … Redelmeier, D. A. (2010). Universal health insurance and health care access for homeless persons. *American Journal of Public Health, 100*(8), 1454–1461. Retrieved from http://doi.org/10.2105/AJPH.2009.182022

Hwang, S. W., Wilkins, E., Chambers, C., Estrabillo, E., Berends, J., & MacDonald, A. (2011). Chronic pain among homeless persons: Characteristics, treatment, and barriers to management. *BMC Family Practice, 12*(1), 1–9. Retrieved from http://doi.org/10.1186/1471-2296-12-73

Laporte, A., Rouvel-Tallec, A., Grosdidier, E., Carpentier, S., Benoît, C., Gérard, D., & Emmanuelli, X. (2006). Epilepsy among the homeless: Prevalence and characteristics. *The European Journal of Public Health, 16*(5), 484–486.

Lee, B. A., Tyler, K. A., & Wright, J. D. (2010). The new homelessness revisited. *Annual Review of Sociology, 36*, 501–521. Retrieved from https://www.annualreviews.org/doi/10.1146/annurev-soc-070308-115940

McKinney-Vento Homeless Assistance Act, 42 U.S.C. § 11301 et seq. (1986).

Ng, S., Rizvi, S., & Kunik, M. (2013). Prevalence of homeless older adults and factors causing their homelessness: A review. *The Internet Journal of Geriatrics and Gerontology, 8*(1), 1–8.

Oregon Housing and Community Services. (2015). Homelessness in Oregon: 2015 Point in Time Count. Retrieved from http://www.oregon.gov/ohcs/pdfs/2015-Point-In-Time-Count-Summary.pdf

Rural Definitions. (2015). Retrieved December 23, 2015, from http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/rural-definitions/index.cfm

U.S. Census Bureau. (2015). State & county Quickfacts: Albany city, Oregon.

Waegemakers Schiff, J., & Schiff, R. A. (2014). Housing first: paradigm or program? *Journal of Social Distress and the Homeless, 23*(2), 80–104.